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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: FMWO
Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245496**

2. STATE VENDOR OR MEDICAID NO. (L2) **611042800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEOTA MANOR HEALTH CARE CENTER**
(L4) **700 NORTH MONROE STREET**
(L5) **MINNEOTA, MN** (L6) **56264**

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) **01/01/2014**

6. DATE OF SURVEY **7/6/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **67** (L18)

13.Total Certified Beds **67** (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)
x 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(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):

Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 7/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/12/2016 (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 **09/01/1987** (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

CMS Certification Number (CCN): 245496

July 12, 2016

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, MN 56264

Dear Ms. Johnson:

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.

Effective the above facility is certified for:

67 Skilled Nursing Facility/Nursing Facility Beds

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 12, 2016

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, MN 56264

RE: Project Number S5496027 and Complaint Number H5496009

Dear Ms. Johnson:

On May 31, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016 that included an investigation of complaint number H5496009. 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 July 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 5, 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 May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 19, 2016, effective June 28, 2016 and therefore remedies outlined in our letter to you dated May 31, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the May 19, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval.

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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
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
245496 Y1	A. Building B. Wing Y2	7/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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 F0176 Reg. # 483.10(n) LSC	Correction Completed 06/28/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 05/23/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 06/28/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 7/12/2016	SIGNATURE OF SURVEYOR 34083	DATE 7/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
5/19/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245496	A. Building 01 - MAIN BUILDING 01 B. Wing	7/5/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 05/20/2016	ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 06/14/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	7/12/2016	25482	7/5/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/18/2016

☐ 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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: FMWO

Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245496**

2. STATE VENDOR OR MEDICAID NO. (L2) **611042800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEOTA MANOR HEALTH CARE CENTER**
(L4) **700 NORTH MONROE STREET**
(L5) **MINNEOTA, MN** (L6) **56264**

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) **01/01/2014**

6. DATE OF SURVEY **05/19/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **67** (L18)

13.Total Certified Beds **67** (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)
_x_ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(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):

Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :

Lois Boerboom, HFE NE II 06/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:

Kamala Fiske-Downing, Health Program Representative 06/23/2016 (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:

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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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 31, 2016

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, MN 56264

RE: Project Number S5496027

Dear Ms. Johnson:

On May 19, 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. In addition, at the time of the May 19, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5496009.

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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 June 28, 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 June 28, 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 August 19, 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 November 19, 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
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING ______ B. WING ______	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

(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. 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. 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. An investigation of complaint #H5496009 was completed. The complaint was substantiated and a deficiency was cited at F314.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and obtain physician orders for safe self -administration of oral medications for 1 of 1 resident (R21) observed to self-administer medications. Findings include:	F 176	F176 1. Resident R21 was assessed for self-administration of her Metamucil, a physician order was obtained and it was care planned the resident is able to self-administer the Metamucil. Resident had current orders to self-administer Systane eye gtts, triamcinolone cream, and Xyimelt. Resident is not able to self-administer the remainder of her	6/28/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/10/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING ______ B. WING ______	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

(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 176	Continued From page 1 Review of R21's current care plan identifies a problem area related to medication administration. The care plan further indicated R21 has potential for injury from medications and inability to self administer oral medications, related to vision loss and limited mobility. During a medication administration observation on 5/18/1615, at 7:40 a.m. registered nurse (RN)-A was observed setting up R21's medications which included: Vitamin D3, lisinipril (for blood pressure), metamucil (laxative), methadone (for pain), Norvasc (for blood pressure), PreserVision (vitamin) and Senna Plus (laxative). After the medications were set up, RN-A placed them on R21's over bed table and walked out of the resident's room, closing the door. RN-A did not observe R21 self-administer the medications. After checking the medical record with RN-A and when interviewed on 5/18/16, at 8:00 a.m. RN-A confirmed R21 did not have a physician order for self-administration of oral medications nor had R21 been assessed for safe self-administration of medications. Although RN-A confirmed R21 did not have an order for the self-administration of oral medications, she failed to check whether R21 had administered the medications delivered to her room. During a subsequent observation and interview on 5/18/16, at 8:45 a.m. the above listed medications for R21 remained on the bed side table (over 1 hour after RN-A left the medications in the room). Nursing assistant (NA)-A indicated R21 had just received her bath and proceeded to remind the resident to take her medications. R21 also included her oral medications are left for her	F 176	medications. RN-A was educated as to observing resident take all of her oral medications except for the Metamucil. The policy regarding the self-administration of medications was (revised/rewritten). 5/19/2016 2. Staff nurses, TMA s, as well as case managers will be interviewed to determine if there are other residents who need an assessment for self-administration of medication.6/28/2016 3. All RN, LPN, TMA staff were educated as to the need to observe the residents taking their medications unless a self-administration assessment is completed, an order is received, and it is care planned. All staff education was provided on 5/25/16. Education was provided to RNs/LPNs/TMAs at the RN/LPN/TMA meeting held on 5/24/16. 4. Audits will be completed of 10 medication passes weekly x4, bi-weekly x4, monthly x4 then quarterly. Any residents observed self-administering their medications will have a chart review completed to check for assessment and orders for self-administration of medications, and care planning.	

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F 176	Continued From page 2 to take when she was ready to take them. The policy related to self-administration of medications was requested to review from the director of nursing (DON) but had not been provided.	F 176		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct ongoing assessments to monitor a pressure ulcer for 1 of 3 residents (R12) reviewed for pressure ulcers. Findings include: R12 was transferred from the nursing home to the hospital on 5/2/16 due to a deteriorating pressure ulcer located on the coccyx. Diagnoses identified on the hospital history and physical dated 5/2/16, for R12 included: pneumonia, weakness, dysphasia, coccyx pressure ulcer (PU) unstageable due to presence of eschar, edema and diabetes type II.	F 314	F314 1. Resident R12 passed away prior to survey starting. 2. Nurse case managers were interviewed to determine if any other facility residents have pressure ulcers. It was discussed and documentation checked to make sure weekly measurements are being completed.5/23/2016 3. Case managers were educated as to the need to measure pressure ulcers on a weekly basis. Facility Pressure Ulcer Documentation Guidelines and Wound Protocol will be reviewed with the case managers to ensure understanding of Guidelines and Protocols. All staff	6/28/16

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F 314	Continued From page 3 Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 3/8/16, identified R12's cognition to be intact, required extensive assistance with activities of daily living (ADL) which included bed mobility transfers, repositioning, toileting and personal hygiene. In addition, the MDS assessment identified R12 at risk for development of PUs and had one Stage I PU . Documentation on the most recent Skin and Wound Assessment dated 3/11/16, included multiple small open areas located on the coccyx, (scarred area) and the skin appeared dark purple in color. No documented measurements were included in this assessment so that the progress of healing could be determined. Although the wound area had been described, no consistent measurements were documented in the record for almost 2 months. A progress noted dated 3/2/16, identified the following: chronic wound area to coccyx/buttock; Area of scarring is approximately 6 x 4 inches in diameter. A Braden scale was completed with the 3/11/16, quarterly MDS assessment and indicted R12 was at risk for skin breakdown. Review of R12's most recent care plan dated 3/20/16, included the following identified care areas: Behavioral recommendations; Educated on risks/benefits; staff and MD (physician) don't feel they understand them. (2) Urinary incontinence- Interventions include: Indwelling 16 french (fr) [indicates the diameter of the catheter] catheter placed 11/16/15, per MD orders due to (d/t) urinary incontinence & retention w/associated moisture associated skin disease (MASD) and skin breakdown in groin/scrotal and	F 314	education was provided on 5/25/16. . Education was provided to RNs/LPNs/TMAs at the RN/LPN/TMA meeting held on 5/24/16. 4. Pressure ulcer documentation will be audited weekly x4 weeks, bi-monthly x2, monthly x1 then quarterly x3. Audit results will be reviewed at monthly QA meetings.	

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F 314	Continued From page 4 coccyx areas. (3) Skin integrity: potential for skin breakdown r/t (related to) limited mobility, incontinence of bowel and bladder (B/B), diabetes, friction/sheer, insulin injections. Interventions include: indwelling Foley catheter, history (Hx) of breakdown to coccyx prior to admission the the nursing facility. Scar tissue development over the coccyx. Hx [history] of coccyx area repeatedly healing and then re-opening. Review of the progress notes dated 3/16/16, included R12's care conference notes. The note indicated the resident's family was in attendance and there had been discussion concerning R12's non-compliance with laying down to eliminate pressure from his buttocks/coccyx. Further review of the progress notes dated 3/16/16, indicated R12 required repositioning every (Q)1 hour (H) after a tissue tolerance assessment was completed due to a history of pressure related to ulcer and wounds. The assessment further identified R12 as refusing positioning most of the time and staff need to encourage to change the residents position from bed to wheelchair (w/c) and recliner to relieve pressure. Interventions included: PU reduction cushion in w/c, pressure reduction mattress on bed, foam heel boots on at night, bed cradle, apply A&D ointment to buttocks twice daily (BID) & PRN (as needed), skin review/check with bath and report noted problems/changes in skin condition to nurse. Documentation of the progress note dated 3/10/16, by the certified nurse practitioner (CNP) stated: " Plan: In all honesty, I am not quite sure how to stage or even describe the wound issues to the coccyx. Initially this may have been a stage II or stage III pressure ulcer, but now it	F 314		

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F 314	Continued From page 5	F 314		

appears to be more of a shearing force that is impairing the skin to heal correctly. Based on Nursing's description; I do not believe this is a current primary pressure ulcer as one day the skin can be intact and 2 days later can be altered".

The RN wound assessment of R12's buttocks/coccyx dated 5/1/16, indicated: "area has improved in some areas & has worsened in others. Center of wound at coccyx site has become nectrotic-w/very foul smell & heavy drainage-area is irregular shaped approx. 3.5 cm x 4 cm in diameter. Wound surrounding this area is improving pale pink keratinous tissue is forming over open areas leaving 25% open w/granulation tissue present-small amount of bleeding noted from sites". A follow-up MD appointment was scheduled.

Documentation on the hospital admission history and physical dated 5/2/16, indicated the chief complaint upon hospitalization was related to a worsening coccyx pressure ulcer after an evaluation earlier that morning (5/2/16) and had a longstanding history of fluctuating areas of breakdown to his coccyx. The hospital discharge note dated 5/16/16, indicated the reason for admission was: coccyx unstageable pressure ulcer with presence of eschar. R12 died at the hospital on 5/16/16, due to cardiac arrest and secondary condition was identified as bibasilar pneumonitis secondary to aspiration and history of hypoxemia (lack of oxygen).

Review of the CNP progress note dated 5/3/16, indicated R12 was admitted to the hospital after an evaluation for a worsening coccyx pressure ulcer. The note further indicated a long standing

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F 314	Continued From page 6	F 314		

history of fluctuating area of breakdown to his coccyx.

On 5/18/16, at 11:24 a.m. the CNP was interviewed and indicated she had examined R12 intermittently for post acute hospitalizations and/or acute conditions. The CNP indicated she had examined R12's buttock area related to skin issues on 3/9/16, upon staff request. At that time, she noted R12's coccyx area was intact and had an irritated appearance, described as if "cheese grated". Staff were to cover this irritated skin area with a duoderm as the identified area would fluctuate in appearance. The CNP stated that R12 did not develop eschar on the coccyx area until the most recent exam on 5/2/16, when the recommendation was made for hospitalization. The CNP indicated she would expect a nursing assessment daily or at least every third day depending on the treatment implemented (duoderm). The CNP confirmed this assessment would include documentation of wound measurements and description by nursing staff.

When interviewed on 5/18/16, at 12:33 p.m. registered nurse (RN)-A the director of nursing (DON) and the administrator indicated R12 had an area of scar tissue on the coccyx area when admitted almost 6 years ago. This identified skin area had a long history of repeated opening and closing, stating the areas were "more open then closed" over the past year. The areas were described as "sheering/cheese grater in appearance". Both the DON and RN-A indicated the skin changes occurred on a day to day basis. After record review, they verified weekly wound measurement had not been documented to describe the progress and/or decline of the open area located on R12's coccyx wound.

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F 314	Continued From page 7 When interviewed on 5/19/16, at 11:33 a.m. nursing assistant (NA)-A indicated R12 refused repositioning on a daily basis, with the only time repositioning was allowed was during the night when R12 was already in bed. NA-B and NA-C also confirmed that R12 refused positioning most of the time during the day when offered by staff. During interview on 5/19/16, at 11:35 a.m. registered nurse (RN)-B stated she had observed the coccyx area the week prior to R12's hospitalization on 5/2/16, and noted a decline/deteriorating change in the condition of the coccyx area. RN-B indicated the area had the appearance of "beefy hamburger" or grated appearance. The undated policy titled, Pressure Ulcer Documentation Guidelines indicated the following: When charting a description of a pressure ulcer, the following components should be a part of your weekly charting. Once charted on weekly assessment, nurses notes should just reflect the progress of the wound and any changes in the plan of care. The plan of care should then be updated. (#3) Dimensions: Always measure length, width, and depth and document it in that order. (#5) Wound Base Description: Describe the wound bed appearance. If the wound base has a mixture, use the percentage of its extent. (#7) Wound Edges: Describe area up to 4 cm from edge of the wound. Measure in centimeters. Describe its characteristics. Review of the undated facility policy titled, Wound Protocol: Pressure Ulceration documented: Weekly assessment by RN. If does not improve	F 314		

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F 314	Continued From page 8 x 2 weeks or gets worse contact MD.	F 314		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to implement hand hygiene practices to minimize the potential for food borne illness. This practice had the potential to affect all residents served in the dining room. Findings include: During observations of the evening meal on 5/16/16 at 5:47 p.m. DA-A was observed to handle a cup used by a resident, and set it on a tray that contained clean dishes. At 5:51 p.m. DA-A cleared soiled dishes, silver ware, and cups from dining room tables. DA-A without washing hands, or changing gloves, was then observed to serve a resident a glass of juice while touching the rim of the glass. At 6:04 p.m. DA-A, still without having washed her hands or change her gloves, served a glass	F 371	F371 1. No specific residents were identified as being affected. 2. Per 2567 This practice had the potential to affect all residents served in the dining room. 3. DA-A will be re-educated to Food Safety in Long term Care, Safety in the Kitchen, and Welcome to the Dietary Department. She will complete the Relias education series by 6/28/16. DA-A received 1:1 education from the Dietary Manager.6/6/2016. All staff education was provided on 5/25/16. . Education was provided to RNs/LPNs/TMAs at the RN/LPN/TMA meeting held on 5/24/16. All dietary staff have received 1:1 education from the dietary manager.6/7/2016. 4. Dining room serving audits will be completed daily x14 days, weekly x6 weeks, monthly x4, then quarterly x2.	6/28/16

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F 371	Continued From page 9 of juice to a resident in the dining room, again touching the rim of the glass. At 6:07 p.m. DA-A entered the kitchen and was observed to open the refrigerator door, pour a glass of milk, and proceeded to deliver it to a resident in the dining room. During an interview with the facility's infection control coordinator (ICC) on 5/19/16, at 10:56 a.m., the observations of DA-A's practices in the dining room 5/16/16 were reviewed. The ICC verified DA-A would require further education regarding safe food handling practices in order to minimize risk and/or prevent food borne illness.	F 371	Audit reports will be reviewed at monthly QA meetings. 6/6/2016 6/7/2016	

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

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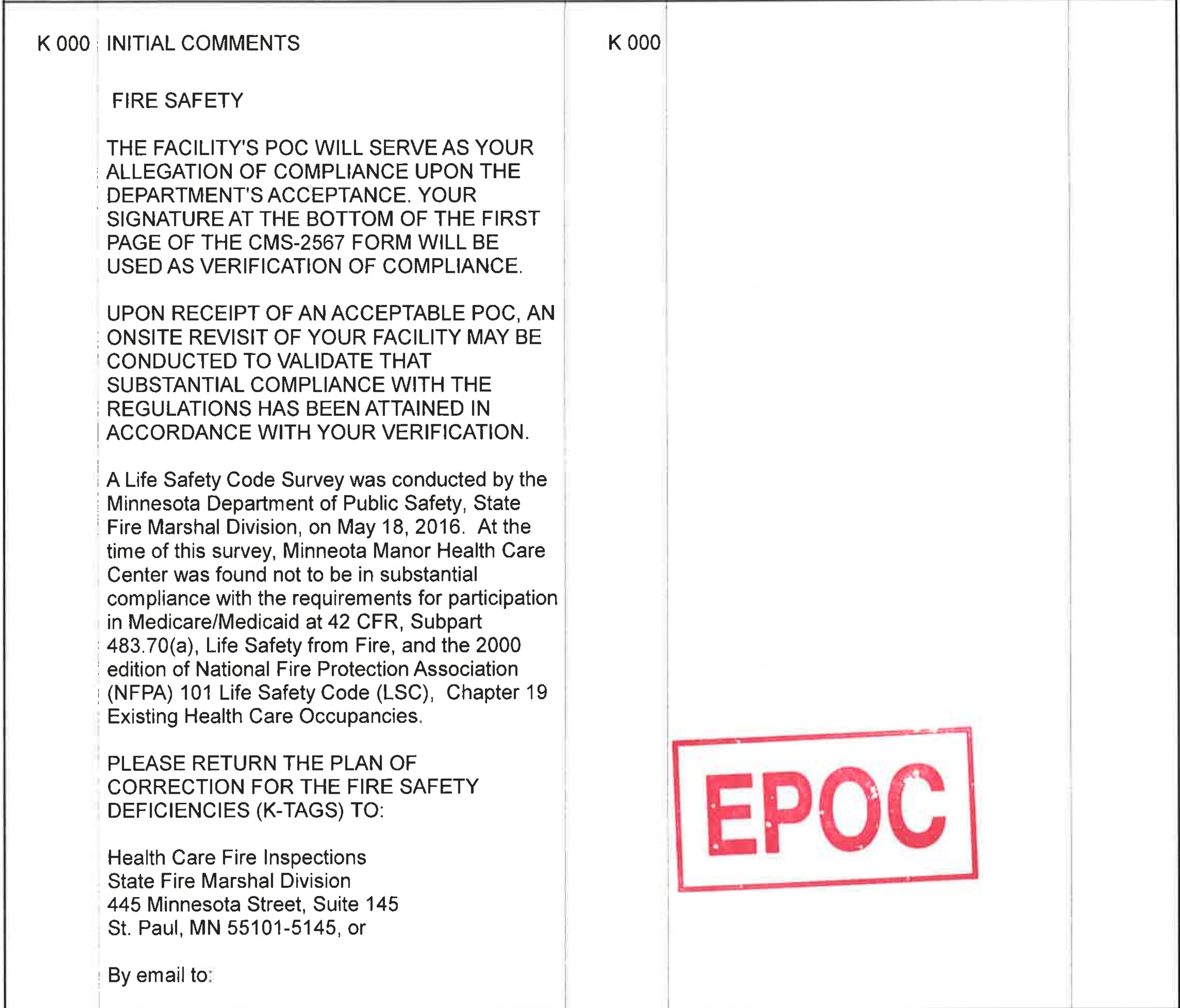
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET** **MINNEOTA, MN 56264**



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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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, on May 18, 2016. At the time of this survey, Minneota Manor Health Care Center was found not to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

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

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

By email to:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/14/2016

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 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Minneota Manor Health Care Center was constructed as follows: The original building was constructed in 1972, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1995 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an assisted living facility by 2-hour fire walls, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire-rated door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 67 beds and had a census of 45 at	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

(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 time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: During Facility Inspection on May 18, 2016, between 11:00 AM and 1:00 PM, observation during the inspection revealed the door on room W-310 was being held open by a magnet door stop. This magnetic door stop was not connected to the facility fire alarm system which would release the door to close upon fire alarm activation.	K 029	The magnetic door stop on the door on room W-310 was removed by the Facility Maintenance Director. 5-18-2016 When any door stops are requested to be installed through the maintenance request process, they will be reviewed by Facility Maintenance Director to ensure they are installed per code. Quarterly audits x 1 year will be completed by Facility Maintenance Director and reported at QA committee. (ongoing)	5/20/16

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
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET** **MINNEOTA, MN 56264**

(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 029	Continued From page 3 This deficient practice was observed by the Facility Maintenance Director.	K 029		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was determined the facility's general ventilating and air conditioning system (HVAC) was not installed in accordance with NFPA 101 (2000), Chapter 19, Section 19.5.2.1 and Chapter 9 Section 9.2 and NFPA 90A (1999). In a fire emergency, a noncompliant HVAC system could adversely affect 46 of 46 Based on observation and a staff interview, it was determined the facility's general ventilating and air conditioning system (HVAC) was not installed in accordance with NFPA 101 (2000), Chapter 19, Section 19.5.2.1 and Chapter 9 Section 9.2 and NFPA 90A (1999). In a fire emergency, a noncompliant HVAC system could adversely affect 67 of 67 residents. FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 05/18/2016, observation revealed the ventilation system in the 1972 building utilized the egress corridors as a return air plenum for the building HVAC system. Specifically, resident rooms were equipped with supply air diffusers only, and the bathroom exhaust fans were switched, i.e., did not run continuously. Further, the concealed spaces above the drop-ceiling assembly in the egress corridors were used to	K 067	Federal Waiver requested	6/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET** **MINNEOTA, MN 56264**

(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 067	Continued From page 4 provide the return air for the building HVAC system. This arrangement was not in conformance with the requirements at NFPA 90A (1999) Chapter 2, Section 2-3.11.1 and CMS Ref: S&C-06-18. This finding was verified with the chief building engineer (RM).	K 067		

Whitney, Marian (DPS)

From:	Linhoff, Tom (DPS)
Sent:	Wednesday, June 15, 2016 10:59 AM
To:	Dehler, Robert (MDH); Dietrich, Shellae (MDH); Henderson, Mary (MDH); Fiske-Downing, Kamala (MDH); Johnston, Kate (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Whitney, Marian (DPS); rochi_lsc@cms.hhs.gov
Cc:	Gannon, Larry (DPS)
Subject:	Minneota Manor - Annual waiver request
Attachments:	Waiver - Minneota Manor - Signed.pdf

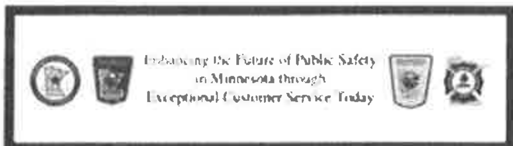
This is to inform you that Minneota Manor Healthcare Center, 245496, is again requesting an annual waiver for K- K067. The exit date was 05-18-2016. No changes.

I am recommending that CMS approve this waiver request.

Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office phone: 651-201-7205
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.fire.state.mn.us

"The unauthorized disclosure or interception of e-mail is a federal crime. See 18 U.S.C SEC. 2517(4). This e-mail is intended only for the use of those whom it is addressed and may contain information which is privileged, confidential and exempt from disclosure under the law. If you have received this e-mail in error, do not distribute or copy it. Return it immediately to the sender with attachments, if any, and notify the sender by telephone."

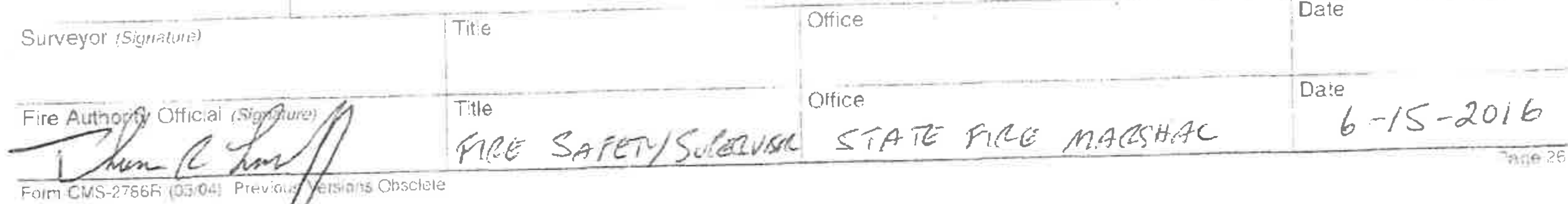


Name of Facility **2000 CODE**

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building heating, ventilation & air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K067. A. Compliance with this provision will cause an unreasonable/financial hardship because: 1. The most recent cost estimate dated 10/29/2013 for complying ducted HVAC system is \$90,000 - \$100,000. 2. A ducted system would decrease the corridor headroom to less than required by the LSC. 3. The building electrical system would need to be upgraded to support a new ducted system. 4. The ducted system would need to penetrate load bearing walls, decreasing building structural integrety. 5. Installation of a ducted system would require asbestos abatement which would increase the cost. 6. Existing non-complying HVAC systems can be allowed to continue to be used. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 Edition. 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. This annual/continuing waiver has been approved in the past.



Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	**Title**	**Office**	**Date**
	FIRE SAFETY/SUPERVISOR	STATE FIRE MARSHAL	6-15-2016

Bisbee Plumbing & Heating

Complete Commercial Mechanical Contracting and Metal Fabricating

604 North Hwy. 59, P.O. Box 3
Marshall, Minnesota 56258

PHONE: 507-537-0596
FAX: 507-537-1431

October 29, 2013.

Mrs. Johnson
Minneota Manor
700 North Monroe St.
Minneota, Minnesota 56264

RE: Return Air Ducting

Mrs. Johnson,

Bisbee Plumbing & Heating did research into the Minneota Manor return air system for the South Wing, North Wing and a couple of rooms in West Wing. Looking at these systems, in order to install return air duct out of every room walls will need to be busted through into hallways and ceilings will have to be taken down in rooms (partially) and all of the hallways ceilings in order for us to install return air duct back to the rooftop air handling units. Also required would be sprinkler contractor to remove some of the sprinkler lines that are above the ceilings and in the way. Because of going from room to hallway there may be fire dampers or fire/smoke damper required for fire protection.

With this being said Bisbee's is estimating that the cost to do this work could be in the range of $ 90,000 to $ 100,000.00 depending on what will be required

Sincerely,
Bisbee Plumbing & Heating

Jack Mead