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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: FB1B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00823

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245039**

2.STATE VENDOR OR MEDICAID NO.
(L2) **106240900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEILSON PLACE**
(L4) **1000 ANNE STREET NORTHWEST**
(L5) **BEMIDJI, MN** (L6) **56601**

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 **08/27/2015** (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)
11/30

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

12.Total Facility Beds **78** (L18)
(L17)

13.Total Certified Beds **78**

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
	78			
(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 :
Lyla Burkman, Unit Supervisor 09/14/2015
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/14/2015
(L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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
01/01/1979
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245039

September 14, 2015

Ms. Linda Barkley, Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, Minnesota 56601

Dear Ms. Barkley:

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 August 18, 2015 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 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 / eNotice.

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 14, 2015

Ms. Linda Barkley, Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, Minnesota 56601

RE: Project Number S5039026

Dear Ms. Barkley:

On July 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 9, 2015. 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 August 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 14, 2015 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 July 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 9, 2015, effective August 18, 2015 and therefore remedies outlined in our letter to you dated July 21, 2015, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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)

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245039	A. Building B. Wing	8/27/2015

Name of Facility	Street Address, City, State, Zip Code
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	**08/18/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**08/18/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	09/14/2015	28035	08/27/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/9/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245039	02 - BUILDING 1	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0052	Correction Completed **08/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0072	Correction Completed **08/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0130	Correction Completed **08/15/2015**
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	**Reviewed By** GS/mm	**Date:** 09/14/2015	**Signature of Surveyor:** 27200	**Date:** 09/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 7/7/2015		**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: FB1B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00823

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245039**

2.STATE VENDOR OR MEDICAID NO.
(L2) **106240900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEILSON PLACE**
(L4) **1000 ANNE STREET NORTHWEST**
(L5) **BEMIDJI, MN** (L6) **56601**

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 **07/09/2015** (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)
11/30

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(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 :
Yvonne Switajewski, HFE NEII — 08/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/11/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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
01/01/1979
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 2250 0001 6357 1782

July 21, 2015

Ms. Linda Barkley, Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, Minnesota 56601

RE: Project Number S5039026

Dear Ms. Barkley:

On July 9, 2015, 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:

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

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

<u>Remedies</u> - 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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 August 18, 2015, 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 August 18, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 October 9, 2015 (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 January 9, 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
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

cc: Licensing and Certification File

RECEIVED
JUL 28 2015
BY: AUG 07 2015
Minnesota Department of Health
Bemidji

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

(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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities in order to meet the individual interests for 2 of 3 residents (R4, R87) in the sample who were reviewed for activities. Findings include: R4 did not receive individualized activities. R4's quarterly Minimum Data Set (MDS) dated 4/18/15, and annual MDS dated 10/21/14,	F 248		

Approved
w Attachments
8/12/15
SB

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Barkley | TITLE: Administrator | (X6) DATE: 08/07/2015

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ıram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	07/09/2015

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F 248	Continued From page 1 indicated R4's diagnoses included a stroke, dementia and cataracts. The MDS also indicated R4 had severe cognitive impairment and required extensive assistance in all activities of daily living. R4's Activity Care Area Assessment (CAA) dated 10/23/14, indicated R4 "needs assistance with desired actives- continues recreation care plan." The assessment did not identity R4's present or past interests nor identify what type of activities R4 chose to be involved with or what type of support services were required to allow R4 to get the most out of the activities. R4's care plan dated 7/15/14, indicated R4 was to participate in activities of choice according to residents identified interests such as church, television, conversation with staff and volunteers, pet visits, music events, church services and devotion/bible study and to come activities involving children. The plan directed staff to invite R4 to activities and assist with activities of interest. R4's Preference for Customary Routine and Activities assessment dated 10/16/14, identified how R4 wished to participate in activities of daily living and community activities. However, the assessment indicated R4 did not respond to the questions related to activities. The Activity Calendar for 7/7/15, indicated the following activities: 10:30 a.m. Reminiscing, 1:15 p.m. Moving and Grooving, 2:15 p.m. popcorn day, 4:15 1:1's (one to one visits) and 5:45 p.m.	F 248		

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F 248	Continued From page 2 card game. On 7/7/15, at 10:30 a.m. R4 was observed resting in his room. -At 3:30 p.m. R4 was observed asleep in his room as the popcorn was served on another unit. R4 was not observed to participate in activities. The Activity Calendar for 7/8/15, indicated 10:45 a.m. church service, 1:30 p.m. movie, 4:15 p.m. manicures, 5:45 p.m. 3-card game. On 7/8/15, from 11:51 a.m. to 12:47 p.m. R4 was observed sitting in the dining room. He was not observed to participate in activities. -At 2:40 p.m.. R4 was observed resting in bed. -At 2:57 p.m. nursing assistant (NA)-A confirmed R4 did not go to the movie activity. -from 2:40 p.m. until 7:40 p.m. R4 was continuously observed and at no time was R4 observed to participate in activities. He was observed to eat his meal in the dining room at 5:00 p.m., watched television alone in his room from 5:45- 6:15 and was assisted to bed at 6:15 p.m. and at 7:45 p.m. the television remained on. The activity calendar for 7/9/15, indicated at 10:30 a.m. a Catholic mass would occur in the main chapel. At 10:15 p.m. R4 was wheeled to the chapel area. Review of the Activity Participation Documentation for R4 revealed the following: - July 1-8, 2015, indicated R4 had participated in	F 248		

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F 248	Continued From page 3 two group activities and had watched television on five occasions. - June 2015, R4 had participated in two group activities and had watched television on 12 days. - May 2015, R4 had participated in four group activities and had participated in independent activities on 17 occasion which included television and radio. - April 2015, R4 had participated in five group activities and had watched television or listened to the radio on 18 occasion. On 7/9/15, at 10:15 a.m. NA-F stated R4 enjoyed watching television because he did not have television prior to moving into the facility. She stated R4 did not routinely attend other activities. On 7/9/15, at 10:48 a.m. activity manager (AM)-A stated R4 enjoyed church services several times a week, enjoyed music, looking out the window and activities which occurred in his neighborhood. She stated R4 required staff assistance to get to the activities and occasional encouragement to participate in the activities. She reviewed R4's clinical record and confirmed the record lacked a compressive activity assessment and did not direct the staff clearly as to the activities R4 would enjoy. AM-A stated the facility had identified a concern with activity assessments and participation and they were working on a system to increase activity participation but verified the program was not fully implemented at this time R87 did not receive individualized activities.	F 248		

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

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F 248	Continued From page 4 R87's quarterly MDS dated 5/28/15, and the significant change MDS dated 9/14/14, identified R87 was diagnosed with Parkinson's disease and dementia. The MDS's also indicated R87 had severe cognitive impairment and required extensive assistance with all activities of daily living. R87's Activity CAA, dated 9/9/14, indicated R87 would continue with activities of his choice. The assessment did not identify the type of activities R87 enjoyed, support services required for R87 to participate in the activities or what the staff would be required to assist him with. The Activity Assessment, preferences for Customary Routine and Activity, dated 11/25/14, was blank and did not identify R87's activity preferences. R87's Activities Preferences for Customary Routine and Activities, dated 9/3/14, and 12/1/14, were also observed blank and did not identify R87's activity preferences. R87's care plan dated 7/15/14, directed staff to encourage R87's activity involvement and to follow personal interests as R87's cognition allowed. R87's clinical record lacked a compressive assessment of R87's personal activity interest	F 248		

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F 248	Continued From page 5 and the care plan did not direct the staff as to the type of activities R87 was interested in. The Activity Calendar for 7/7/15, indicated the following activities: 10:30 a.m. Reminiscing, 1:15 p.m. Moving and Grooving, 2:15 p.m. popcorn day, 4:15 1-1's (one to one visits) and 5:45 p.m. card game. On 7/7/15, at 10:30 a.m. R87 was observed resting in his room. At 3:30 p.m. R87 was asleep in his room as the popcorn was served on another unit. R87 was not observed to participate in activities. The Activity Calendar for 7/8/15, indicated 10:45 a.m. church service, 1:30 p.m. movie, 4:15 p.m. manicures, 5:45 p.m. 3-card game. On 7/8/15, from 12:00 p.m. to 12:45 p.m. R87 was observed in the dining room, eating the noon meal. - At 4:30 p.m.. R87 was observed seated in the dining room. R87 remained in the dining room area until 6:40 p.m. At no time was R87 observed to participate in the activities. The activity calendar for 7/9/15, indicated at 10:30 a.m. a Catholic mass would occur in the main chapel. On 7/9/15, at 10:15 p.m. R87 was observed in the dining room. At no time did he leave the unit to attend church services.	F 248		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 248	Continued From page 6 Review of the Activity Participation Documentation revealed the following information: - July 1-8, 2015, indicated R87 had participated in two group activities and had participated in independent resident activity on nine occasions which included television, reading and family visit. - June 2015, R87 had participated in one group activity and participated in individual activities on 13 days including television, company, radio and he received one 1:1 visit. - May 2015, R87 did not participate in any group activities and participated in independent activities on 14 occasions which included television, radio and company. - April 2015, R87 participated in one group activities and had participated in individual activity on 12 occasions which included television, radio and family visits. On 7/8/15, at 2:30 p.m. registered nurse (RN)-A reviewed R87's record and confirmed the record did not contain a comprehensive assessment related to R87's individualized activity needs. On 7/9/15, at 10:15 a.m. licensed practical nurse (LPN)-C stated R87 enjoyed playing bingo and visiting with his family. She stated R87 did not	F 248		

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F 248	Continued From page 7 seem to like other activities. On 7/9/15, at 10:15 a.m. NA-F stated R87 liked to watch television and visit with his family. On 7/9/15, at 10:30 a.m. AM-A stated R87 enjoyed going for wheelchair rides, reading the news paper and talking to the staff. She stated the direct care staff members were to provider R87 these activities. She also found a Therapeutic 1:1 form which had directed staff to read and discuss the newspaper, talk about the pictures in his room or take for wheelchair rides. She stated she had started the form about 2 months ago but the form was blank which indicated the staff had not provided 1:1 visiting. She stated the activity documentation could be completed by any of the staff members. She also stated the facility had identified a weakness in the activity assessments and implementation of activities and she had started training the new direct care staff members on the activity needs for the residents. She confirmed R87's clinical record lacked a comprehensive activity assessment and it did not direct staff members as to what type of activities R87 would enjoy. The Activity Assessment Policy dated 2/5/15, directed staff to complete a comprehensive activity assessment within 14 days of admission to help with the development of an activity plan that reflected the choice and interest of the resident.	F 248		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 8 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. (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.	F 441		

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F 441	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a multi use glucometer (device utilized for monitoring blood sugars) was disinfected in between resident use for 2 of 2 residents (R119, R41) observed to utilize the community glucometer on the Strawberry Neighborhood. In addition, the facility failed to ensure appropriate infection control measures were followed during wound care for 1 of 1 resident (R142) observed during a dressing change. Findings include: On 7/8/15, at 4:42 p.m. licensed practical nurse (LPN)-A was observed to perform R119's blood glucose check. Immediately following the completion of the glucometer check, LPN-A was observed to place the glucometer on the computer cart, sanitized her hands and exited R119's room. LPN-A did not attempt to disinfect / clean the glucometer after it had been used. -At 4:47 p.m. LPN-A was observed pick up the same glucometer used to check R119's blood glucose and perform a blood glucose check on R41. After completion of the blood glucose check, LPN-A placed the glucometer on the computer cart, sanitized her hands and exited R41's room. LPN-A did not attempt to disinfect / clean the glucometer after it had been used to check R41's blood glucose. On 7/8/15, at 4:58 p.m. LPN-A confirmed the facility utilized a community glucometer for the	F 441		

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F 441	Continued From page 10 residents on the Strawberry Neighborhood. LPN-A stated the glucometers were supposed to be cleansed with a disinfecting wipe between each resident use however, stated she did not disinfect the glucometer in between each use because the cleansing wipes were not on her cart. On 7/9/15, at 11:04 a.m. the director of nursing (DON) stated staff were expected to disinfect the glucometer before initial use and after each resident use with cleansing / disinfecting wipes by wiping the glucometer then wrapping the disinfecting wipe around the machine in order to keep the glucometer moist with the cleansing agent in the wipe for 3-5 minutes, depending on the type of wipe utilized. The Nova StatStrip-Whole Blood Glucose Testing policy dated 4/14, directed staff to clean the exterior of the meter between each patient. Commercial surface decontamination preparations approved by Sanford Health of Northern Minnesota such as PDI Sani-Cloth Plus may be used and directed staff to follow the wipes container's instructions for wet contact time to ensure disinfection. R142's wound care was observed and the facility failed to follow proper hand hygiene practices. R142's Physician Order Report dated 6/8/15, identified diagnoses which included cellulitis (bacterial skin infection) and abscess (localized collection of plus that generally develops in response to infection) of the right lower leg. The report also included an order for daily right leg	F 441		

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F 441	Continued From page 11 wound dressing changes. On 7/7/15, at 8:21 a.m. LPN-D was observed to gather wound care supplies which were located in a cupboard in R142's room and wash her hands. R142 was seated in her recliner. LPN-D situated herself on the floor with her legs spread in a V, and placed the bin of supplies adjacent to her right leg. LPN-D donned a pair of gloves, took a pair of scissors out of her uniform pocket and cut R142's gauze dressing on her right leg wound, which had a large amount (approximately 8 centimeters (cm) by 5 cm) of greenish/yellowish drainage which had seeped through and was visible on the outside of the dressing. LPN-D placed the scissors on her right leg. LPN-D was observed to use a saline filled syringe to moisten and dislodge the dressing which was adhered to R142's wound and discard the dressing. LPN-D measured the two wounds on R142's leg. LPN-D removed her gloves and placed the packaged gauze dressing and other supplies on her right leg. LPN-D donned a new pair of gloves. LPN-D placed wound gel on separate sterile Q-tip's and applied gel to both wounds. LPN-D removed sterile wound packing from its container and used the same scissors which she had used to cut the soiled dressing to cut off a portion of packing for the smaller sized wound which had tunneling (narrow opening or passageway underneath the skin). LPN-D used a sterile Q-tip and placed the wound packing in the wound. LPN-D opened the adaptic dressing (non-adhering wound dressing designed to protect the wound) and used the same scissors to cut a portion of the sterile adaptic dressing and placed it over both wounds. LPN-D placed a dressing over the adaptic dressing, wrapped gauze around the dressing	F 441		

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F 441	Continued From page 12 and taped the gauze. LPN-D removed her gloves, cleaned up her supplies, and washed her hands in the sink in R142's room. LPN-D was not observed to wash her hands after removed the soiled dressing. On 7/7/15, at 8:47 a.m. LPN-D verified she had not washed her hands or used hand sanitizer between the removal of the soiled dressing and applying the clean dressing during the dressing change observed for R142. LPN-D added, she used a sani-wipe (wipe used to disinfect reusable resident care equipment) to clean scissors between each resident. On 7/7/15, at 9:42 a.m. LPN-D verified she had not disinfected her scissors after she had used them to cut the soiled dressing and prior to them being used to cut the sterile dressing which she had placed in and on R142's wound. On 7/7/15, at 3:12 p.m. the DON, who oversaw the infection control program, verified her expectation was for staff to perform hand hygiene after the removal of a soiled dressing and the application of a new one. In addition, the DON stated a good practice was to have a clean barrier down to place dressing supplies and LPN-D should have cleaned/disinfected the scissors after they had been used to cut off the soiled dressing and prior to them being used to cut the clean dressing. Wound Care policy dated 2/2015, directed staff to	F 441		

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F 441	Continued From page 13 wash their hands after removal of a soiled dressing and prior to donning a new pair of gloves. Also, reusable supplies (scissors) should be wiped with alcohol.	F 441		

MINNESOTA DEPARTMENT OF HEALTH ANNUAL SURVEY OF NEILSON PLACE
PLAN OF CORRECTION

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
F 248 Addendum	R4 and R87 had comprehensive activity assessments completed with an update to each activity care plan as appropriate along with activity staff education on the need for regular attendance at activities per these resident's choices. Education will be provided to all direct care staff by the Activity Coordinator on August 7, 2015, regarding the need for timely completion of the activity comprehensive assessment with activity care planning in accordance to this assessment as well as staff inviting and encouraging resident attendance per his/her choice at activity events. All residents will receive an updated activity comprehensive assessment if needed with an ongoing activity program and care plan designed specifically for each resident in accordance with timely completion of the comprehensive activity assessment. Through the Quality Assurance Performance Improvement (QAPI) process the Activity Department Coordinator or designee will choose a different activity each day and assure residents with that preference are attending. Audits will be completed 5 days a week x 4 weeks then 2 times a week x 2 weeks. All audit results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations. (See Attachment #1) Weekly audits x 4 weeks, then monthly audits x 3months will be completed by Activity Department coordinator or designee to ensure that Comprehensive Activity Assessments and care plans are completed and updated within the appropriate time frame. All audit results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations. (See Attachment #1)	August 6, 2015 August 18,2015 August 18,2015

Rec'd
8/12/15
SB

Attachment # 1

QAPI

Major aspect of care or function: Date: Year:

Timely Activity Comprehensive Assessment completion, Care Planning and Resident attendance at self-chosen activities

Sample size and time frame:

5 days a week x 4weeks, 2 times a week x2 weeks- Residents attending activities of self-chosen preference

Weekly audits x4 weeks, then monthly x 3 months-Comprehensive assessments and Care plans

Neighborhood: Mulberry, Strawberry, Huckleberry, Elderberry

Data Collection:

Admission Date										
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
1. Comprehensive Activity Assessments completed within the appropriate timeframe										
2. Timely Care Plan development and update										
3. Residents are attending activities of their self-chosen preference										

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
F 441 Addendum	On 7/8/15, licensed staff were re-educated by the DON and RN Neighborhood Manager on the Glucometer Care and Use policy and Procedure which included hand hygiene and the proper cleansing of the Glucometer machine. R119 and R41's care plan was updated to address proper cleansing of Glucometer machine. All residents that have Glucometer testing will have care plans updated with regard to proper cleansing of Glucometer machine. Education will be provided to all Licensed Staff and Trained Medication Aides by the DON and RN Neighborhood Manager on August 11, 2015, on the need to follow Neilson Place Policy and Procedure for Glucometer testing of residents. Through the Quality Assurance Performance Improvement process (QAPI) weekly random neighborhood/shift audits will be completed by the DON or designee x 4 weeks to ensure compliance with Infection Control Policies. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations. Audits will be completed by the DON or designee. (See Attachment #2) On 7/7/15, licensed staff were re-educated by the DON on the Dry/Clean Dressing Change Procedure which included hand hygiene after removing an old dressing and prior to application of a new dressing to a wound. Licensed staff were also re-educated on the need to have a clean barrier in place for placement of dressing supplies and cleaning/disinfecting scissors prior to use and between clean and dirty dressings. All residents that have wound care will have care plans updated to address proper wound care dressing procedures. Education will be provided to all Licensed Staff by the DON and RN Neighborhood Manager on August 11,2015, on the need to follow the Neilson Place Policy and Procedure for Clean/Dry Dressing Changes Through the Quality Assurance Performance Improvement process (QAPI) weekly random neighborhood/shift audits will be completed by the DON or designee x 4 weeks to ensure	July 8, 2015 July 30,2015 August 15,2015 August 15, 2015 July 7, 2015 August 15, 2015 August 15, 2015

	compliance with Infection Control Policies. The audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee for further recommendations. (see Attachment #3)	

Attachment # 2

QAPI

Major aspect of care or function: Date- Year: 2015

Glucometer machine cleansing per procedure

Sample size and time frame:

Audit of residents with Glucometer testing and licensed staff cleansing of glucometer between and after patient use -weekly audits, random shifts and neighborhoods

Neighborhood:

Data Collection

Admission Date										
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
1. Glucometer cleansed per Policy and Procedure prior to resident testing and upon completing resident testing										

Attachment #3

Major aspect of care or function: Month: Year: 2015

Clean/Dry Dressing Procedure followed

Sample size and time frame:

All residents that have wound care

Neighborhood:

Data Collection

Admission Date										
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
1. Hand hygiene performed after removing dirty dressing and before application of clean dressing										
2. Clean barrier down to place dressing supplies										
3. Scissors cleansed/disinfected prior to use and between dirty and clean dressings										

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING _____	07/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

(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
K 000	INITIAL COMMENTS 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 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Neilson Place 02 Main Building 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	APPROVED 8/31/2015 RECEIVED AUG - 7 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Linda Barkley — Administrator — 08/07/2015

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING _____	07/07/2015

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Barbara.lundberg@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.

Neilson Place was constructed in 2004, is 2-stories, without a basement and was determined to be of a Type I (332)construction. In 2009, 3 additions were constructed, a services wing to the south and connecting links to an apartment building to the north. The two connecting links into the north assisted living building are 1-story, Type II (111) construction. The building is divided into 3 smoke zones on each floor by 1 hour fire barriers.

The facility has corridor smoke detection and smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have single station smoke detectors with annunciation in the corridor and at the nurse's station that serves that room with

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING _____	07/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

(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
K 000	Continued From page 2 additional automatic fire detection in all rooms required by the Minnesota State Fire Code 2007 edition. The fire alarm is monitored for automatic fire department notification. The building is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a capacity of 78 beds and had a census of 74 at the time of the survey. The facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING	07/07/2015

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K 052	Continued From page 3 affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 07/07/2015, observations revealed that There was a smoke detectors that is located within 36 inches of a HVAC diffusers located in the Huckleberry Wing soiled utility room. This deficient condition was verified by the Maintenance Supervisor.	K 052		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observations the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.10. These obstructions could interfere with the convenient and effective removal all residents, staff and visitors in an emergency situation, and impede fire fighting operations during a fire emergency.	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING 02 - BUILDING 1 B. WING _____	07/07/2015

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K 072	Continued From page 4 Findings include: On facility tour between 10:30 AM to 1:30 PM on 07/07/2015, it was observed that there were several computer monitors mounted on the walls that extended beyond 4 inches throughout the corridors. This deficient condition was verified by the Maintenance Supervisor.	K 072		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain one of several facility storage locations in accordance with the requirements of the Minnesota State Fire Code (07) Section 315.2.3.2. This deficient practices could cause the spread of smoke and fire into the corridors in the event of an fire negatively affecting the evacuation of residents, staff, and visitors of the facility in the event of a fire. Findings include: On facility tour between 10:30 AM to 1:30 PM on 07/07/2015, observations revealed that there was combustible storage that is within 3 feet of a fuel-fired appliance located in the 2nd floor Strawberry wing housekeeping storage room.	K 130		

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	COMPLETION DATE
K 052	A work order was entered for the facility maintenance staff to relocate the smoke detector, the HVAC diffuser, or both, located in the Huckleberry Wing soiled utility room to obtain the necessary minimum of 36 inch separation of smoke detectors and HVAC diffusers.	7/7/15
	The work order was entered on July 7, 2015. Maintenance staff completed the work order on July 8, 2015. Maintenance staff moved the HVAC diffuser to create the necessary 36 inch minimum separation.	7/08/15
	General Services Manager and Maintenance staff is responsible for the correction of K 052 and will monitor the facility to prevent any further occurrence.	8/15/15
K 072	Wall mounted computer monitors will be maintained in the fully stored position when not in use by staff. Being fully stored maintains the monitor within the maximum six inch projection as allowed by CMS per the May 14, 2010 S&C Letter which revises S&C-04-41 dated August 12, 2004.	8/15/15
	Facility nursing staff will be educated by the Director of Nurses on the requirement for maintaining the wall mounted monitors in the fully stored position when not in use.	8/11/15
	General Services Manager and/or designee will be responsible to monitor the facility to prevent any further occurrence. See Attachment #1.	8/15/15
K 130	Storage racks have been ordered that will allow for minimal storage while maintaining the required 36 inch minimum separation of stored items and a fuel fired appliance in the Strawberry wing housekeeping storage room. Markings will be located on the floor to illustrate where storage is not allowed.	
	A work order has been entered for completion of this project as soon as the storage racks arrive. General Services Manage Maintenance staff is responsible for the correction of K 130 and will monitor the facility to prevent any further occurrence.	8/15/15

Attachment # 1

QAPI

Major aspect of care or function: Month: Year: 2015

Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

Sample size and time frame:

Eight computer monitors located two per neighborhood will be audited monthly.

Neighborhood:

All

Data Collection

Date	Mulberry Date:		Huckleberry Date:		Strawberry Date:		Elderberry Date:			
Indicators:	Yes	No	Yes	No	Yes	No	Yes	No	Our Record Outcome	Desired Record Outcome
Monitors are maintained in the fully stored position										
Monitor 1										
Monitor 2										