DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EVM4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245275**

2.STATE VENDOR OR MEDICAID NO.
(L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDINA CARE & REHAB CENTER**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

4. TYPE OF ACTION: 7 (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/05/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Mary Bruess, HFE NEII — 05/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist 06/29/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/16/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245275

June 29, 2016

Mr. John Doughty, Administrator
Edina Care & Rehab Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

Dear Mr. Doughty:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 26, 2016 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 118 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

May 23, 2016

Mr. John Doughty, Administrator
Edina Care & Rehab Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275026

Dear Mr. Doughty:

On March 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 17, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 18, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 17, 2016, effective April 26, 2016 and therefore remedies outlined in our letter to you dated March 29, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245275 Y1	A. Building B. Wing Y2	5/5/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0282	Correction	ID Prefix F0311	Correction
Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(2)	Completed
LSC	04/26/2016	LSC	04/26/2016	LSC	04/26/2016
ID Prefix F0356	Correction	ID Prefix F0371	Correction	ID Prefix F0411	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.55(a)	Completed
LSC	04/26/2016	LSC	04/26/2016	LSC	04/26/2016
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	04/26/2016	LSC	04/26/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GA/mm	05/23/2016	32976	05/05/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/17/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245275	A. Building 01 - MAIN BUILDING 01 B. Wing	4/18/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/11/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 05/23/2016	SIGNATURE OF SURVEYOR 37009	DATE 04/18/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/17/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EVM4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245275**
2.STATE VENDOR OR MEDICAID NO.
(L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDINA CARE & REHAB CENTER**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/17/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **118** (L18)
13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Mary Bruess, HFE NEII — 04/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/10/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0250

March 29, 2016

Mr. John Doughty, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275026

Dear Mr. Doughty:

On March 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 26, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 17, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 0	F000 It is the policy of Edina Care and Rehab Center to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. F 1 The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of		F164 It is the policy of Edina Care and Rehab Center to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. All new hires are educated on Resident Bill of Rights which includes dignity and respect. This is also completed annually. To assure continued compliance, the following plan has been implemented:	

POC accepted 4/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/7/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement measures to ensure personal visual privacy for 1 of 1 resident (R100) during a wound dressing. Findings include: R100 was observed on 3/17/16, at 9:23 a.m. seated in her wheelchair in the living room facing the opened door, her legs wrapped with Kerlix (a dressing used to cover wounds). A licensed practical nurse (LPN)-A proceeded to perform a wound dressing change to R100's legs. The resident and LPN could easily be viewed by other residents, visitors (including the surveyor), and staff as they walked past the room. Five residents were eating breakfast in the adjacent dining room with one staff person, and the room was in full view of the living room. Following the observation at 9:30 a.m. R100 was interviewed. She stated the nurses usually performed the dressing change in her room, but "sometimes they do it here." LPN-A was interviewed at 9:35 a.m. explained, "We do the dressing change wherever the resident is comfortable doing it." LPN-A explained that although she preferred to perform it in R100's room, she did not want to go to her room,	F 164	Education was provided on the spot for this nurse at the time of survey. Care Plan and TAR for R100 was reviewed/revised on 3/28/16. All staff will be educated on this matter on April 13, 14 and 15, 2016. For other residents this may affect, Treatment/Dressing Change audits will be completed weekly for 4 weeks, monthly for 3 months and quarterly for three months. DON or designee responsible for compliance. Date of compliance April 26, 2016.	

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F 164	Continued From page 2 so she decided to do it in the living room. R100's significant change Minimum Data Set (MDS) assessment dated 2/3/16, identified the resident was moderately cognitively impaired and resisted care 1-3 times during the assessment period. R100 required limited assistance of one person with bed mobility, transferring, dressing, toilet use and personal hygiene. Skin issues were not addressed on the assessment. A registered nurse (RN)-A was interviewed on 3/17/16, at 10:01 a.m. explained that her expectation was that dressing changes be performed in a resident's room. RN-A explained that privacy should have been observed during dressing changes. RN-A stated, "I did not expect my nurse to do that...I've coaching to do." The director of nursing (DON) was interviewed on 3/17/16, at 10:43 a.m. explained R100 sometimes refused to go to her room for dressing change, but "we have a private room behind the nurse's desk we can use." The DON explained her expectations was staff to provide full privacy, and she would not expect a dressing change would be performed in the living room in full view of "everyone." The DON stated, "We are doing re-education on the spot and I will look into that." A facility policy was requested. The undated facility's Notice of Privacy Practices did not address personal privacy.	F 164		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

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F 282	Continued From page 3 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 1 of 3 residents (R103) reviewed for activities of daily living (ADLs). Findings include: R103's 11/17/13, care plan indicated the resident required staffs' assistance at meals to set up and provide adaptive equipment for eating. A care plan addition on 10/21/15, directed staff to assist with meal set up as needed, cueing and encouragement as needed. The staff was to provide finger foods as needed and to assist with eating when the resident was fatigued. R103's 5/18/14, care plan indicated the resident required assistance with morning cares due to cognitive deficits and limitations in mobility. The NAs were instructed to trim the resident's nails on bath day. R103's care plan also indicated R103 required extensive assistance with oral hygiene and combing hair. The resident had visual impairment and staff were directed to assist the resident to put on her glasses every day. R103 was observed on 3/15/16, at 10:57 a.m. The resident had a few long facial hairs on the front of her chin below her mouth approximately 1/2 to 3/4 of an inch, as well as a few shorter facial hairs on the bottom of her chin. In addition, her fingernails were long, of varying lengths,	F282	It is the policy of Edina Care and Rehab Center to provide each resident with services to meet their individual needs and preferences as defined in the resident's plan of care. To assure continued compliance, the following plan has been implemented: Care Plan for R103 was reviewed/revised on 3/28/16. Speech therapy evaluated her eating and swallowing on 3/10/16 and she continued to feed herself with no swallowing problems. Staff will continue to assist with feeding when resident is feeling tired. Nutritional interventions will remain as indicated on the care plan. Education for all staff completed on April 13, 14 and 15, 2016. For other residents this may affect, weekly weights have been initiated on all residents. A whole house grooming assessment was completed on 4/7/16. Grooming Audits and Dining Audits will be completed weekly for 4 weeks, monthly for 3 months and quarterly for 3 months. DON or designee responsible for compliance. Date of compliance April 26, 2016.	

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were jagged, and were soiled on the underside of the nails. The resident told the surveyor, "Sometimes they help me brush my teeth--I would want it more often."

R103's morning cares were performed on 3/16/16, at 8:13 a.m. by a nursing assistant (NA)-A. NA-A washed and dressed the resident in bed. NA-A and NA-B then assisted R103 into her wheelchair (w/c). NA-A combed the back of R103's hair and then assisted the resident to the dining area. NA-A did not set up or perform oral hygiene or provide R103 with her eyeglasses. The resident's teeth appeared unclean, and her nails and facial hair remained in the same condition as on the previous day.

At breakfast at 8:43 a.m. NA-A gave the resident a glass of orange juice, scrambled eggs and a banana. R103 ate in a dining area adjacent to the main dining area with her back to the entrance. R103 began feeding herself, taking several bites, not swallowing and spilling the food on her clothing protector. Although staff intermittently entered and left the dining area, they were not present the majority of the time R103 ate her breakfast. As R103 fed herself, she coughed and removed the pancake out of her mouth with her fingers. She quickly ate a banana, and at 8:50 a.m. NA-B asked the resident, "How was your banana?" Without waiting for R103's reply, NA-B turned and left the dining area. A trained medication assistant (TMA)-A gave the resident an ice cream cup. At 9:01 a.m. R103 picked up a large amount of pancakes on her spoon, touched to her mouth and then returned them to the plate uneaten. At 9:08 a.m. a NA walked into the dining area and past R103. Two large pieces of

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F 282	Continued From page 5	F 282		

pancake were on the clothing protector. R103 ate her ice cream, however, most of the eggs and pancake remained on the plate and resident's clothing protector. At 9:20 a.m. R103 sat alone at the table in the dining area head down with her eyes closed.

R103 was seated in her w/c in the small dining area on 3/17/16, at 8:43 the resident was wearing eyeglasses. The resident's chin hair and nails continued to be untrimmed and her nails were dirty. NA-B placed a clothing protector around R103's neck, handed her a cup of coffee and warned the resident, "Be careful the coffee is hot!" and left the area. At 9:01 R103 had eaten just the inside of her pancake. At 9:16 she attempted to eat strips of bacon, however, it fell onto her clothing protector. No staff were present in the dining area. At 9:23 the resident picked up the outer ring of her pancake with syrup and tried to eat it, but it also fell onto the clothing protector. RN-B set an ice cream container on R103's plate and walked away. The resident ate the ice cream. NA-B then stood by R103, offering her a bite of food.

The surveyor then alerted RN-A of R103's failed attempts to feed herself. RN-A instructed NA-B, "You need to sit down to feed." NA-B responded, "Oh no, she is an independent eater!" and then left the dining area. RN-A sat down by R103 and asked her, "Would you like me to help you eat?" R103 answered, "Okay." RN-A warmed the remaining food in the microwave. RN-A sat with R103 and assisted her to eat the rest of her breakfast. At 9:32 a.m. RN-A told NA-C and NA-D, "Going forward one staff needs to sit down at the table at meals and she needs assistance

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F 282	Continued From page 6 with eating." On 3/17/16, at 10:59 a.m. the director of nursing (DON) stated residents' nails should have been looked at least daily during cares and trimmed as needed, at least weekly with bathing. In addition, the DON said oral care was to definitely be provided for residents daily. Unwanted facial hair was to be taken care of daily as needed, as well as on shower days. The DON expected staff to follow residents' care plans. A 2006, Nails, Care of (Finger and Toe) policy indicated, "PURPOSE 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems." A 2006, Oral Hygiene policy indicated, "PURPOSE 1. To cleanse mouth, teeth and dentures...To promote personal hygiene PROCEDURE NOTE: OFFER ORAL HYGIENE BEFORE BREAKFAST, AND AT BEDTIME." The facility's Care Plan Policy and Procedure, revised 3/12, indicated, "The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible."	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 311		

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F 311	Continued From page 7 Based on observation, interview and document review the facility failed to provide assistance with grooming and eating for 1 of 3 residents (R103) reviewed for activities of daily living (ADLs). Findings include: R103 was observed on 3/15/16, at 10:57 a.m. The resident had a few long facial hairs on the front of her chin below her mouth approximately 1/2 to 3/4 of an inch, as well as a few shorter facial hairs on the bottom of her chin. In addition, her fingernails were long, of varying lengths, were jagged, and were soiled on the underside of the nails. The resident told the surveyor, "Sometimes they help me brush my teeth--I would want it more often." R103's morning cares were performed on 3/16/16, at 8:13 a.m. by a nursing assistant (NA)-A. NA-A washed and dressed the resident in bed. NA-A and NA-B then assisted R103 into her wheelchair (w/c). NA-A combed the back of R103's hair and then assisted the resident to the dining area. NA-A did not set up or perform oral hygiene or provide R103 with her eyeglasses. The resident's teeth appeared unclean, and her nails and facial hair remained in the same condition as on the previous day. At breakfast at 8:43 a.m. NA-A gave the resident a glass of orange juice, scrambled eggs and a banana. R103 ate in a dining area adjacent to the main dining area with her back to the entrance. R103 began feeding herself, taking several bites, not swallowing and spilling the food on her clothing protector. Although staff intermittently	F	F311 It is the policy of Edina Care and Rehab Center that each resident is given the appropriate treatment and services to maintain or improve his or her abilities. To assure continued compliance, the following plan has been implemented: Care Plan for R103 was reviewed/revised on 3/28/16. Speech therapy evaluated her eating and swallowing resident and she continued to feed herself with no swallowing problems. Staff will continue to assist with feeding when she is feeling tired. Nutritional interventions will remain as indicated on the care plan. Education for all staff completed on April 13, 14 and 15, 2016. For other residents this may affect, weekly weights have been initiated on all residents. A whole house grooming assessment was completed on 4/7/16. Grooming Audits and Dining Audits will be completed weekly for 4 weeks, monthly for 3 months and quarterly for 3 months. DON or designee responsible for compliance. Date of compliance April 26, 2016.	

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entered and left the dining area, they were not present the majority of the time R103 ate her breakfast. As R103 fed herself, she coughed and removed the pancake out of her mouth with her fingers. She quickly ate a banana, and at 8:50 a.m. NA-B asked the resident, "How was your banana?" Without waiting for R103's reply, NA-B turned and left the dining area. A trained medication assistant (TMA)-A gave the resident an ice cream cup. At 9:01 a.m. R103 picked up a large amount of pancakes on her spoon, touched to her mouth and then returned them to the plate uneaten. At 9:08 a.m. a NA walked into the dining area and past R103. Two large pieces of pancake were on the clothing protector. R103 ate her ice cream, however, most of the eggs and pancake remained on the plate and resident's clothing protector. At 9:20 a.m. R103 sat alone at the table in the dining area head down with her eyes closed.

On 3/17/16, at 8:43 a.m. R103 was seated in her w/c in the small dining area wearing eyeglasses. The resident's chin hair and nails continued to be untrimmed and her nails were dirty. NA-B placed a clothing protector around R103's neck, handed her a cup of coffee and warned the resident, "Be careful the coffee is hot!" and left the area. At 9:01 R103 had eaten just the inside of her pancake. At 9:16 she attempted to eat strips of bacon, however, it fell onto her clothing protector. No staff were present in the dining area. At 9:23 the resident picked up the outer ring of her pancake with syrup and tried to eat it, but it also fell onto the clothing protector. RN-B set an ice cream container on R103's plate and walked away. The resident ate the ice cream. NA-B then stood by R103, offering her a bite of food.

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The surveyor then alerted RN-A of R103's failed attempts to feed herself. RN-A instructed NA-B, "You need to sit down to feed." NA-B responded, "Oh no, she is an independent eater!" and then left the dining area. RN-A sat down by R103 and asked her, "Would you like me to help you eat?" R103 answered, "Okay." RN-A warmed the remaining food in the microwave. RN-A sat with R103 and assisted her to eat the rest of her breakfast. At 9:32 a.m. RN-A told NA-C and NA-D, "Going forward one staff needs to sit down at the table at meals and she needs assistance with eating."

R103's weight on 2/23/16, was 121.4 pounds, and on 3/8/16 she weighed 116 pounds. A 3/13/16, progress note indicated the resident's weight "is down" and the resident "may benefit from more assistance with dinner meal, staff are to feed, provide more cueing and encouragement" as needed. A subsequent weight was not recorded on her bath day on 3/16/16.

The 11/17/13, care plan for R103's eating indicated the resident required staffs' assistance at meals to set up and provide adaptive equipment. A care plan addition on 10/21/15, directed staff to assist with meal set up as needed, cueing and encouragement as needed. The staff was to provide finger foods as needed and to assist with eating when the resident was fatigued.

R103's 5/18/14, care plan indicated the resident required assistance with morning cares due to cognitive deficits and limitations in mobility. The

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NAs were instructed to trim the resident's nails on bath day. R103's care plan also indicated R103 required extensive assistance with oral hygiene and combing hair. The resident had visual impairment and staff were directed to assist the resident to put on her glasses every day.

R103's 1/20/16, annual Minimum Data Set indicated the resident had dementia and severely impaired cognition. Although she displayed occasional verbal behaviors, she did not exhibit rejection of care during the assessment period. R103 required extensive assistance to groom and was fully dependent to bathe. She had adequate vision with the use of corrective lenses. R103 required supervision, oversight, encouragement, and cueing for eating.

On 3/17/16, at 8:15 a.m. NA-B explained that residents' nails were trimmed on their shower day, and fingernails were cleaned when they were dirty. NA-B said she assisted residents to brush their teeth during morning cares unless a resident refused the care. NA-B stated she also trimmed female resident's facial hair when she noticed them, and made sure she removed the facial hair after their showers.

RN-A stated on 3/17/16, at 9:41 a.m. she expected staff to clean residents' nails with weekly bathing and when nails were dirty. Oral care was completed daily. RN-A stated R103's bath day was Wednesday, and she had been given a bath the day prior.

Following the interview with RN-A, NA-D explained she ensured residents' nails were cleaned on bath days and in between if needed.

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F 311	Continued From page 11 NA-D stated residents' teeth were brushed with morning cares and female facial hair was trimmed after a resident's weekly bath or when it was noticeable. On 3/17/16, at 10:59 a.m. the director of nursing (DON) stated residents' nails should have been looked at least daily during cares and trimmed as needed, at least weekly with bathing. In addition, the DON said oral care was to definitely be provided for residents daily. Unwanted facial hair was to be taken care of daily as needed, as well as on shower days. The DON expected staff to follow residents' care plans. A 2006, Nails, Care of (Finger and Toe) policy indicated, "PURPOSE 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems." A 2006, Oral Hygiene policy indicated, "PURPOSE 1. To cleanse mouth, teeth and dentures...To promote personal hygiene PROCEDURE NOTE: OFFER ORAL HYGIENE BEFORE BREAKFAST, AND AT BEDTIME."	F 311		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed	F356	It is the policy of Edina Care and Rehab Center to maintain a current and up to date daily staffing document per State guidelines. A New corporate staffing post has been developed and was put into place on 3/15/16. Education to the staffing	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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F 356	Continued From page 12 vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide an accurate census sheet (daily staffing schedule). This had the potential to affect all residents as well as visitors and staff. Findings include: On 3/17/16, at 1:53 p.m. the staffing manager (SM) explained that one of the health unit coordinators (HUC)-A was a trained medication assistant (TMA) and nursing assistant (NA). When scheduled to work as a TMA, she was counted in the posting as a NA. The SM also said if a nurse called in sick and needed to be	F 356	coordinator, managers and supervisors who will be ensuring this is in place and accurate and will be updated as needed was completed on April 13, 14 and 15, 2016. Staff posting audits will be completed weekly for 4 weeks, monthly for 3 months and quarterly for 3 months. DON or designee responsible for compliance. Date of compliance April 26, 2016.	

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F 356	Continued From page 13	F 356		

replaced with a TMA, she did not indicate the change on the posting. SM said she posted the daily information when she arrived at work in the mornings, Monday through Friday. She did not update the posting if scheduling changes were made. The SM explained that schedule changes occurred such as a registered nurse was replaced with a licensed practical nurse or vice versa. The SM also stated nurses were also sometimes replaced by a TMA. Sometimes nurses worked longer or shorter shifts because other staff had called in, and she was unaware the posting needed to be updated. SM verified the 3/16/16, census sheet (daily staffing schedule) was inaccurate as HUC-A had worked as a TMA in the morning when a nurse called in, which was not reflected in the posting. The SM stated when she came in on Monday mornings typically Friday's posting was still hanging on the wall. The facility had no procedure for another staff person designated to replace the posting on the weekends and making changes as necessary to reflect the facility's actual staffing on the weekends. The SM said the facility did not have a related policy, but she planned on creating one. The SM stated that on 3/14/16, the administrator had looked at the daily staffing schedule and said it looked "fine."

Nursing staff schedules dated 1/16, 2/16, and 3/16 indicated changes in nurse staff originally scheduled and those who actually worked the shift. The Census sheets (daily staffing schedules) that had been posted for 1/16, 2/16, and 3/16, however, did not reflect those changes.

The administrator reported on 3/17/16, at 2:25 p.m. he was unaware the Census sheets were

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F 356	Continued From page 14 not being posted daily on the weekends as required.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure microwaves and ice machines were kept clean and in good repair. This had the potential to impact 90 of 93 residents in the facility who may have consumed food and fluids from those sources. Findings include: An initial tour of the main kitchen and units was completed on 3/14/16, at 12:00 p.m. with the the dietary supervisor (DS). The following concerns were noted and confirmed by the DS: 1) Ice and water machines on the main kitchen, 1st, and 2nd floors all had brown and white (lime-type) build-up on the grates below and in the ice and water spouts. The DS confirmed the presence of the substance, but was unable to identify the substance. The air filters on the	F	F371 It is the policy of Edina Care and Rehab Center to procure food from sources approved or considered satisfactory by Federal, State or local authorities and to Store, prepare, distribute and serve under sanitary conditions. To assure continued compliance, the following plan has been implemented: All of the Ice making/water machines in the building were cleaned and disinfected the week of 3/14/16. They will be on a monthly cleaning schedule. Starting in April 2016. Audits on the ice making/water machines will be done weekly for 4 weeks, monthly for 3 months and quarterly for 3 months. Education to the maintenance staff regarding the cleaning of the ice/water machines and the importance of schedule cleaning and maintenance was completed on 4/18/16	

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F 371	Continued From page 15 machines were also coated with dust. The 1st floor ice machine's front panel door was loose and hanging down. The DS explained maintenance staff was responsible for cleaning and maintaining the ice and water machines. 2) The microwaves in the main kitchen, 2nd floor and 3rd floor south all had brown sticky food build-up on the insides. The DS reported the microwaves were dirty and were used to warm residents' food. The DS explained dietary staff was responsible for cleaning the main kitchen microwave and the housekeeping staff was responsible for cleaning microwaves on the units. On 3/16/16, at 12:00 p.m. the dietary manager (DM) was interviewed and explained maintenance was responsible for ice machines and housekeeping was responsible for cleaning unit microwaves. The DS explained all ice machines and microwaves "have now been cleaned...." On 3/16/16, at 1:42 p.m. the director for environmental services (DES) was interviewed, and said ice machines were cleaned quarterly and sometimes more frequently if needed. The DES explained the ice machine were "cleaned in February and we just did it a couple of days ago." Although the manufacturer's guidelines suggested cleaning every six months, "if they are dirty we try to do it monthly." The DES confirmed housekeeping was responsible for cleaning microwaves on the units, but a specific schedule was not available. A Preventative Maintenance schedule for ice machines directed, "define and clean	F 371	The Director of Maintenance will be responsible for compliance. Date of Compliance April 26, 2016 The microwaves in the building were cleaned and inspected on 4/18/16. The microwaves will be on a weekly cleaning schedule which will start in March. The maintenance/housekeeping staff was educated on the importance of weekly cleaning of the microwaves on 4/18/16. The Director of Maintenance will be responsible for compliance. Date of Compliance April 26, 2016.	

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F 371	Continued From page 16 compressor monthly." The schedule indicated ice machines were cleaned and the water filters changed on 2/18/16. On 3/9/16 it read, "ok." A manufacturer's manual for Follet Ice and water dispenser cleaning--from manual part #208595R11" titled Icemaker Cleaning and Sanitizing directed, "Periodic cleaning of Follet's icemaker system is required to ensure peak performance and delivery of clean, sanitary ice. The recommended cleaning procedure which follow should be performed at least as frequently as recommended below or more often if environmental conditions dictate." A facility's 2010 Cleaning Instructions: Microwave Oven directed, "The microwave oven will be kept clean, sanitized and odor free."	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced	F411	It is the policy of Edina Care and Rehab Center to ensure all residents have access to routine and emergency dental care. To assure continued compliance, the following plan has been implemented: Family was contacted regarding continued dental care. They signed the dental consent on 3/22/16. On-Site Dental will be in the building on April 11, 2016 and she will be seen at that time. For all other residents this may effect, The Social Service Department is going through each chart to ensure	

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F 411	Continued From page 17 by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 2 residents (R167) reviewed for dental care. Findings include: R167 reported during an interview on 3/14/16, at 4:25 p.m. "I need teeth on the bottom. I told them I wanted to go to the dentist!" The resident pointed to her mouth, where missing teeth were noted on the front and bottom. R167 emphatically stated, "Many times I told them I wanted to go to the dentist, but I have no appointment!" R167's significant change Minimum Data Set dated 2/17/16, was marked "obviously or likely cavity or broken natural teeth." The corresponding Care Area Assessment summary indicated "has missing teeth, broken and possible decaying teeth in her mouth. She does wear a lower denture...has gone off hospice--to see dentist." On 3/16/16, at 12:54 p.m. a licensed practical nurse (LPN)-B stated Apple Tree dentistry visited the facility quarterly and that the health unit coordinator (HUC)-A scheduled all of the Apple Tree appointments. At 1:00 p.m. R167 stated she had requested a dental appointment as she needed two teeth in the front, but she had not seen a dentist. R167 explained her partial had been lost at the hospital prior to her admission to the facility. She had talked to "a lady and a guy" at the facility about the need for an appointment.	F	consents are signed and visits are up to date, this will be completed by April 15. Dental Consent/examination audits will be completed weekly for 4 weeks, monthly for 3 months and quarterly for 3 months. DON or designee responsible for compliance Date of compliance April 26, 2016.	

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F 411	Continued From page 18 On 3/16/16, at 1:23 p.m. a licensed social worker (LSW)-A explained that at the beginning of last week R167 had requested assistance in making a dental appointment. LSW-A stated R167 was upset about her appearance related to the missing teeth, and she wanted a full set of teeth "so she could smile." LSW-A stated a day or two later R167's son also approached him about it. R167's son reported that "somewhere in the discharge" from the hospital and the resident's admission to the facility, her bottom partial went missing. LSW-A had not yet made any progress on securing an appointment for R167. HUC-A was responsible for scheduling appointments and transportation, and LSW-A had not informed her the resident needed an appointment. LSW-A said although follow up was needed, but there was a concern regarding insurance The resident was admitted to the facility on hospice, but this had ended as of 2/5/16. LSW-A wanted to confirm Medicare would cover the cost of the partial, but this had not been completed yet. LSW-A stated there were no social work notes in R167's record regarding the dental situation. HUC-A then explained at 1:36 p.m. Apple Tree dentistry had been at the facility last Thursday 3/10/16, but R167 could not be seen because there was no signed consent for treatment available. HUC-A explained consents were signed at the time of a resident's admission and then were reviewed quarterly at care conferences. HUC-A stated she had informed the licensed practical nurse (LPN-C) "last week" that R167's family needed to sign a new consent form for her to be seen by the dentist. The dentist was not scheduled at the facility again until April. After	F 411		

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verifying there was no signed consent form available, HUC-A said she would put a blank form on the bulletin board so the nurses could obtain the required signature from R167's son.

At 1:54 p.m. LPN-C stated she did not recall HUC-A asking her to obtain consent from R167's son. LPN-C stated she saw R167's son at the facility three times a week.

The following morning at 7:52 a.m. on 3/17/16, a registered nurse (RN)-A stated she had a signed consent form from R167's son from the resident's last care conference. RN-A then looked through folders and in the computer, but stated she had been mistaken. Although R167 had requested at the last care conference to see a dentist, her son was not present and no consent form had been signed. RN-A said HUC-A would not have been able to coordinate the dental visit until this was available, and it was her responsibility to obtain it. RN-A said she would ensure consent was obtained so R167 could be seen for needed dental work.

A 2/22/16, care conference summary note for R167 indicated the resident "would like to see the dentist, RN to set up appointment for resident."

R167's care plan dated 12/31/15, directed staff to, "Ensure dentures are in place and rinse dentures after each meal" R167's care plan did not note the resident had missing or broken teeth, or had a missing partial, nor the resident's request to see a dentist.

The director of nursing (DON) stated on 3/17/16, at 10:50 a.m. in-house dentistry was provided, or

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F 411	Continued From page 20 a resident could go out to see their own dentist. It was RN-A and HUC-A's responsibility to obtain the signed consent forms. After consent was obtained, HUC-A coordinated the appointment. Since R167's son visited frequently, consent should have been "more than accessible." If a resident consistently required dental visits, it should have been noted on the resident's care plan. The facility's 8/09, Dental Care policy indicated, "The facility will meet the dental needs of the residents, to ensure quality of life, proper nutrition, dignity, and psychosocial well-being...Referrals will be made to the dentist as needed, per MD [medical doctor] order and approval of resident/responsible party...Social services will assist with in determining provider, and will assist with any issues related to payment/financial resources necessary...Health Unit Coordinator or designee will make the residents appointment with the provider of choice...Health Unit Coordinator or designee will inform resident and family of appointment, and determine if the family will provide transport...In addition to on-going assessment by staff when doing care, dental needs will be reviewed at quarterly care conferences as identified on the care conference summary form."	F 411		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 21 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete wound dressing changes in a manner that minimized contamination for 1 of 1 resident (R100) whose wound dressing change was observed, and to	F 441	F441 It is the policy of Edina Care and Rehab Center to follow all infection control measures to prevent the spread of infection and communicable diseases. The facility received all new glucometers on 3/25/16. The cleaning and disinfecting directions in the glucometer manual match the state requirements. This procedure was copied and will be placed with each glucometer, along with the required cleaning wipes after the education to the nurses on April 13 ,14 and 15, 2016. Audits on glucometer use and cleaning will be completed weekly for 4 weeks, monthly for 3 months and quarterly thereafter. DON responsible for compliance. Date of compliance April 26, 2016	

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F 441	Continued From page 22 properly sanitize a glucometer for 1 of 1 resident (R85) whose blood sugar testing was observed. This practice also had the potential to affect two additional residents who shared the glucometer. Findings include: R100 was observed on 3/17/16, at 9:23 a.m. seated in her wheelchair in the living room where a licensed practical nurse (LPN)-A was performing a dressing change. The resident's legs were wrapped with Kerlix (a dressing used to cover wounds). Supplies were on the carpeted floor, including tape, scissors, and the clean Kerlix dressing. LPN-A unwrapped the dressing from R100's legs and placed the dirty dressing on the carpeted floor. Without changing the contaminated gloves, LPN-A picked up the clean Kerlix from the floor and wrapped it on R100's legs. She then picked up the scissors from the floor and cut the dressing to size. LPN-A then picked up the tape from the floor and taped the dressing together. LPN-A then picked the soiled dressing from the floor and placed it in the trash container. With same gloves, LPN-A picked up the scissors and tape, walked across the dining room to the nurses' desk, where she placed both the tape and scissors in a container. LPN-A then removed her contaminated gloves. Following the observation at 9:35 a.m. LPN-A was asked about infection control practices a.m. LPN-A stated, "The dressing did not have any drainage, so I didn't see any issue with infection control." R100's significant change Minimum Data Set assessment dated 2/3/16, revealed diagnoses	F 441		

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including dementia and diabetes. The resident was moderately cognitively impaired and rejected care 1-3 times during the assessment period. Skin problems were not identified on the 2/3/16 assessment, and the resident required limited assistance of one person with bed mobility, transferring, dressing, toilet use and personal hygiene.

A registered nurse (RN)-A was interviewed on 3/17/16, at 10:01 a.m. explained that proper infection control practices should have been used during dressing changes. RN-A stated, "I did not expect my nurse to do that...I've coaching to do."

The director of nursing (DON) was interviewed on 3/17/16, at 10:43 a.m. said her expectation was for staff to adhere to their infection control program regarding dressing changes. The DON stated, "We are doing re-education on the spot and I will look into that."

A facility's 2015, Infection Control Program directed that, "The infection control program exists to assure a safe, sanitary and comfortable enviroment for residents and personal. It is designed to help prevent the development and transmission of disease and infection."

R85's blood glucose testing was observed on 3/16/16, at 8:52 a.m. performed by LPN-D. LPN-D washed his hands, donned gloves, wiped R85's finger with an alcohol wipe and then stuck R85's finger. LPN-D then took a sample of blood from R85 using a glucose test strip, obtained the reading and told R85 he would return to administer her insulin. LPN-D walked to the medication cart, opened a drawer, and without

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	245275	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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sanitizing the glucometer, placed the plastic container with the unclean glucometer into the medication cart. LPN-D then drew up R85's insulins and administered it to the resident. Following the insulin administration, LPN-D put the insulins away and reported he was finished. LPN-D was asked if there was anything else he needed to do involving the blood sugar administration and replied, "No." When asked about sanitizing the glucometer, LPN-D stated he normally did this after he was finished using the computer, but would show the surveyor the process. LPN-D attempted to don a small glove and wiped the glucometer with a Sani Wipe cloth. LPN-D then pulled the glove all the way on his hand and donned a second glove. He took a second Sani Wipe and wiped the glucometer using the first and second wipe together, and placed the glucometer and the wipes into a plastic cup. LPN-D explained the glucometer needed to be wrapped with the wipes for at least two minutes. LPN-D verified it was a shared glucometer he had used earlier on two other diabetic residents, and LPN-D reported he had cleaned it after use with each resident.

At 12:36 p.m. RN-A explained glucometers were supposed to first be cleaned with one Sani Wipe and then wrapped with a second wipe for two minutes. RN-A stated LPN-D should have wiped the glucometer with the first wipe, and then used a second wipe to wrap the glucometer. RN-A stated glucometers needed to be cleaned between each resident's use.

Later at 1:18 p.m. RN-C stated the glucometers were shared by residents and should have been sanitized between each resident. RN-C stated

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the glucometer should have been wiped with a Sani Wipe and then thrown away. A second Sani Wipe and then would then be wrapped around and kept on the glucometer for two minutes. RN-C stated she cleaned glucometers immediately following each use.

The DON on 3/17/16, at 12:26 p.m. stated the glucometers in the facility were shared glucometers and should have been cleaned with each use. The DON also stated staff should have been following the facility's related policy and procedures. The DON explained glucometers were supposed to have been sanitized with a Sani Wipe and then that wipe was to be disposed. A second wipe was then to be wrapped around the glucometer and left for two minutes. At that time, the glucometer could continue to be used for another resident.

The facility's 2015 Cleaning and Disinfecting Blood Glucose Meters Policy indicated, "It is the policy of the facility to clean and disinfect blood glucose meters that are shared between residents. Indirect contact transmission--Patient-care devises (e.g., electronic thermometers, glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared between patients without cleaning and disinfecting between patients. If a glucometer that has been used for one resident must be reused for another resident, the device must be cleaned and disinfected before it can be used for another resident...Use of disinfectants, antiseptics, and germicides are in accordance with manufacturers' instructions and EPA or FDA [Environmental Protection Agency or Food and

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F 441	Continued From page 26 Drug Administration] label specifications to avoid harm to staff, residents and visitors and ensure effectiveness."	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the environment was free of odors and in good repair. This had the potential to affect all 93 residents in the facility. Findings include: Observations of the bathroom in room in room 113 on 3/14/16 at 5:56 p.m. revealed multiple scrapes near the bottom, with one particularly significant scrape. The overbed table was in poor condition with multiple scrapes on the top and chipped corners. Strong urine odors could be detected near the first floor elevator area on 3/15/16, at 10:01 a.m. No residents were present in the area. At 11:12 a.m. the odor was again detected near the elevator. Four residents were seated in the area. On 3/16/16, at 11:37 a.m. and again at 1:50 p.m. the urine order was again noted near the main elevators on the first floor. On 3/17/16, at 1:28 p.m. the urine odor persisted.	F	F465 It is the policy of Edina Care and Rehab Center to maintain a clean, safe environment to work and live. The carpet at the entrance to the main dining room and kitchen area will be replaced on 4/25/16 with the same flooring that is currently in the dining room. The vinyl base board in the bathroom of room 116 was replaced on 3/22/16. For all other rooms that may be affected by this, a whole house audit was completed on 3/31/16. Any other replacements and or repairs needed will be completed by 4/26/16. The plastic kick plates will be replaced on the doors to rooms 113 and 315 by 4/20/16. For all other rooms that may be affected by this, a whole house audit was completed on 3/31/16. All kick plates needing to be replaced will be completed by 4/26/16.	

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F 465	Continued From page 27 An environmental tour was completed on 3/17/16, at 11:03 a.m. with the director of environmental services (DES) and the executive director (ED). The following issues were identified and were confirmed by both the DES and the ED: 1) In the shared bathroom in room 116 on the first floor unit, the base board across the wall behind the sink was loose and falling apart with visible sharp edges to the corners. The base board was loosely held together with black tape. The ED stated, "Yeah, that needs fixing. We will fix that." The DES explained there "might be a work order for it" but would check. The DES explained that some work orders were received electronically while others were verbal. 2) The shared bathroom door in room 113 on the first floor unit had a large scrape on the bottom. The DES explained, "I think it's from the wheelchair," and said it would be fixed with a "quick plate." R59's overbed table was in poor condition and was largely scraped on the top and edges. The DES and ED explained that there were more overbed tables available in storage. The DES stated, "We will get rid of that table and replace it with a new one," and removed the overbed table from the room. 3) The wall at the head of the bed in room 315 had peeling paint and scraped plaster approximately one foot above the bed and the width of the bed. The lower part of the bathroom door was also scraped. In addition, the lining inside a table lamp shade was in poor repair and hung approximately one foot beneath the bottom	F	The over bed table in room 113 was removed and disposed of on 3/16/16. For all other rooms that may be affected by this, a whole house audit was completed on 3/31/16. All other bed side tables that need to be replaced with new ones will be done by 4/26/16. The lamp shade in room 315 was removed and replaced by the facility. For all other lamps that may be in this condition, a whole house audit was completed on 3/31/16. All shades in disrepair will be removed and replaced by 4/26/16. The sheet rock in room 315 was repaired and painted on 3/25/16. For all other rooms that may be affected like this, a whole house audit was completed on 3/31/16. All walls	

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of the shade. The ED stated, "This wall is bad. It definitely needs to be fixed." The ED explained it was the resident's personal lamp, but would ensure it was replaced.

The DES explained on 3/17/16, at 1:32 p.m. the facility had a cleaning schedule and the carpet in the elevator area was cleaned every Monday. He verified the carpet had been cleaned on 3/14/16. The DES said the facility used "word of mouth" for cleaning that was needed between the scheduled tasks. He explained that sometimes a note was left by the telephone or a work order was initiated. The The DES further explained the facility was working on a budget to get hardwood floors in that area. He then verified the smell and stated it was "most likely urine" and could be from the incontinent residents who sit in the common area.

The facility's undated Carpet Shampoo When [DES] Tells You was provided. Areas of the facility were highlighted on the form. An undated Monday Carpet Shampoo noted the elevator was shampooed on "Monday," however, the date was not noted.

The ED explained in an interview on 3/17/16, at approximately 2:00 p.m. that the facility was trying to find another location for residents to congregate versus adjacent to the elevators on first floor. He also added that the facility was working toward getting the facility's financial situation "turned around" so improvements to the environment could be made.

During a follow-up interview with the DES at 2:29

needing to be repaired will be completed by 4/26/16.

The chandeliers in the dining room on 3rd floor were cleaned and new bulbs placed on 3/18/16. For all other chandeliers, a whole house audit was completed on 3/18/16. All other cleaning and repairs were completed on 3/18/16.

Audits on these issues will be completed weekly for 4 weeks, monthly for 3 months and quarterly for 3 months.

The Director of maintenance will be responsible for compliance.

Date of Compliance April 26, 2016.

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F 465	Continued From page 29 p.m. he explained the facility had a work order system, but mostly work orders were verbal as staff was not utilizing the system. The DES explained after normal work hours, staff left notes or a voicemail. The lead maintenance staff was supposed to be checking doors "per our preventative measures, and I don't know how that [scraped doors] got missed." The facility's monthly Preventative Maintenance directed, "Visually check all doors on 1st/2nd/3rd floor (repair any splinters or rough edges)." The checklist indicated it was completed on 2/23/16, and indicated "ok" as part of the description.	F 465		

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	245275	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	03/17/2016

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 17, 2016. At the time of this survey, Edina Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

APPROVED
By Tom Linhoff at 12:05 pm, Apr 12, 2016

RECEIVED
APR - 8 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4/7/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 140 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050		

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K 050	Continued From page 2 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 91 residents. Findings include: On facility tour between 10:30 Am and 2:30 PM on March 17, 2016, it was observed that the fire drills for the first shift were conducted at the following times: 1000, 0922, 1019, 1002; and for the second shift at: 1825, 1858, 1830, and 1834. These times are not varied in accordance with the 2000 edition of the Life Safety Code (NFPA 101). This deficient practice was confirmed by the Director of Maintenance at the time of inspection.	K 050	KO50: A fire drill schedule has been established on 4/11/16 for the remainder of 2016 thru 4/30/17 which varies the time on every shift and every unit. This will ensure that fire drills will be held at unexpected times under varying conditions on every shift and floor on a quarterly basis. The Director of Environmental Services will be responsible for creating, maintaining and following the fire drill schedule. Following the fire drill schedule will be performed by the Environmental Services Director, monitored by the Administrator and reported to the quality assurance/performance improvement committee on an annual basis. The correction completion date is 4/11/16.	