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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GPIS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245401**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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 **08/10/2016** (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 **40** (L18)
13.Total Certified Beds **40** (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
	40			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 09/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/19/2016 (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
12/01/1986
(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
08/12/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245401

September 19, 2016

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

Dear Mr. Pelovsky:

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 July 29, 2016 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this 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
September 6, 2016

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

RE: Project Number S5401025

Dear Mr. Pelovsky:

On July 14, 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 29, 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 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on 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 29, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 29, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 29, 2016, effective July 29, 2016 and therefore remedies outlined in our letter to you dated July 14, 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
Phone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

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
245401 Y1	A. Building B. Wing Y2	8/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	07/28/2016	LSC	07/28/2016	LSC	07/28/2016
ID Prefix F0279	Correction	ID Prefix F0280	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25	Completed
LSC	07/29/2016	LSC	07/26/2016	LSC	07/26/2016
ID Prefix F0329	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	07/29/2016	LSC	07/29/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	09/06/2016	15507	08/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/29/2016

☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245401 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/19/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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 K0025	06/30/2016	LSC K0052	06/30/2016	LSC K0054	06/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0070	06/29/2016	LSC K0144	07/07/2016	LSC K0147	07/21/2016
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
[x]	TL/mm	09/06/2016	35482	08/19/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/28/2016

[ ] 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: GPIS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245401**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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 **06/29/2016** (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 **40** (L18)
13.Total Certified Beds **40** (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
	40			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NEII 08/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5401

On June 29, 2016, a standard survey was completed at this 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 i the Medicare and/or Medicaid programs. In addition, at the time of the June 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5401017 and was found to be unsubstantiated.

Refer to the CMS 2567 along with the facility's plan of correction for both health and life safety code.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail #7015 0640 0003 5695 0557

July 14, 2016

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

RE: Project Number S5401025, H5401017

Dear Mr. Pelovsky:

On June 29, 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 June 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5401017.

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. In addition, at the time of the June 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5401017 that was found to be unsubstantiated.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the**

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 8, 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 8, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Submit to acknowledge your receipt of the 2567, your review and your PoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 29, 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 29, 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 PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) was also completed at the time of the standard survey. An investigation of complaint H5401017 was found to not be substantiated during this survey.	F 000	POC accepted (see attachment) /s/ Lan Ho 8/3/16	
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 ensure 1 of 1 (R18) resident who was observed self-administering medication was deemed safe to do so. Findings include: R18 was observed on 6/28/16, at 9:47 a.m. as a registered nurse (RN)-A set up a nebulizer	F 176		

RECEIVED
AUG 03 2016
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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

Paul Schoenky | President | 7-29-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING _____ B. WING _____	06/29/2016

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F 176	Continued From page 1 treatment (to aid in breathing). RN-A placed the mouthpiece, turned on the machine, instructed the resident to use her call light to inform the nurse when the medication was gone, and then left the room. RN-A was then asked whether R18 was deemed capable of self-administering medications after the observation. RN-A stated, "She doesn't usually take it off or anything." RN-A stated at 10:38 a.m. "We would usually watch the resident to ensure they can do it and then get an order for self-administration." The DON was also present and explained that the trained medication aide (TMA) who passed medications usually watched the resident throughout the treatment, and RN-A was filling in from the night shift. R18 reported to the surveyor on 6/29/16 at 9:28 a.m. that she preferred self-administering the nebulizer treatment, "as long as they [staff] are nearby." On 6/29/16 at 9:40 a.m. a licensed practical nurse (LPN)-A located a self-administration assessment in the paper medical record for R18 dated 2/12/15. The Assessment Results section indicated, "The resident is deemed unable to safely self-administer medications for the following reasons: [diagnosis], staff is to dispense & admin. [administer] all medications per orders." The assessment included re-evaluations dated, 5/16/15, 8/20/15 and 11/18/15, each of which indicated "Reviewed [no] changes." A more recent assessment was provided later that day from the electronic medical record that indicated as of 5/21/16, R18 did not wish to self-administer medication, nor was it appropriate for the resident to do so.	F 176		

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F 176	Continued From page 2 During an interview on 6/29/16 at 10:43 a.m. the DON indicated she would have expected if a self-administration assessment indicated R18 should not have self-administered medication due to her diagnosis, she would have expected a deeper assessment. The DON stated she knew R18 "is perfectly capable of holding the nebulizer," and said the assessment form was too generic. The facility's Self-Administration of Medication policy directed that "Facility in conjunction with the Interdisciplinary Care Team (ICT), [to] assess and determine, with respect to each resident, whether Self-Administration of medications is safe and appropriate" unless the resident was determined unsafe to do so.	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225		

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F 225	Continued From page 3 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations to the administrator and designated State agency (SA) of rough treatment alleged by 1 of 1 resident (R3), as well as potential drug diversion prior to investigation (affecting R12, R24, and R33). Findings include: 1) R3's allegation of rough treatment by staff was submitted on 6/27/16, although the facility had knowledge of the allegation on 6/25/16. R3 was hospitalized from 6/24 to 6/25/16, according to the LSW who was interviewed on 6/28/16, at 8:25 a.m. Hospital staff notified a licensed practical nurse (LPN-A) on 6/25/16, that R3 alleged a new male nursing assistant (NA-B) handled her	F 225		

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F 225	Continued From page 4 roughly prior to her hospitalization, but the resident said she had not told anyone at the facility. R3 returned to the facility that afternoon. The LSW explained she had just been informed of the allegation "yesterday" (6/27/16) and filed report with the SA. The LSW stated LPN-A should have immediately notified the DON and administrator of R3's allegation, as the safety of the resident needed to be ensured. She had devised and left a cheat sheet at the nursing desk for staff to follow, and the instructions directed staff to immediately notify the DON and administrator of any allegations. The LSW said regardless of whether the hospital may have reported the resident's allegation to the SA, LPN-A should have reported it immediately. The director of nursing (DON) was interviewed on 6/27/16, at 3:00 p.m. The DON explained the staff were directed to report any allegations of abuse to the DON and LSW, as well as the administrator. At 3:09 p.m. the LSW stated she read online facility progress notes every couple of days to ensure information was properly documented, and to ensure information such as bruises included complete documentation. The LSW stated all the nurses had been trained to make reports to the SA. LPN-A was interviewed on 6/28/16, at 9:42 a.m. and explained she had not reported R3's allegation immediately because it was a Saturday. In addition, she figured the hospital would have reported it and her report would have been "secondhand." LPN-A said hospital staff told her R3's hip probably hurt from NA-B handling her roughly. The nurse had talked to R3 the following day after she returned form the hospital and the resident told her NA-B handled her	F 225		

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F 225	Continued From page 5 roughly and grabbed her hip the day before she went to the hospital. Because of an investigation, NA-B was not currently working with R3. When asked why the administrator and SA were not immediately notified of R3's report, LPN-A stated it was because she did not see any injury or bruising, and she thought she had 24 hours to make a repot. LPN-A verified she waited until the following day after talking to R3 before she notified the DON. On 6/28/16, at 10:06 a.m. the DON stated she notified the administrator of allegations of abuse or neglect and usually documented it. At 1:29 p.m. the LSW said the facility's policy had been updated in 3/16, and staff had been trained in abuse prohibition in 4/16, which included reading the entire policy to the staff. Although LPN-A had received training, she usually had to leave training's early to return to the unit. 2) A SA report was submitted on 2/23/16, related to possible documentation errors, medication errors, and/or theft of narcotic medication. Incident details indicated the incident occurred between 12/10/15 and 2/13/16. During interview with the LSW on 6/28/16, at 2:13 p.m. the LSW explained the DON had informed her on either 2/17 or 2/18/16, that she was working on an issue that might have been reportable. A report was then made the to Minnesota Adult Abuse Reporting Center (MAARC) on 2/19/16. She received a call from the Office of Health Facility Complaints (OHFC) on 2/22/16, at 1:35 p.m. indicating she needed to report this using the online OHFC site. The LSW stated since she was leaving early that day for an	F 225		

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F 225	Continued From page 6 appointment she had waited and filed it with OHFC the next day on 2/23/16. On 6/28/16, at 2:24 p.m. DON stated she had waited until 2/19/16, to have LSW file the SA report because she was unsure if it was a potential drug diversion or just a documentation problem. The LSW then stated at 2:27 p.m. that on 2/19/16, the DON informed her "We have a big problem." 3) A report of misappropriation of property was submitted to the SA on 4/20/16, along with a police report. Incident details indicated the misappropriation occurred between 3/1/16 and 4/19/16, and facility LSW was notified of this "big problem" on 4/19/16. On 6/28/16, at 2:43 p.m. the LSW stated the SA report was not filed until 4/20/16, as the DON wanted to verify with the pharmacy on 4/19/16, that the Tramadol was missing from the facility. On 6/29/16, at 9:22 a.m. LSW stated the facility trained the NAs to notify the charge nurse for any allegation of abuse or neglect and the charge nurse was to immediately call the DON or LSW and the administrator. A voice message was usually left for the administrator, but the date and time was not recorded. Going forward, the LSW said she would document the date and time the administrator was notified in her notes. On 6/29/16, at 11:12 a.m. the administrator stated staff had been trained to leave a voice message for him regarding any allegation. When he returned to the office he would then get the message which also indicated whether the incident had been reported to the SA. The	F 225		

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F 225	Continued From page 7 administrator stated he had not been notified on "Saturday" of R-- report of rough treatment, and LPN-A "probably forgot." The administrator said he could have been notified of incidents "as soon as you find out about it," and added, "We will make sure I am notified immediately." The administrator said potential drug diversion should have been reported, and "should be reported as soon as you know--report it after a little bit of looking." At 11:51 a.m. DON stated she had waited until 4/19/16, to have the LSW report the potential drug diversion because, "You can't make that allegation without proof," and it "took awhile to put all pieces together." The facility's undated Vulnerable Adult reporting & Investigation policy directed staff to "Immediately call the Director of Nursing [name] and the Administrator [phone number]...Complete the MN Dept. of Health online VA [Vulnerable Adult] report at: [link]."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prohibition policies for immediately reporting	F 226		

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F 226	Continued From page 8 allegations to the administrator and designated State agency (SA) of rough treatment alleged by 1 of 1 resident (R3), as well as potential drug diversion prior to investigation (affecting R12, R24, and R33). Findings include: The facility's undated Vulnerable Adult reporting & Investigation policy directed staff to "Immediately call the Director of Nursing [name] and the Administrator [phone number]...Complete the MN Dept. of Health online VA [Vulnerable Adult] report at: [link]." 1) R3's allegation of rough treatment by staff was submitted on 6/27/16, although the facility had knowledge of the allegation on 6/25/16. R3 was hospitalized from 6/24 to 6/25/16, according to the LSW who was interviewed on 6/28/16, at 8:25 a.m. Hospital staff notified a licensed practical nurse (LPN-A) on 6/25/16, that R3 alleged a new male nursing assistant (NA-B) handled her roughly prior to her hospitalization, but the resident said she had not told anyone at the facility. R3 returned to the facility that afternoon. The LSW explained she had just been informed of the allegation "yesterday" (6/27/16) and filed report with the SA. The LSW stated LPN-A should have immediately notified the DON and administrator of R3's allegation, as the safety of the resident needed to be ensured. She had devised and left a cheat sheet at the nursing desk for staff to follow, and the instructions directed staff to immediately notify the DON and administrator of any allegations. The LSW said regardless of whether the hospital may have reported the resident's allegation to the SA, LPN-A should have reported it immediately.	F 226		

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F 226	Continued From page 9 The director of nursing (DON) was interviewed on 6/27/16, at 3:00 p.m. The DON explained the staff were directed to report any allegations of abuse to the DON and LSW, as well as the administrator. At 3:09 p.m. the LSW stated she read online facility progress notes every couple of days to ensure information was properly documented, and to ensure information such as bruises included complete documentation. The LSW stated all the nurses had been trained to make reports to the SA. LPN-A was interviewed on 6/28/16, at 9:42 a.m. and explained she had not reported R3's allegation immediately because it was a Saturday. In addition, she figured the hospital would have reported it and her report would have been "secondhand." LPN-A said hospital staff told her R3's hip probably hurt from NA-B handling her roughly. The nurse had talked to R3 the following day after she returned form the hospital and the resident told her NA-B handled her roughly and grabbed her hip the day before she went to the hospital. Because of an investigation, NA-B was not currently working with R3. When asked why the administrator and SA were not immediately notified of R3's report, LPN-A stated it was because she did not see any injury or bruising, and she thought she had 24 hours to make a repot. LPN-A verified she waited until the following day after talking to R3 before she notified the DON. On 6/28/16, at 10:06 a.m. the DON stated she notified the administrator of allegations of abuse or neglect and usually documented it. At 1:29 p.m. the LSW said the facility's policy had	F 226		

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F 226	Continued From page 10 been updated in 3/16, and staff had been trained in abuse prohibition in 4/16, which included reading the entire policy to the staff. Although LPN-A had received training, she usually had to leave training's early to return to the unit. 2) A SA report was submitted on 2/23/16, related to possible documentation errors, medication errors, and/or theft of narcotic medication. Incident details indicated the incident occurred between 12/10/15 and 2/13/16. During interview with the LSW on 6/28/16, at 2:13 p.m. the LSW explained the DON had informed her on either 2/17 or 2/18/16, that she was working on an issue that might have been reportable. A report was then made the to Minnesota Adult Abuse Reporting Center (MAARC) on 2/19/16. She received a call from the Office of Health Facility Complaints (OHFC) on 2/22/16, at 1:35 p.m. indicating she needed to report this using the online OHFC site. The LSW stated since she was leaving early that day for an appointment she had waited and filed it with OHFC the next day on 2/23/16. On 6/28/16, at 2:24 p.m. DON stated she had waited until 2/19/16, to have LSW file the SA report because she was unsure if it was a potential drug diversion or just a documentation problem. The LSW then stated at 2:27 p.m. that on 2/19/16, the DON informed her "We have a big problem." 3) A report of misappropriation of property was submitted to the SA on 4/20/16, along with a police report. Incident details indicated the misappropriation occurred between 3/1/16 and 4/19/16, and facility LSW was notified of this "big	F 226		

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F 226	Continued From page 11 problem" on 4/19/16. On 6/28/16, at 2:43 p.m. the LSW stated the SA report was not filed until 4/20/16, as the DON wanted to verify with the pharmacy on 4/19/16, that the Tramadol was missing from the facility. On 6/29/16, at 9:22 a.m. LSW stated the facility trained the NAs to notify the charge nurse for any allegation of abuse or neglect and the charge nurse was to immediately call the DON or LSW and the administrator. A voice message was usually left for the administrator, but the date and time was not recorded. Going forward, the LSW said she would document the date and time the administrator was notified in her notes. On 6/29/16, at 11:12 a.m. the administrator stated staff had been trained to leave a voice message for him regarding any allegation. When he returned to the office he would then get the message which also indicated whether the incident had been reported to the SA. The administrator stated he had not been notified on "Saturday" of R-- report of rough treatment, and LPN-A "probably forgot." The administrator said he could have been notified of incidents "as soon as you find out about it," and added, "We will make sure I am notified immediately." The administrator said potential drug diversion should have been reported, and "should be reported as soon as you know--report it after a little bit of looking." At 11:51 a.m. DON stated she had waited until 4/19/16, to have the LSW report the potential drug diversion because, "You can't make that allegation without proof," and it "took awhile to put all pieces together."	F 226		

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan related to dialysis care for 1 of 1 resident (R3) reviewed for dialysis. Findings include: R3's care plan dated 5/27/16, indicated the resident was at risk for excessive bleeding due to the use of blood thinning medications. A goal was for R3 not to bleed excessively or sustain excessive bruising. Interventions did not include direction for staff should bleeding occur at the	F 279		

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CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

(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 279	Continued From page 13 fistula (access) site. The care plan also indicated R3 received dialysis three times weekly to maintain kidney function. Interventions included coordinating with the dialysis unit to ensure R3 followed recommendations regarding treatment, had laboratory testing, as well as weights and vitals taken routinely between the dialysis unit and the facility. Interventions did not direct staff to monitor the fistula for function and bleeding, or steps to take should bleeding occur. On 6/27/16, at 12:30 p.m. R3 returned to the facility from a dialysis. A licensed practical nurse (LPN)-A was attending to the resident, who was bleeding from the shunt site and had blood on her arm. LPN-A cleaned up the blood and then took a scheduled blood sugar test. On 6/29/16, at 1:00 p.m. LPN-A explained the dialysis staff applied a dressing to the fistula after each dialysis treatment. Facility staff then removed the dressing and monitored the shunt for bruit and thrill (to ensure proper shunt function) on the evening shift. LPN-A believed the monitoring was documented on the medication administration record (MAR), however, a review of the MAR revealed no documentation of bruit and thrill or the dressing removal. At 1:30 p.m. the director of nursing (DON) and the assistant director of nursing (ADON) reviewed the MAR. Although they believed the monitoring would be documented on the MAR, they verified there was no physician orders nor documentation to showed the fistula site was being checked for function and/or bleeding.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 14 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a family member of 1 of 1 resident (R6) was accommodated to allow attendance at care conferences. Findings include: R6's family member (F)-A was interviewed on 6/27/16, at 12:28 p.m. and expressed concern for the resident's health. F-A explained R6 was admitted into the facility the previous year, and had been hospitalized five times since her admission. Twice the resident was airlifted to a hospital and "both times I thought she was going	F 280		

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F 280	Continued From page 15 to pass away" F-A explained she could not attend the resident's quarterly care conference meetings because they were held on Tuesdays, which was a day she was unable to attend. F-A explained when R6 was first admitted to the facility, she had asked the licensed social worker (LSW) if R6's care conference could instead be held on a Monday or Thursday when F-A regularly visited R6. F-A said she was told "no" by the LSW and she had never asked again. F-A explained the LSW visited with her following the care conference to discuss issues and encouraged her to contact her with questions or to discuss issues, but F-A stated, "I would prefer to be at the original care conference." R6's Minimum Data Set (MDS) dated 5/14/16, indicated it was very important for the resident's family members to be involved in discussions about her cares. R6 was totally dependent on staff for cares due to her diagnoses. The MAR indicated R6 was only be up in chair for two hours in a 24 hour period. R6's care plan dated 5/24/16, indicated a goal to maintain involvement in stimulating activities and 1:1 visits from staff and family. During an interview on 6/27/16, at 1:25 p.m. the LSW stated she was aware R6's F-A wanted to schedule R6's care conference on a different day, but the assistant director of nursing (ADON) arranged care conference schedules. The LSW explained after R6's care conference she called F-A to discuss what each department head had to say about R6, and told her she was available to discuss any concerns. The LSW verified the discussion was a summary of the issues, and may not have included the level of detail discussed at the time of the care conference.	F 280		

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F 280	Continued From page 16 During an interview on 6/28/16, at 12:18 p.m. the ADON stated she was unaware F-A wanted to attend the care conference in person or requested it be held on a different day of the week. The ADON explained care conference were typically held on Tuesdays when all the team members were present, however, if there were more than four conferences scheduled on one day, she sometimes scheduled them on a different day, and would have been more than willing to do this for F-A. On 6/29/16, at 10:26 the LSW verified F-A had requested conferences on a day other than Tuesdays, and she believed she had informed the ADON. The LSW said "back then [at the time of R6's admission] the rules were more strict." Care conference reports indicated R6 attended one of five Tuesday care conferences, however, F-A had not attended any conferences. A care conference policy was requested, but was not provided.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		

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F 309	Continued From page 17 by: Based on observation, interview and record review, the facility failed to provide monitoring of dialysis access site for 1 of 1 resident (R3) reviewed for dialysis. Findings include: R3 attended hemodialysis treatments three times weekly for kidney failure. The resident had a fistula access site on the left upper for the dialysis treatments. On 6/27/16, at 12:30 p.m. R3 returned to the facility from a dialysis. A licensed practical nurse (LPN)-A was attending to the resident, who was bleeding from the shunt site and had blood on her arm. LPN-A cleaned up the blood and then took a scheduled blood sugar test. On 6/29/16, at 1:00 p.m. LPN-A explained the dialysis staff applied a dressing to the fistula after each dialysis treatment. Facility staff then removed the dressing and monitored the shunt for bruit and thrill (to ensure proper shunt function) on the evening shift. LPN-A believed the monitoring was documented on the medication administration record (MAR), however, a review of the MAR revealed no documentation of bruit and thrill or the dressing removal. An order was noted staff was to apply a special cream to the site before dialysis and wrap in plastic wrap. At 1:30 p.m. the director of nursing (DON) and the assistant director of nursing (ADON) reviewed the MAR. Although they believed the monitoring would be documented on the MAR, they verified there was no physician orders nor documentation to showed the fistula site was being checked for function and/or bleeding.	F 309		

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F 309	Continued From page 18 R3's care plan dated 5/27/16, indicated the resident was at risk for excessive bleeding due to the use of blood thinning medications. A goal was for R3 not to bleed excessively or sustain excessive bruising. Interventions did not include direction for staff should bleeding occur at the fistula site. The care plan also indicated R3 received dialysis three times weekly to maintain kidney function. Interventions included coordinating with the dialysis unit to ensure R3 followed recommendations regarding treatment, had laboratory testing, as well as weights and vitals taken routinely between the dialysis unit and the facility. Interventions did not direct staff to monitor the fistula for function and bleeding, or steps to take should bleeding occur. A dialysis policy was requested, but was not provided.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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	F 329		

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F 329	Continued From page 19 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure non-pharmacological interventions were utilized and failed prior to administering anti-anxiety medication, and to monitor for medication efficacy for 1 of 5 residents (R5) reviewed for unnecessary medication. Findings include: R5's Minimum Data Set (MDS) dated 4/19/16, indicated the resident's diagnoses included dementia, anxiety and depression. R5 had impaired cognition and required assistance from one staff with bathing. A 4/15/16, care plan indicated R5 was able to wash his face, and could be resistive to bathing a times. The care plan lacked interventions to minimize R5's anxiety during the bathing process. Physician orders included the anti-anxiety medication lorazepam 0.5 milligrams on Thursdays prior to bathing (start date 9/15/15). R5's medication administration record (MAR) for 4/16, 5/16, and 6/16 revealed R5 was administered the medication prior to bathing on	F 329		

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F 329	Continued From page 20 all Thursdays with the exception of 4/7, 5/6, and 6/2/16. No documentation was made to indicate why the medicaiton was not given prior to bathing, or how the resident tolerated bathing with or without the use of the psychotropic medication. Documentation in R5's medical record lacked any reference to non-pharmacological approaches used or effectiveness of the anti-anxiety medication when used prior to bathing. Nursing notes regarding bathing were as follows: 1) 2/25/16, "Resident received a shower this shift. Resident was hitting at staff when they were giving him a shower, swinging his arms at them. Resident was reminded that this is inappropriate behavior." 2) 3/3/16, "Resident received Ativan for his bath this shift, but resident still was hitting out at the aide that was giving him his bath." 3) 3/17/16, "Staff was unable to give resident his scheduled Ativan [for lorazepam] which is scheduled for today because he has a bath this shift. Staff reported that resident was pleasant and had no behaviors without the Ativan, so it was not given this time." 4) 6/16/16, "Resident had some behaviors this shift when staff gave him his shower, hitting out at staff and sticking his tongue out at them." On 6/28/16, at 2:48 p.m. R5 was sitting in his wheelchair with a puzzled, anxious look on his face. As the surveyor spoke to the resident, he did not answer and his facial expression showed he did not wish to engage in conversation. The following day at 10:18 a.m. R5 smiled widely	F 329		

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F 329	Continued From page 21 when spoken to by the surveyor. He responded positively with a few words when asked whether he had enjoyed an activity. He was unable to answer any questions regarding his baths or medications. A nursing assistant (NA)-A reported on 6/28/16, at 1:51 p.m. she often gave R5 his Thursday evening bath. NA-A verified she was aware he was prescribed anti-anxiety medication prior to bathing, but stated, "I have given him a bath prior to him starting on an anti-anxiety medication and his behaviors have been the same." NA-A explained she did not document R5's response to bathing, rather she informed the evening nurse. On 6/28/16, at 2:08 p.m. a licensed practical nurse (LPN)-A and assistant director of nursing (ADON) were interviewed. LPN-A explained R5 had scheduled anti-anxiety medication administered prior to bathing because of a history of striking out or was difficult to bathe. However, neither LPN-A or the ADON could find documentation regarding the efficacy of the medication related to R5's bathing. At 2:19 p.m. (LPN)-B who worked the evening shift verified the resident was prescribed anti-anxiety medication prior to bathing, but did not know whether the medicaiton had been helpful. LPN-B explained if R5 is having a "bad day" with his bath it would have been charted in a nursing note. LPN-B said, "I'm not sure if anyone is actually monitoring if the Ativan is helpful or not. That is something that should be looked into more closely." Later that day at 2:59 p.m. the director of nursing (DON) verified R5 was prescribed lorazepam for	F 329		

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F 329	Continued From page 22 bathing, however the staff had not been monitoring its effectiveness. In addition, the DON verified staff had not attempted non-pharmacological interventions related to bathing. Although the DON was aware the efficacy should have been monitored she stated, "I guess it was missed [in the new computer system] but I will add it now." The facility's 8/14, Psychotropic Drug Protocol policy directed staff to ensure consistent monitoring to assess the risk/benefit and include the appropriateness of the drug selected. This was to included tracking and documenting the number of episodes by charting each shift.	F 329		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure rooms of 5 of 5 residents (R1, R2, R5, R7, R19) and shower rooms were maintained in good repair, potentially affecting all residents who utilitzed the shower rooms. Findings include: The maintenance supervisor (MS) was interviewed regarding the facility's preventive maintenance plan on 6/28/16, at 2:15 p.m. The	F 465		

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F 465	Continued From page 23 MS explained that the facility did not utilize a preventive maintenance plan, rather if repairs were needed, the staff wrote the issue on a maintenance list that was kept at the nursing station, or reported it to him in person. Hallway carpeting was shampooed twice monthly, and two resident rooms were checked monthly and when a resident was discharged to see if repairs were needed. He did not document when room checks were conducted. During an environmental tour with the maintenance supervisor (MS) and the director of nursing (DON) on 6/29/16, at 9:00 a.m. the following was observed: 1) R1's bathroom room door had a deep gouge and paint was missing on the side of the door. The bathroom door also had multiple scrape lines running the entire length of the door about 1.5 feet from the floor. 2) R2's floor tiles under a recliner chair had two large holes. 3) R5's bedroom and bathroom room doors had multiple scrape lines running the entire length of the door about 1.5 feet from the floor. The bathroom wall had several areas of loose plaster and missing paint. Some patchwork had been completed on the walls that had not been painted. The floor in the bathroom was sticky with unknown substance. 4. R7's bathroom was in poor repair. Behind his toilet on the floor tile had large dark lines. The caps that should have covered the screws to the toilet were missing and a dark mold-like substance was around the screws. The wall	F 465		

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F 465	Continued From page 24 behind the toilet had a large area where plaster work had been completed, however plaster and paint was bubbled up about three inches from the wall. The walls in general in the bathroom were missing paint where plaster work had been completed but had not been painted. 5. R19's bathroom had four holes and multiple scratches on all four walls that had not been repaired, as well as plaster work that was left unpainted. 6. Shower rooms on both the north and south hallways had notable mildew odors. The heat registers in both shower rooms had scratches the entire length with missing paint. Following the tour the MS and DON verified the findings in the resident rooms. In addition, they verified the shower rooms should have been without odors and repairs to the walls should have been completed. A review of the facility's Maintenance List indicated the following concerns had been identified: 1) On 4/26/16 north shower area and room 304 walls are peeling and are in need of paint. 2) On 5/12/16, resident room 313 has blacks spots on the floor. 3) On 5/15/16, resident room 213 toilet leaking water around the base of it. 4) On 6/18/16, resident room 308 carpet needs shampooing.	F 465		

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F 465	Continued From page 25 5) On 6/22/16, resident room 308 and 304 carpets needs cleaning looks bad. 6) On 6/27/16, resident room 313 ceiling tiles need fixing. A facility maintenance policy and procedure was requested but was not provided.	F 465		

This Action Plan and Response to these survey findings is written solely to maintain clarification in the Medicare and Medical assistance programs.

These written responses do not constitute any admission of noncompliance with any requirement nor any agreement with any findings.

We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action.

F 176 Self administration of Medications

A physician order was obtained during survey for R18 to self administer her nebulizer treatments based upon a new assessment. Resident care plan was also updated to reflect her independence with procedure.

All new orders for nebulizers will be reviewed by the Charge Nurse to determine if any resident is capable of self administering and a order will be requested. the DON will review on a weekly basis. Resident preferences will also be determined during care conference. The facility has been using electronic forms that are located in the residents electronic medical record.

All residents who self administer medications will be reviewed on a monthly basis to ensure they are administered per Physician Order. Results will be reviewed by the DON/ADON Quarterly at the QAA meeting.

Log has been completed listing all current residents and meds that they can self administer, which will be reviewed monthly. Review done quarterly and PRN to determine ongoing ability to perform in a safe manner. Results to be discussed at quarterly QAA meetings.

Attachment A

Date Certain: 07.28.2016

F 225 Investigate/report allegations/individuals

It is Central Health Care's policy to thoroughly investigate all reports of resident abuse, neglect, financial exploration and injuries of unknown source. R3 was hospitalized at the time of notification and did not inform Central Health Care staff members prior to or upon return from the hospital.

Involved staff members were re-educated on 6.27.2016 with instructions to contact the DON or Social Services immediately with questions or concerns of any possible abuse or maltreatment so that a report can be made.

An investigation was completed for the allegation of abuse for R3, the investigation concluded that no abuse occurred to resident. (VA report # 98482 OHFC still pending)

Facility policy for investigating Maltreatment has been updated to reflect that any employee suspected of abuse will be suspended until the outcome has been determined. Resident did report that employee did not hurt her on purpose and per resident and employee decision, employee no longer works with R3. Staff member did receive additional informal training on proper care techniques.

Attachment B

All staff have been re-educated on VA policy and Procedure on 7.28.16 at All Staff In-Service.

All allegations of abuse will be reported immediately upon report with investigation to follow according to the guidelines.

All VA reports will be brought to quarterly QAA to ensure ongoing monitoring and compliance .

Date certain 07.28.2016

F226 Develop/Implement abuse/neglect policy

Facility policy has been updated to reflect the definition of "Immediately".

Involved staff members were re-educated on the definition of "Immediately" on 6.27.2016 Staff have been re-educated at All Staff In-Service on 7.28.2016.

VA training is provided upon orientation and annually, additional VA training opportunity will be added to the list of Mandatory In-services to ensure that all employees understand all components of the Vulnerable Adult Law.

The facility Vulnerable Adult Reporting & Investigation procedure has been updated to include documentation of notification to DON/SW and date and time of Administrator notification. Procedure also includes to report any report of alleged abuse from staff, family or other medical providers.

All VA reports will be brought to quarterly QAA to ensure ongoing monitoring and compliance .

Attachment C

Date Certain: 0.7.28.2016

F279 Develop Comprehensive Care Plan

R3 care plan was updated to include monitoring of dialysis shunt site. Interventions include monitoring for excessive bleeding or bruising and what to do in case of uncontrollable bleeding.

Policy and Procedure was completed on how to monitor an AV Shunt site for "thrill" and "Brut". Nurses were instructed on proper technique on 7.07.2016

All residents who receive Dialysis services have been reviewed to ensure monitoring protocols and care plans updated as needed.

Care plan updates will be completed as changes occur but at least quarterly with MDS with monitoring by ADON/DON.

Attachment: D/E

Date Certain: 7.29.2016

F280 Right to Participate Planning Care

The facility has begun notifying all residents and families that they can make alternative arrangements completed on 7.6.16. A new Care Conference Invite letter has been developed and put into place

A notification will also be placed in next newsletter informing res/family about changing times/dates if needed.

R6 care conference is scheduled for Thursday August 25 at a time that is convenient for the mother.

Residents were informed of their choice to schedule alternate date at Resident Council meeting on 7.26.2016

Families will also be informed at care conference meeting that they have the right to change the time/date if they need to.

Ongoing monitoring will be done quarterly to determine involvement of family participation by the Social Services. Results will be presented to QAA on a quarterly basis.

Date certain: 7/26/16

F309 Provide Care/Services for Highest well being

R3 care plan was updated to include monitoring of dialysis shunt site. Interventions include monitoring for excessive bleeding or bruising and what to do in case of uncontrollable bleeding.

Policy and Procedure was completed on how to monitor an AV Shunt site for "thrill" and "Brut". Nurses were instructed on proper technique on 7.07.2016

All residents who receive Dialysis services have been reviewed to ensure monitoring protocols and care plans updated as needed.

Care plan updates will be completed as changes occur but at least quarterly with MDS with monitoring by ADON/DON.

Attachment: D/E

Date certain: 7/26/16

F329 Drug Regimen Review/Unnecessary Drugs

R 5 medication was changed to PRN on 7.5.16.

Care plan has been updated to reflect non pharmacological interventions prior to use of medication.

A Behavior committee is in the process of development. The first meeting is planned for August 10th. The committee will review all psychoactive medication use for proper use and will be held monthly x 3 to review all psychoactive medication use is appropriate and all guidelines are followed.

All residents who receive psychotropic medications have been reviewed to ensure that a dose reduction has been done within the past 6 months or have a documented order indicating that no dose reduction can be done.

See attachment:

Date Certain: 7.29.2016

F465 Safe/functional comfortable Environment

A Preventative maintenance program has been initiated which includes a monthly checklist for monitoring of needed repair issues in resident rooms. Monthly checklist will include documentation of issues and repairs completed in each room.

The Maintenance Supervisor was also re-trained on the importance of documenting all repairs completed in each room.

The maintenance department is responsible to review all resident units on a monthly basis and with any resident discharge and admit.

All issues found during survey have been corrected with verification by the Director of Nursing.

1. The bathroom door has been repainted
2. The floor tile was found to be intact without holes, however, paper was noted to be "glued" to the floor.
3. Bathroom was repainted, repairs made to the wall and repainted.
4. Bathroom floor was replaced and walls were repaired and painted.
5. Bathroom wall was repaired and painted.
6. Shower room registers were cleaned and repainted. Rooms were cleaned and free of any Mildew smell.

Environmental audits will be conducted weekly for 4 weeks and then monthly. Audits will be done by DON or designee with results forwarded to Maintenance Supervisor and Administrator.

Date certain: 7/29/16

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

F5401024

PRINTED: 07/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	**444 NORTH CORDOVA** **LE CENTER, MN 56057**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 28, 2016. At the time of this survey, Central Health Care was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	**APPROVED** Tom Linhoff **By Tom Linhoff at 9:59 am, Aug 05, 2016** RECEIVED AUG - 1 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kent Petersburg | TITLE: President | (X6) DATE: 7-29-16

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: 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. Central Health Care is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1969, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility has a capacity of 40 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: 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. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on June 28, 2016, between the hours of 9:30 AM and 12:30 PM, observation revealed a penetration above the lay-in ceiling around wires in the North Wing smoke barrier wall. This deficient practice was verfied by the Maintenance Supervisor.	K 025		

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K 025	Continued From page 3 NOTE: All smoke barriers need to be checked to ensure compliance.	K 025		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7. FINDINGS INCLUDE: During Facility Inspection on June 28, 2016, between the hours of 9:30 AM and 12:30 PM, documentation review indicated that the last annual fire alarm inspection was conducted on 05/15/2015. This deficient practice was observed by the Facility Maintenance Director.	K 052		
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance	K 054		

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K 070	Continued From page 5 During Facility Inspection on June 28, 2016, between 09:30 AM and 12:30 PM, a portable space heater was observed in Resident Room # 313. This deficient practice was observed by the Maintenance Director.	K 070		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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) This STANDARD is not met as evidenced by: 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) FINDINGS INCLUDE: On 6/28/2016 between 9:30 AM and 12:30 PM, during a review of available records provided by facility staff, no documentation could be provided verifying a Natural Gas Reliability Letter was available to be reviewed to show that the natural gas fuel to the emergency generator would not be interrupted. This deficient practice was observed by the Maintenance Director.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2	K 147		

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K 147	Continued From page 6 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 FINDINGS INCLUDE: During Facility Inspection on June 28, 2016, between 09:30 AM and 12:30 PM, the following electrical deficiency was observed: 01.) A power strip was observed being used as a source of fixed wiring for the computer wi-fi in the North Wing. This deficient practice was observed by the Maintenance Director.	K 147		

APPROVED
By Tom Linhoff at 9:54 am, Aug 05, 2016

This Action Plan and Response to these survey findings is written solely to maintain clarification in the Medicare and Medical assistance programs.

These written responses do not constitute any admission of noncompliance with any requirement nor any agreement with any findings.

We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action.

K025

Penetration in the ceiling was caulked with fire resistant caulking on 6/30/2016

K052

The annual fire alarm inspection had completed on 04/29/2016. The report was requested and received to document that compliance was met. Report placed in maintenance book. Paperwork received on 6/30/2016

K054

The Inspection and testing of the facility smoke detectors were requested and received. Testing was done on 04/29/16. Inspection report placed in maintenance book.

K070

Portable heater was removed from room 313. Residents were informed that portable heaters are not allowed in their rooms. All heaters were removed on 6/29/2016

K144

A letter was obtained from Center Point Energy on 7.7.16 in regards to availability of Natural gas supply during unplanned outages and need for emergency generator usage.

See Attachment

K147

Power strip was removed and fixed outlet as installed on 7/21/2016

Maintenance Supervisor is responsible to monitor that Life Safety Codes are met and will monitor for ongoing compliance.