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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: FMEI

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**

2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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 **08/09/2016** (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)
**09/30**

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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 |
|---|---|---|---|---|
| | 50 | | | |
| (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 — 08/20/16 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 09/19/016 (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
**01/01/1988**
(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) **00**

VOLUNTARY
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
**08/12/2016**
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245512

September 19, 2016

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

Dear Mr. Dish:

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 15, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility bed.

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 eNotice.

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

MDH
Minnesota Department of Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

Electronically delivered
August 20, 2016

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512026

Dear Mr. Dish:

On July 6, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 24, 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 August 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 16, 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 June 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 24, 2016, effective August 15, 2016 and therefore remedies outlined in our letter to you dated July 6, 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 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

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 |
|---|---|---|
| 245512 Y1 | A. Building<br>B. Wing Y2 | 8/9/2016 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ESSENTIA HEALTH FOSSTON | 900 HILLIGOSS BOULEVARD SOUTHEAST<br>FOSSTON, MN 56542 |

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 F0282 | Correction | ID Prefix F0312 | Correction | ID Prefix F0314 | Correction |
| Reg. # 483.20(k)(3)(ii) | Completed | Reg. # 483.25(a)(3) | Completed | Reg. # 483.25(c) | Completed |
| LSC | 08/03/2016 | LSC | 08/03/2016 | LSC | 08/03/2016 |
| ID Prefix F0329 | Correction | ID Prefix F0425 | Correction | ID Prefix F0428 | Correction |
| Reg. # 483.25(l) | Completed | Reg. # 483.60(a),(b) | Completed | Reg. # 483.60(c) | Completed |
| LSC | 08/03/2016 | LSC | 08/03/2016 | LSC | 08/03/2016 |
| ID Prefix F0441 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 483.65 | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 08/03/2016 | LSC | | 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 |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 6/24/2016 | ☐ YES ☐ NO |

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 |
|---|---|---|
| 245512 Y1 | A. Building 01 - NURSING HOME<br>B. Wing Y2 | 8/16/2016 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ESSENTIA HEALTH FOSSTON | 900 HILLIGOSS BOULEVARD SOUTHEAST<br>FOSSTON, MN 56542 |

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 | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | NFPA 101 | Completed | Reg. # | NFPA 101 | Completed |
| LSC | K0018 | 08/15/2016 | LSC | K0025 | 07/08/2016 | LSC | K0051 | 07/25/2016 |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | K0144 | 07/08/2016 | LSC | | | 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 | | |
| 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 |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 6/23/2016 | ☐ 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: FMEI

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**
2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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 **06/24/2016** (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)
**09/30**

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (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 |
|---|---|---|---|---|
| | 50 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 07/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/07/2016 (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
**01/01/1988**
(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

Electronically delivered
July 6, 2016

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512026

Dear Mr. Dish:

On June 24, 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;

Electronic 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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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 3, 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 August 3, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### 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 September 24, 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 December 24, 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 an ePoC 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 electronic 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.

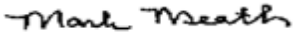
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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 eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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Telephone: (651) 201-4118
Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245512 | A. BUILDING _____ B. WING _____ | 06/24/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ESSENTIA HEALTH FOSSTON | 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic 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 282 SS=E | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide oral hygiene services as directed by the care plan for 3 of 3 residents (R12, R34, R26) in the sample who required assistance with oral hygiene. In addition, the facility failed to provide turning and repositioning assistance as directed by the care plan for 1 of 4 residents (R31) at risk for pressure related ulcers and required assistance with repositioning.<br><br>Findings include: | F 282 | First Care Living Center strives to provide services by qualified person in accordance with each residents written plan of care.<br>A. Review of Oral Hygiene policy.<br>B. RN MDS Coordinator completed assessment/care plan updates of oral hygiene needs for R12, R34, R26.<br>C. Health Support Specialist completed review of all residents oral hygiene care plans and audit of personal oral care products on 7/8/16. RN Coordinators review and update of all residents care | 8/3/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/14/2016

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| F 282 | Continued From page 1<br><br>R12 did not receive oral cares as directed by the care plan.<br><br>R12's care plan dated 5/3/16, indicated R12 had several missing teeth and directed the staff to provide mouth care twice a day.<br><br>On the evening of 6/22/16, at 5:22 p.m. nursing assistant (NA)-B and NA-A were observed to assist R12 with evening cares. The NA's were observed to change R12's clothing and provided a partial bath. At 5:38 p.m. the NA's completed the personal cares by positioning R12 in the bed and leaving the room. At no time were the NA's observed to offer or attempt to assist R12 with oral cares.<br><br>On 6/22/16, at 7:00 p.m. NA-B stated R12's evening cares were complete and would not be receiving any other personal cares. She verified R12 had not received oral cares as directed by the care plan.<br><br>On 6/23/16, at 1:20 p.m. registered nurse (RN)-A confirmed R12 was to receive assistance with oral cares as directed by the care plan.<br><br>R34 was not provided assistance with oral hygiene as directed by the care plan.<br><br>R34's care plan dated 5/11/16, indicated R34 had no teeth, had dentures and directed staff to swab mouth twice a day and as needed. | F 282 | plans by 8/3/16.<br>D. Review/updates of oral hygiene needs will be maintained by RN Coordinators upon admission, quarterly, and with any changes in oral health.<br>E. Two classes for Staff Education on geriatric oral health will be provided on 8/4/16 by Licensed Dental Hygienist with Geriatric specialty. All nursing staff unable to attend will review video Growing Old with a Smile by 8/19/16.<br>F. Health Support Specialist will audit by observation to ensure Oral Hygiene is provided according to care plan on two residents in the AM and two residents in the PM weekly x 4 weeks until compliant with care plan, then monthly thereafter. Result of audit reviewed by DON weekly.<br>G. Review & updates to Repositioning policy.<br>H. RN MDS Coordinator completed a comprehensive assessment, tissue tolerance, and care plan review/updates for R31.<br>I. All current residents who are unable to change their own position & at risk for pressure ulcers will have RN assessment, care plan review, updates to NA care sheets/EHR profile for appropriate repositioning schedule by 8/3/16.<br>J. Review and updates of repositioning needs will be maintained by RN Coordinators upon admission, quarterly and with significant change in condition, or change in seating device.<br>K. DON or her designee will audit by documentation on monitoring forms of appropriate repositioning schedules on 2 residents at risk for pressure ulcers | |

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| F 282 | Continued From page 2<br><br>On 6/23/16, at 7:15 am. NA-E and NA-C was observed to provide R34 morning cares. During the observation, NA-C was observed to place R34's upper denture and lower partial into R34's mouth without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-E and NA-C positioned and lowered bed and R34 remained in bed. At no time did NA-C offer R34 the opportunity to rinse or swab her mouth out prior to inserting the clean dentures.<br><br>On 6/23/16, at 2:15 p.m. NA-C verified oral hygiene was not completed prior to inserting R34's dentures. NA-C stated she should have offered her oral hygiene as directed by the care plan.<br><br>On 6/24/16, at 8:45 a.m. RN-B verified the care plan was correct and oral hygiene should have been provided.<br><br>On 6/24/16, at 9:15 a.m. the director of nursing (DON) verified R34's care plan and stated oral hygiene should have been provided, as directed.<br><br>R26 was not provided assistance with oral hygiene as directed by the care plan.<br><br>R26's care plan revised 6/6/16, indicated R26 required extensive assist of one to two staff to complete oral hygiene. | F 282 | weekly x 4 weeks until compliant with care plan, then monthly thereafter.<br>L. Education provided at nursing/ NAR meetings 6/30/16, 7/6/16, 7/7/16 for following the care plan for repositioning<br>M. Staff not attending will be provided education on Repositioning policy and repositioning schedules on NAR care sheets by 8/3/16, and with all new employee orientation.<br>N. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly.<br>O. Completion date August 3, 2016. | |

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| F 282 | Continued From page 3<br>On 6/23/16, at 8:27 am. NA-C and NA-D were observed to provide R26 morning cares. During the observation, NA-D was observed to ask R26 if she wanted to have her oral hygiene done at that time or wait until after breakfast. R26 stated she would wait until after breakfast.<br>-At 10:00 a.m. R26 was wheeled back to her room by NA-D.<br>-At 10:15 a.m. R26 stated she had not had her oral hygiene done after breakfast.<br>-At 10:45 a.m. NA-E wheeled R26 to the beauty shop.<br>-At 1:35 p.m. R26 returned from the beauty shop and planned to eat lunch.<br><br>At 1:40 p.m. NA-D verified oral hygiene had not been completed on R26 after breakfast as R26 had requested.<br><br>At 1:42 p.m. NA-E stated R26 did not like to have her oral hygiene completed when she got up for the day because she did not like to taste the oral hygiene products when she was eating her breakfast. So, she would have her oral hygiene completed after breakfast.<br><br>On 6/24/16, at 8:50 a.m. RN-B verified R26's care plan and stated oral hygiene should have been provided, as directed.<br><br>At 9:15 a.m. the DON verified R26's care plan and stated oral hygiene should have been provided, as directed.<br><br>R31 was not provided every two hour | F 282 | | |

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| F 282 | Continued From page 4<br>repositioning assistance as directed by the care plan.<br><br>R31's care plan dated 4/6/16, indicated R31 had an increased risk for pressure ulcer due to decreased mobility and cachexia (severe and progressive loss of muscle). The care plan directed the staff to offload (relieve pressure) at least every 2 hours.<br><br>On 6/22/16, R31 was continuously observed from 4:06 p.m. until 7:19 p.m. ( 3 hours and 13 minutes) during this time, R3 remained seated in her wheelchair.<br><br>- at 5:46 p.m. NA-E assisted R31 from the dining room into the activity room. NA-E stopped at residents room and obtained a blanket and placed on R31's lap and continued to the activity room. NA-E was not observed to offer or provide R31 repositioning assistance.<br><br>- at 6:49 p.m. licensed practical nurse-(LPN)-D assisted R31 from the activity room and positioned R31 outside of R31's room door. LPN-D was not observed to offer or provide R31 repositioning.<br><br>- at 7:19 p.m. NA-I was observed to assist R31 into her room and proceeded to complete personal cares. Following cares, NA-H entered the room and assisted NA-I to transfer R31 into bed.<br><br>-at 7:45 p.m. LPN-D stated R31 was to be repositioned every two hours and it was not provided. | F 282 | | |

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| F 282 | Continued From page 5<br><br>On 6/23/16, at 12:09 p.m. the DON confirmed it was her expectation for staff to follow R31's care plan with respect to repositioning every two hours.<br><br>The facility's Repositioning policy, revised 9/15, indicated residents at risk for developing a pressure ulcer should avoid uninterrupted sitting in a chair or wheelchair, and to reposition per residents' individual care plan, to prevent skin breakdown.<br><br>The facility's Care Planning policy dated 1/2009, directed the staff to develop a care plan and pass the information from the care plan to the direct care staff. The staff members were to follow the care plan to ensure safety for the resident, staff members and the facility. | F 282 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assistance with oral cares for 3 of 3 residents (R12, R34, R26) who were dependent on staff for oral hygiene and did not receive the assistance. | F 312 | First Care Living Center will ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral | 8/3/16 |

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| F 312 | Continued From page 6<br><br>Findings include:<br><br>R12 did not receive oral cares as directed by the care plan.<br><br>R12's quarterly Minimum Data Set (MDS) dated 5/13/16, indicated R12 was diagnosed with Alzheimer's dementia, had severe cognitive impairment and was totally dependent upon staff for all activities of daily living.<br><br>R12's Oral Assessment dated 5/2/16, directed the staff to provide assistance with all oral care needs.<br><br>R12's care plan dated 5/3/16, indicated R12 had several missing teeth and directed the staff to provide mouth care twice a day.<br><br>On 6/22/16, at 5:22 p.m. nursing assistant (NA)-B and NA-A were observed to assist R12 with evening cares. The NA's were observed to change R12's clothing and provided a partial bath.<br>-At 5:38 p.m. the NA's completed the personal cares by positioning R12 in the bed and leaving the room. At no time were the NA's observed to offer or attempt to assist R12 with oral cares.<br><br>On 6/22/16, at 7:00 p.m. NA-B stated R12 would receive assistance with repositioning and | F 312 | hygiene. Services to maintain oral hygiene may include brushing the teeth, cleaning dentures, cleaning the mouth and tongue.<br>A. Review of Oral Hygiene policy.<br>B. RN MDS Coordinator completed assessment/ care plan updates of oral hygiene needs for R12, R34, R26.<br>C. Health Support Specialist completed review of all residents oral hygiene care plans and audit of personal oral care products 7/8/16. RN Coordinators updated individual resident care plans accordingly on 7/14/16.<br>D. Review/updates of oral hygiene needs will be maintained by RN Coordinators upon admission, quarterly, and with any changes in oral health.<br>E. Two classes for Staff Education on geriatric oral health will be provided on 8/4/16 by licensed Dental Hygienist with Geriatric specialty. All nursing staff unable to attend will review video Growing Old with a Smile by 8/19/16.<br>F. Health Support Specialist will audit by observation to ensure Oral Hygiene is provided according to care plan on two residents in the AM and two residents in the PM weekly x 4 weeks until compliant with care plan, then monthly thereafter. Results of audits to be reviewed by DON weekly.<br>G. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly.<br>H. Completion date August 3, 2016. | |

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| F 312 | Continued From page 7 | F 312 | | |

incontinence cares as needed and would not be receiving any other personal cares. She verified R12 had not received oral cares.

On 6/23/16, at 12:30 a.m. licensed practical nurse (LPN)-B stated all residents were to receive assistance with oral cares.

On 6/23/16, at 1:20 p.m. registered nurse (RN)-A stated R12 was to receive assistance with oral cares as directed by the care plan.

On 6/24/16, at 8:00 a.m. the director of nurses (DON) verified R12 should have received oral cares as directed by the care plan.

R34 was not provided oral hygiene as directed by the care plan.

R34's significant change MDS dated 3/14/16, indicated R34 had diagnoses of cancer, heart failure and chronic obstructive disease (COPD). The MDS also indicated R34 had intact memory and required extensive assistance for bed mobility, dressing and personal hygiene. The MDS further indicated R34 had no dental concerns.

R34's ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 3/16/16, indicated R34 required extensive assistance with dressing, grooming, and physical assistance with bathing due to impaired balance. R34 did not have any of

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| F 312 | Continued From page 8 | F 312 | | |

her own teeth. Risk factors indicated R34 had the potential for mouth pain, weight loss, and changes in oral intake.

R34's care plan dated 5/11/16, indicated R34 did not have own teeth, refused to wear dentures and required assist of one staff to swab mouth twice a day and as needed.

On 6/23/16, at 7:15 am. NA-E and NA-C was observed to provide R34 morning cares. During the observation, NA-C was observed to place R34's upper denture and lower partial into R34's mouth without providing or offering the opportunity to cleanse mouth prior to the insertion of the dentures. Following the completion of the morning cares, NA-E and NA-C positioned R34 in bed where she remained. At no time did NA-C offer R34 the opportunity to rinse or swab her mouth out prior to inserting the clean dentures.

On 6/23/16, at 2:15 p.m. NA-C verified oral hygiene was not completed prior to inserting R34's dentures. NA-C stated she should have offered her oral hygiene.

On 6/24/16, at 8:45 a.m. RN-B verified R34's care plan and stated oral hygiene should have been provided before the dentures were put in mouth.

At 9:15 a.m. the DON verified R34's care plan and stated oral hygiene should have been provided, as directed.

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| F 312 | Continued From page 9 | F 312 | | |

R26 was not provided oral hygiene as directed by the care plan.

R26's annual MDS dated 6/7/16, indicated R26 had diagnoses of hemiplegia (paralysis of one side of the body) from a stroke, arthritis, and malnutrition. The MDS also indicated R26 was cognitive and required extensive assistance for personal hygiene, dressing and toileting. The MDS further indicated R26 had no dental concerns.

R26's ADL [activities of daily living] Functional/Rehabilitation Potential CAA dated 6/14/16, indicated R26 required assistance with all ADL's due to diagnosis of hemiplegia..

R26's care plan revised 6/6/16, indicated R26 wore partial dentures and required extensive assist of one to two staff twice a day for oral care.

On 6/23/16, at 8:27 am. nursing assistant (NA)-C and NA-D was observed to provide R26 morning cares. During the observation, NA-D was observed to ask R26 if she wanted to have her oral hygiene done at that time or wait until after breakfast. R26 stated she would wait until after breakfast. R26 was assisted to the dining room.
-At 10:00 a.m. R26 was wheeled back to her room by NA-D.
-At 10:15 a.m. R26 stated she had not had her oral hygiene done after breakfast.
-At 10:45 a.m. NA-E wheeled R26 to the beauty shop. Oral cares were not offered nor provided.
-At 1:35 p.m. R26 returned from the beauty shop

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| F 312 | Continued From page 10<br>and planned to eat lunch. Oral cares were not offered nor provided.<br><br>On 6/23/16, at 1:40 p.m. NA-D verified oral hygiene had not been completed on R26 after breakfast.<br><br>On 6/23/16, at 1:42 p.m. NA-C stated R26 did not like to have her oral hygiene completed when she got up for the day because she did not like to taste the oral hygiene products when she was eating her breakfast. So, she would have her oral hygiene completed after breakfast.<br><br>On 6/24/16, at 8:50 a.m. RN-B verified R26's care plan was correct and oral hygiene should have been offered after breakfast, as directed.<br><br>On 6/24/16, at 9:25 a.m. the DON verified R26's care plan and stated oral hygiene should have been provided, as directed.<br><br>The facility's Oral Hygiene policy dated 4/24/16, directed the staff to provide oral cares to the residents every morning and every evening. | F 312 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that | F 314 | | 8/3/16 |

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| F 314 | Continued From page 11<br>they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide every two hour turning and repositioning assistance as directed by the care plan for 1 of 3 resident (R31) identified at risk for pressure ulcers.<br><br>Findings include:<br><br>R31's quarterly Minimum Data Set (MDS) dated 3/29/16, indicated R31 had severe cognitive impairment, required extensive assistance with bed mobility, transferring and personal hygiene. R31's Pressure Ulcer Care Area Assessment (CAA) dated 10/20/15, indicated R31 had impaired mobility, was frequently incontinent of bowel and bladder and was at risk for changes in skin integrity, pressure, pain and infection.<br><br>R31's quarterly skin review dated 6/17/16, indicated R31 had a history of pressure areas on her coccyx/buttocks and along the bony prominence's of her spine, had fragile skin and was high risk for bruising. Staff directed to assist to reposition/offload every two hours and as needed.<br><br>R31's care plan dated 4/6/16, indicated R31 had | F 314 | First Care Living Center will ensure that a resident who enters the facility without a pressure sore does not develop pressure sores unless the individuals clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br>A. Review & updates to Repositioning policy.<br>B. RN MDS Coordinator completed a comprehensive assessment, tissue tolerance, and care plan review/updates for R31 on 7/14/16.<br>C. All current residents who are unable to change their own position & at risk for pressure ulcers will have RN assessment, care plan review, updates to NA care sheets/EHR profile for appropriate repositioning schedule by 8/5/16.<br>D. Review and updates of repositioning needs will be maintained by RN Coordinators upon admission, quarterly and with significant change in condition, or change in seating device.<br>E. DON or her designee will audit by documentation on monitoring forms of appropriate repositioning schedules on 2 residents at risk for pressure ulcers | |

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| F 314 | Continued From page 12<br>an increased risk for pressure ulcer due to decreased mobility and cachexia (severe and progressive loss of muscle) and directed the staff to offload at least every two hours.<br><br>On 6/22/16, R31 was continuously observed from 4:06 p.m. until 7:19 p.m. ( 3 hours and 13 minutes) during this time, R3 remained seated in her wheelchair.<br><br>- at 5:46 p.m. nursing assistant (NA)-E assisted R31 from the dining room to the activity room. NA-E stopped at residents room and obtained a blanket and placed on R31's lap and continued to the activity room. NA-E was not observed to offer or provide R31 repositioning.<br><br>- at 6:49 p.m. licensed practical nurse-(LPN)-D assisted R31 from the activity room to the dining room, LPN-D did not enter the dining room with R31, turned and proceeded to take R31 to the doorway of her room. LPN-D left R31 seated in her wheelchair at the doorway of her room. LPN-D was not observed to offer or provide R31 repositioning.<br><br>- at 7:19 p.m. NA-I was observed to take R31 into her room and proceed to complete personal cares for her. NA-I was observed to wash and dry R31's face and upper body and replaced her shirt with a gown. NA-H entered the room and both NA-I and NA-H transferred R31 into bed.<br><br>On 6/22/16, at 7:45 p.m. LPN-D stated R31 was to be repositioned every two hours and it was not provided. | F 314 | weekly x 4 weeks until compliant with care plan, then monthly thereafter.<br>F. Education provided at nursing/ NAR meetings 6/30/16, 7/6/16, 7/7/16 for following the care plan for repositioning<br>G. Staff not attending will be provided education on Repositioning policy and repositioning schedules on NAR care sheets by 8/3/16 and with all new employee orientation.<br>H. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly.<br>I. Completion date August 3, 2016. | |

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| F 314 | Continued From page 13<br><br>On 6/23/16, at 12:09 p.m. the director of nursing (DON) confirmed it was her expectation for staff to follow R31's care plan with respect to repositioning every two hours.<br><br>The facility's Repositioning policy, revised 9/15, indicated residents at risk for developing a pressure ulcer should avoid uninterrupted sitting in a chair or wheelchair, and to reposition per residents' individual care plan. | F 314 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | F 329 | | 8/3/16 |

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| F 329 | Continued From page 14<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to identify the need to administer medication as directed by the physician when 1 of 1 resident (R14) experienced a low blood pressure.<br><br>Findings include:<br><br>R14's Resident Face Sheet printed 6/23/16, indicated R14's diagnoses included diabetes, end stage renal disease, dependence on renal dialysis, post heart transplant status and anemia.<br><br>R14's Physician Order Report dated 6/10/16, directed staff to administer Midodrine (a medication to treat a low blood pressure) 5 milligrams (mg) once a day, when needed, for a systolic blood pressure (the top number of the blood pressure reading which refers to the amount of pressure in the arteries during a contraction of the heart muscle) less than 100. This medication should not be administered after the evening meal or within four hours of bedtime.<br><br>On 6/23/16, at 12:20 p.m. registered nurse (RN)-A confirmed R14's blood pressure readings listed below and that Midodrine 5 mg had not been administered as ordered, and it should have been: | F 329 | First Care Living Center will ensure that each resident□s drug regimen must be free from unnecessary drugs - ensure adequate monitoring to prevent adverse consequences.<br>A. Electronic Medical Record for R14 updated 6/24/16with Special Instructions +++Document Giving PRN Midodrine in EMAR+++<br>B. RN Coordinators reviewed 6/24/16 EMAR of all residents with regards to parameters to ensure medication administered as ordered.<br>C. Education provided by Pharmacy consultant on July 6, 2016 for Licensed staff and TMAs to make sure orders with parameters are followed.<br>D. Licensed Staff & TMAs not attending provided handouts Pharmacy 101 and Med Administration Guidelines & individual instruction from DON on proper medication administration for medications ordered with parameters by 8/3/16.<br>E. DON or her designee will audit EMAR documentation for R14□s Blood Pressure readings and Administration History weekly and PRN to ensure compliance x 4 weeks and monthly thereafter.<br>F. Compliance will be added to our QA program by DON and reported to QAPI quarterly and Pharmacy & Therapeutics committee quarterly.<br>G. Completion date August 3, 2016. | |

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| F 329 | Continued From page 15<br><br>-5/5/16, at 7:23 a.m. a blood pressure reading of 88/64<br>-5/12/16, at 1:19 p.m. a blood pressure reading of 96/58<br>-6/1/16, at 8:52 a.m. a blood pressure reading of 90/42<br>-6/2/16, at 9:57 a.m. a blood pressure reading of 96/42<br><br>On 6/23/16, at 12:37 p.m. director of nursing (DON) confirmed physician orders should be followed with regards to parameters for medication administration.<br><br>Medication Administration policy dated 4/2015, indicated general guidelines for safe and accurate medication administration must be followed. In addition, when medication administration was dependent on parameters the vital signs should be conducted prior to administration of the medication. | F 329 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and | F 425 | | 8/3/16 |

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| F 425 | Continued From page 16<br>administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure a mouth rinse was provided after the administration of a metered dose inhaler medication as directed by the medication's manufacturer recommendations for 1 of 1 resident (R50) who received medication via a metered dose inhaler without a mouth rinse afterward.<br><br>Findings include:<br><br>R50's Physician Order Report dated 5/7/16 - 6/7/16, included an order dated 1/13/16, for Advair Diskus 250-50 micrograms (mcg)/dose; 1 puff inhalation twice a day for chronic obstructive pulmonary disease.<br><br>On 6/23/16, at 8:05 a.m. licensed practical nurse (LPN)-A was observed to place an Advair Diskus inhaler up to R50's mouth. LPN-A administered a puff of the medication while R50 inhaled. LPN-A then administered a nasal spray and instilled eye drops for R50 and returned to the medication cart | F 425 | First Care Living Center will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals) to meet the needs of each resident.<br><br>A. RN MDS Coordinator completed EMAR review for R50 and updated order with special instructions added to rinse mouth after administration of steroid inhaler on 6/24/16.<br>B. RN MDS Coordinator completed EMAR review of all residents who have orders for steroid inhalers, & special instructions added to rinse mouth after administration of steroid inhaler on 6/24/16..<br>C. RN MDS Coordinator educated by DON on 6/24/16 to add special instructions to all new orders for steroid inhalers to rinse mouth after administration of steroid inhaler.<br>D. Education provided by Pharmacy consultant on July 6, 2016 for Licensed staff and TMAs to ensure mouth is rinsed | |

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| F 425 | Continued From page 17<br>outside R50's room. LPN-A did not offer or suggest R50 swish/rinse the mouth.<br><br>On 6/23/26, at 8:18 a.m. the manufacturer's Medication Guide and Instruction for Use provided in the medication packaging was reviewed with LPN-A. The Medication Guide and Instructions for Use directed to rinse mouth with water without swallowing after using Advair Diskus to help reduce the chance of getting thrush (a fungal infection). LPN-A confirmed she had not offered R50 a mouth rinse after use of the medication.<br><br>On 6/23/16, at 8:23 a.m. the director of nursing (DON) confirmed a mouth rinse should have been offered as recommended by the manufacturer after the use of the medication.<br><br>The Nursing Skills policy dated 9/2013 directed the Mosby's Nursing Skills Library would be adapted as the nursing procedures standard. The Medication Administration: Metered-Dose Inhalers procedure dated 11/4/15, directed staff to instruct the patient to rinse his or her mouth with warm water and then spit the water out after each metered dose inhaler use. | F 425 | following giving inhaled steroids.<br>E. Licensed Staff and TMAs not attending provided copies of Mosby□s Metered-Dose Inhaler instructions to sign off that they read/understand proper medication administration in regards to rinsing mouth after giving inhaled steroids by 8/3/16.<br>F. DON or her designee will audit by observation the administration of inhaled steroids and rinsing of the mouth afterwards weekly x 4 weeks and randomly thereafter.<br>G. Compliance will be added to our QA program by DON and reported QAPI and Pharmacy and Therapeutics committee quarterly.<br>H. Completion date August 3, 2016. | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to | F 428 | | 8/3/16 |

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| F 428 | Continued From page 18<br>the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the licensed pharmacist identified and reported to the attending physician and the director of nursing (DON) when medication administration parameters where not followed for 1 of 1 resident (R14) who required a medication to be administered for a low blood pressure.<br><br>Findings include:<br><br>R14's Resident Face Sheet printed 6/23/16, indicated R14's diagnoses included diabetes, end stage renal disease, dependence on renal dialysis, post heart transplant status and anemia.<br><br>R14's Physician Order Report dated 6/10/16, directed staff to administer Midodrine (a medication to treat a low blood pressure) 5 milligrams (mg) once a day, when needed, for a systolic blood pressure (the top number of the blood pressure reading which refers to the amount of pressure in the arteries during a contraction of the heart muscle) less than 100. This medication should not be administered after the evening meal or within four hours of bedtime. | F 428 | First Care Living Center will ensure that each resident□s drug regimen will be reviewed monthly by Licensed Pharmacist.<br>A. Electronic Medical Record for R14 updated 6/24/16 with Special Instructions +++Document Giving PRN Midodrine in EMAR+++<br>B. RN Coordinators reviewed EMAR of all residents 6/24/16 with regards to parameters to ensure medication administered as ordered.<br>C. Education provided by Pharmacy consultant on July 6, 2016 for Licensed staff and TMAs to make sure orders with parameters are followed.<br>D. Licensed Staff and TMAs not attending provided copies of Pharmacy 101 and Med Administration Guidelines & individual instruction from DON that they read/understand proper medication administration for medications ordered with parameters by 8/3/16.<br>E. DON or her designee will audit EMAR documentation for R14 weekly times four weeks and monthly thereafter to ensure Blood Pressure readings and Midodrine Administration History are in compliance.<br>F. Pharmacy Consultant will audit Electronic Medical Record for R14 | |

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| F 428 | Continued From page 19<br><br>On 6/23/16, at 12:20 p.m. registered nurse (RN)-A confirmed R14's blood pressure readings listed below and that Midodrine 5 mg had not been administered as ordered, and it should have been:<br><br>-5/5/16, at 7:23 a.m. a blood pressure reading of 88/64<br>-5/12/16, at 1:19 p.m. a blood pressure reading of 96/58<br>-6/1/16, at 8:52 a.m. a blood pressure reading of 90/42<br>-6/2/16, at 9:57 a.m. a blood pressure reading of 96/42<br><br>R14's Pharmacist's Drug Regimen Review dated 5/26/16, and 6/16/16, lacked identification of the parameters not being followed for the administration for Midodrine when R14's systolic blood pressure went below 100 systolic as ordered by the physician.<br><br>On 6/23/16, at 12:37 p.m. the DON confirmed physician orders should be followed with regards to parameters for medication administration.<br><br>On 6/24/16, at 9:43 a.m. the consulting pharmacist (CP) confirmed the facility should have administered the Midodrine as ordered by the physician. In addition, the CP should have identified and reported that the Midodrine was not consistently administered according to the parameters outlined by the physician to the DON and physician as part of R14's monthly pharmacy drug regime review. | F 428 | monthly to ensure compliance with Midodrine administration if systolic blood pressure of under 100.<br>G. Pharmacy Consultant will address orders with parameters with DON on each consultant visit monthly.<br>H. Compliance will be added to our QA program by DON and reported to QAPI quarterly and Pharmacy & Therapeutics committee quarterly by Pharmacy Consultant.<br>I. Completion date August 3, 2016. | |

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| F 428 | Continued From page 20<br><br>Medication Administration policy dated 4/2015, indicated general guidelines for safe and accurate medication administration must be followed.<br><br>Consultant Pharmacist Medication Regime Review Policy dated 4/2015, indicated each month the CP would review the regimes of each resident for appropriateness, which included adequate monitoring. | F 428 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if | F 441 | | 8/3/16 |

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| F 441 | Continued From page 21<br>direct contact will transmit the disease.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to establish an appropriate infection control surveillance program for infections which were not treated with antibiotics. This practice had the potential to affect all 41 residents who resided in the facility, staff and visitors. In addition, the facility failed to facilitate infection control policy related to terminal cleaning for 1 of 1 resident (R14) who had been in contact isolation.<br><br>Findings include:<br><br>INFECTION CONTROL PROGRAM:<br><br>Review of the facility's infection control program revealed a system which lacked a comprehensive surveillance program with ongoing analysis and interpretation of infections and infection risks. The Infection Summary Resident Infection Surveillance log for March 2016, April 2016, May 2016, and June 2016, revealed only infections | F 441 | First Care Living Center will establish and maintain an Infection Control Program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br>A. Resident Illness Tracking Form developed 6/27/16 to track/trend infections which are not treated with antibiotics. This includes Fever>100 degrees F., cough, sore throat, runny or stuffy nose, body ache, headache, chills, fatigue, diarrhea or nausea/vomiting.<br>B. DON or her designee will track/trend signs/symptoms of all resident infectious signs and symptoms daily from onset to resolution.<br>C. HUC will audit monthly Resident Illness Tracking Form for all residents who have had symptoms of infection in the past month.<br>D. DON and HUC will look for trends of signs/symptoms of infections, then compare residents/employee infections | |

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| (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 |
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| F 441 | Continued From page 22<br>with a prescribed antibiotic were identified and tracked. The facility's tracking system lacked monitoring, tracking, and trending of infections without antibiotics.<br><br>The Resident Illness Tracking Form for 2/8/16 - 5/21/16, revealed only infections with a prescribed antibiotic were being recorded.<br><br>On 6/23/16, at 12:35 p.m. the facility infection control program was reviewed with the director of nursing (DON) and health unit coordinator (HUC) who were responsible for the facility-wide infection control program. DON stated at their morning meetings, which were held every Monday - Friday, the staff talk about any resident who was sick and placed on an antibiotic. This information including the resident's name, wing and room number, labs completed, organism identified, date of when the symptoms started, how long the symptoms lasted, if the physician had been notified, and the antibiotic prescribed, were collected and placed on the Infection Summary Resident Infection Surveillance log. DON stated she utilized the Resident Illness Tracking Form for her own use and confirmed this log had not been updated. DON confirmed at the end of each month the surveillance log was reviewed for trends and a summary reported to the infection control committee. The HUC and DON confirmed the Resident Illness Tracking Form and the Infection Summary Resident Infection Surveillance form only identified those residents who had been placed on an antibiotic and lacked those residents who may have had signs and symptoms of an infectious disease and had not been placed on an antibiotic. | F 441 | monthly and as needed with current infections.<br>E. Terminal cleaning of R14□s room including proper disposal of pool noodles on 6/23/16.<br>F. Nursing staff, Community Support, housekeeping, therapy dept educated on the Environmental Services Dept policy and procedure for cleaning of rooms for C-diff & Essentia Health isolation reference guide for contact precautions by 8/3/16.<br>G. Residents confirmed or suspected C-diff or any other known/suspected infectious disease or condition will be placed on Contact Precautions by RN Coordinator.<br>H. RN Coordinators will contact housekeeping staff when need for Contact precautions have resolved and they will immediately clean the resident rooms per Environmental Services dept policy and procedure.<br>I. DON or her designee will audit by observation any future C-diff infections or any other known/suspected infectious disease or condition to ensure Contact Precautions are maintained. Audits will be done 3 x weekly until infection resolved & will oversee terminal cleaning when infection resolved.<br>J. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly and Essentia Infection Prevention and Control meetings quarterly.<br>K. Completion date August 3, 2016 | |

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| | 245512 | A. BUILDING _____ B. WING _____ | 06/24/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 441 | Continued From page 23 | F 441 | | |

Surveillance of Health Care Associated Infections policy dated 4/12, indicated the infection control officer would perform ongoing total or target house surveillance activities under the direction of the infection prevention and control committee.

Infection Prevention and Control Program dated 4/23/12, indicated the infection prevention and control program at the facility incorporated the following on an ongoing basis:

-Surveillance, prevention, and control of infections throughout the organization
-Development of alternative techniques to address real and potential exposures
-Selection and implementation of the best techniques to minimize adverse outcomes
-Evaluation and monitoring of the results and revision of techniques as needed

In addition, defined surveillance as a systemic method of collecting, consolidating, and analyzing data concerning the distribution and determinants of a given disease or event, followed by dissemination of that information to those who can improve the outcomes.

TERMINAL CLEANING:

On 6/21/16, at 9:15 a.m. during the initial tour of the facility, two foam swim noodles were observed duct taped together laying at the bottom of R14's bed. R14 had a stop sign on the door, which directed visitors and staff to check at the nursing station before entering. Positioned

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| F 441 | Continued From page 24<br>directly on the inside doorway of R14's room was an isolation cart.<br><br>R14's Resident Face Sheet, printed 6/23/16, indicated R14 had a diagnosis of enterocolitis (inflammation of the small and large intestine) due to Clostridium difficile (a bacteria).<br><br>On 6/23/16, at 1:20 p.m. registered nurse (RN)-A confirmed R14 had been on contact precautions for a positive Clostridium difficile (C-diff) culture. The DON thought R14's isolation precautions had been lifted over the weekend and that the sign and isolation cart had just not been removed. RN-A stated the two swim noodles which were taped together at the bottom of R14's bed had been placed by the occupational therapist. RN-A was unable to articulate how these swim noodles were disinfected, and if they had been tossed and replaced once the contact isolation precautions had been discontinued.<br><br>On 6/23/16, at 2:13 p.m. The DON confirmed R14 had been on contact isolation precautions from June 2, 2016, thru June 16, 2016, and the swim noodles had been placed on R14's bed on June 10, 2016. DON stated as far as the facility was aware the swim noodles had not been cleaned or tossed and replaced once the contact isolation precautions had been discontinued on June 16, 2016. DON stated they would repeat the terminal cleaning in R14's room and appropriately dispose of the swim noodles immediately. | F 441 | | |

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| F 441 | Continued From page 25<br>Environmental Services Department Policy and Procedure for Cleaning Rooms for C-Diff dated 5/30/2014, indicted the facility would ensure proper decontamination of resident's room would be completed to prevent the spread of C-diff spores to other residents and staff. | F 441 | | |

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| | 245512 | A. BUILDING **01 - NURSING HOME** B. WING _____ | **06/23/2016** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Essentia Health NH 01 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 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101<br><br>Or by e-mail to:<br>Marian.Whitney@state.mn.us | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/14/2016 |

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<br>and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>Essentia Health NH is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activates room to the north east corner were constructed. Theses additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers.<br><br>The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms and in common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire | K 000 | | |

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| K 000 | Continued From page 2<br>detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition).<br><br>The facility has a capacity of 50 beds and had a census of 41 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 018 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 resident room door and the proper latching on 1 corridor door according to NFPA 101 LSC (00) section 19.3.6.3.1 and 19.3.6.3.2 This deficient practice could affect the safety of 32 of the 41 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to | K 018 | Room #102 and #107 smoke gasketing will be applied to bring the gap within tolerance. Parts ordered 7-11-2016 - Tentative completion 8-15-2016.<br><br>Doors on room #351 - we will install positive latching on both doors and add a door coordinator. Parts ordered 7-8-2016 | 8/15/16 |

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| K 018 | Continued From page 3<br>enter the exit access corridors making it untenable.<br><br>Findings include:<br><br>On the facility tour between 7:30 am to 11:00 am on 06/23/2016 observations and staff interview revealed:<br>1. Resident room doors 107 & 102 did not fit tightly in the frame.<br>2. Doors on linen storage room 351 did not latch properly due to the use of roller latches.<br><br>This deficient condition was verified by the Environmental Services Manager | K 018 | - Tentative completion 8-15-2016. | |
| K 025 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.<br>8.3, 19.3.7.3, 19.3.7.5<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain proper construction of 1 of 5 smoke barrier walls according to the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 16 of the 41 residents and an undetermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another.<br><br>Findings include:<br><br>On the facility tour between 7:30 am to 11:00 am on 06/23/2016 observations and staff interview | K 025 | In room 313 we have sealed all wall penetrations with fire rated materials. | 7/8/16 |

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| K 025 | Continued From page 4<br>revealed penetrations above the ceiling in the smoke barrier adjacent to the soiled utility room 313.<br><br>This deficient condition was verified by the Environmental Services Manager | K 025 | | |
| K 051 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6<br>This STANDARD is not met as evidenced by:<br>Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 19.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined | K 051 | The diffusers will be moved to attain the 36 inch clearance between the smoke detectors and diffusers. Materials have been ordered and correction will be made by 7/25/16. | 7/25/16 |

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| K 051 | Continued From page 5<br>amount of staff.<br><br>Findings include:<br><br>On the facility tour between 7:30 am to 11:00 am on 06/23/2016 observations and staff interview revealed 4 single station smoke detectors within 3 feet of a diffuser in the staff sleeping rooms.<br><br>This deficient condition was verified by the Environmental Services Manager | K 051 | | |
| K 144 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)<br>This STANDARD is not met as evidenced by:<br>Based on observations and staff interview, the facility failed to maintain the emergency illumination in the generator enclosure in accordance with the requirements of NFPA 110 - 1999 edition. This deficient practice could affect the safety of all 41 residents and an undetermined amount of staff and visitors if service to the generator was needed during a power outage.<br><br>Findings include:<br><br>On the facility tour between 7:30 am to 11:00 am on 06/23/2016 observations and staff interview revealed the emergency light in the generator enclosure did not operate when tested.<br><br>This deficient condition was verified by the Environmental Services Manager | K 144 | The Emergency Light has been replaced and is now functioning properly. | 7/8/16 |

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| K 144 | Continued From page 6 | K 144 | | |