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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GU16

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF MPLS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **08/11/2014** (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 **268** (L18)

13.Total Certified Beds **268** (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
	268			
(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 :
Sue Miller, HFE NEII — 08/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(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
06/24/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5242

On August 11, 2014, a Post Certification Revisit (PCR) as completed to verify deficiencies not corrected at the June 26, 2014 PCR pursuant to the May 2, 2014 standard survey. Based on our visit we have deteremined the facility has corrected the deficiencies issued pursuant to the standard survey completed on May 2, 2014, effective August 1, 2014. As a result, this Department discontinued the Category 1 remedy of State monitoring, effecitve August 1, 2014.

In addition, this Department recommended to the CMS Region V office the following actions outlined in our letter of July 9, 2014:

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective August 2, 2104, be rescinded (42 CFR 488.417 (b))

Since DPNA did not go into effect. The facility would not be subject to a two year loss of NATCEP.

Refer to the CMS 2567b for the results of this visit.

Effective August 1, 2014, the facility is certified for 268 skilled nursing facility beds.

Life Safety Code (LSC) deficiency cited at K067 has been recommended for approval for a continuing waiver due to the unreasonable hardship financially and period of time it would displace residents. The facility is complying with the LSC requirements as the facility"s corridors are being used as a plenum.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5242

August 21, 2014

Ms. Jean Cole, Administrator
Augustana Health Care Center of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

Dear Ms. Cole:

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.

Effective August 1, 2014 the above facility is certified for:

268 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 268 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 21, 2014

Ms. Jean Cole, Administrator
Augustana Health Care Center of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

RE: Project Number S5242024

Dear Ms. Cole:

On July 9, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 14, 2014. (42 CFR 488.422)

On July 9, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 2, 2014. (42 CFR 488.417 (b))

Furthermore, this Department notified you in our letter of July 9, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 2, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on May 2, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 26, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On August 11, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 26, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 1, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 26, 2014, as of August 1, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 1, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of July 9, 2014.

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 2, 2014, be rescinded. (42 CFR 488.417 (b))

In our letter of July 9, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 2, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 1, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245242	A. Building B. Wing	8/11/2014

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0323 Reg. # 483.25(h) LSC	08/01/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	08/01/2014	ID Prefix F0441 Reg. # 483.65 LSC	08/01/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PHL/mm	08/21/2014	03023	08/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/2/2014

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: GU16

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF MPLS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

4. TYPE OF ACTION: **7** (L8)
1. Intial 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 **06/26/2014** (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 **268** (L18)

13.Total Certified Beds **268** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	268			
(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 :
Teresa Ament, HFE NEII 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 08/26/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(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
Posted 09/03/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/24/2014
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GU16

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Sue Miller, HFE NEII — 08/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/23/2014 (L20)

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26. TERMINATION ACTION: (L30)
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03001
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30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/24/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5242

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Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5242

August 21, 2014

Ms. Jean Cole, Administrator
Augustana Health Care Center of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

Dear Ms. Cole:

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.

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268 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 268 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 21, 2014

Ms. Jean Cole, Administrator
Augustana Health Care Center of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

RE: Project Number S5242024

Dear Ms. Cole:

On July 9, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 14, 2014. (42 CFR 488.422)

On July 9, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 2, 2014. (42 CFR 488.417 (b))

Furthermore, this Department notified you in our letter of July 9, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 2, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on May 2, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 26, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On August 11, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 26, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 1, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 26, 2014, as of August 1, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 1, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of July 9, 2014.

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 2, 2014, be rescinded. (42 CFR 488.417 (b))

In our letter of July 9, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 2, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 1, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245242	A. Building B. Wing	8/11/2014

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0323 Reg. # 483.25(h) LSC	08/01/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	08/01/2014	ID Prefix F0441 Reg. # 483.65 LSC	08/01/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PHL/mm	08/21/2014	03023	08/01/2014
Reviewed By CMS RO				

Followup to Survey Completed on: 5/2/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

CCN: 24-5242

On May 2, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections were required. In addition, at the time of the standard survey, an investigation of complaint number H5242091 was conducted and found to be unsubstantiated. The facility has been given an opportunity to correct before remedies would be imposed.

On June 26, 2014 Post Certification Revist (PCR) was completed by health and on June 23, 2014 a PCR was completed by Public Safety to verify correction of deficiencies issued pursuant to the March 2, 2014 survey. The revisit revealed three deficiencies had not been corrected. As a result of the revist findings, this Department imposed the Catergory 1 remedy of State Monitoring, effective July 14, 2014.

In addition, we recommended to the CMS Region V Office the following remedy for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid Admisions, effective August 2, 2014.

If Mandatory Denial of payment for new Medicare and Medicaid Admissions goes into effect, the facility would be subject to a two year loss of NATCEP beginning August 2, 2014.

The facility's request for Life Safety Code (LSC) deficiency cited at K067 has been recommended for approval for a continuing waiver due to the unreasonable hardship financially and period of time it would displace residents. The facility is complying with the LSC requirements as the facility's corridors are being used as a plenum

Refer to the CMS 2567b, CMS 2567 along with the facility's plan of correction

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 9, 2014

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

RE: Project Number S5242024

Dear Ms. Cole:

On May 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 2, 2014. 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 June 26, 2014, the Minnesota Department of Health and on June 23, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 11, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 2, 2014. The deficiency not corrected is as follows:

F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs

In addition, at the time of this revisit, we identified the following deficiencies:

F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective July 14, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 2, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 2, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 2, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Augustana Hcc Of Mpls is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 2, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Patricia Halverson, Supervisor
Duluth Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 340-6623

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 2, 2014 (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
Division of Compliance Monitoring
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.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245242	A. Building B. Wing	6/26/2014

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **06/11/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **06/11/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **06/11/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/11/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/11/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/11/2014**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	07/09/2014	29433	06/26/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/2/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245242	A. Building B. Wing 01 - MAIN BUILDING 01	6/23/2014

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	06/11/2014	ID Prefix Reg. # NFPA 101 LSC K0050	06/11/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	07/09/2014	28120	06/23/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
5/1/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	R 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 323 SS=D	Census 255 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to discuss the safety risks associated with leaving the facility without signing out for 1 of 1 residents (R404) reviewed for elopement. Findings include:	F 323	It is the policy of Augustana Health Care Center to ensure that the resident environment remains as free of accident hazards as is possible: and each resident receives adequate supervision and assistance devices to prevent accidents CORRECTIVE ACTION: Resident expired on 7/2/14. Prior to the	8/1/14

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

Electronically Signed

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
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F 323	Continued From page 1 A computer-generated Diagnosis Listing by Client form dated 6/24/14, indicated R404's diagnoses included malignant neoplasm of the larynx and stage 4 pressure ulcer. A cognitive/dementia Care Area Assessment dated 6/3/14, indicated R404 had an independent routine, went out into the community from time to time, was reminded to sign out first, got around in the wheelchair, and had intact cognition with minimal symptoms of depression. The Plan of Care (POC) dated 3/13/14, indicated R404 was alert and oriented times 3, and was own decision maker but did not always make safe choices. The POC did not address the safety risks of leaving the facility without signing out. An electronic Progress Note dated 5/30/14, indicated R404 left the facility without signing out. The Progress Note also indicated R404 would be monitored every 30 to 60 minutes as R404 was a flight risk. Additional notes on 5/30/14, indicated R404 was allowed to leave the facility per the care plan. There was no indication of R404 being informed of the risks of leaving the facility without signing out. The electronic Progress Note dated 6/6/14, indicated R404 left the facility without signing out and fell over in the wheelchair while trying to get up onto the cement curb. The Progress Note lacked documentation to indicate R404's risks versus benefits of leaving the facility were discussed. On 6/24/14, R404 was observed from 7:24 a.m. until 8:48 a.m., when went to the smoking room in the wheelchair. At 9:45 a.m. R404 was no longer	F 323	survey exit however the unit Clinical Manager and Social Worker completed a risk to benefits discussion and form with the resident re: the importance of signing out upon his return on June 24, 2014. The resident acknowledged the importance of signing out and agreed he would do that in the future. There were no further incidences of this resident not signing out during his stay at Augustana. 6/24/14 IDENTIFICATION OF OTHER RESIDENTS: All residents identified at risk for elopement and whose normal routine includes going outside were assessed and evaluated for their safety outside. Outdoor activity was added to the care plan for these residents by the Activity staff. If any resident was identified to have safety or elopement risks, the individuals care plan was reviewed, updated as needed for any appropriate interventions and if necessary a specific risk to benefits of noncompliance of proper procedure was completed. 7-31-14 MEASURES PUT IN PLACE: Upon admission residents will be informed by their Social Worker about the sign out procedures at the facility. The activity staff person will assess for their interest in outdoor activity. If outdoor activity is desired, activity staff will determine type, duration, and any assistance needed to be safe when outside, outdoor activity will be documented in a progress note and added to the plan of care. If a risk to benefits is required this will by completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	R 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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F 323	Continued From page 2 observed in the smoking room and had not returned to the floor or to the room. At 10:30 a.m. the surveyor alerted registered nurse (RN)-A as to R404's absence. On 6/24/14, at 11:15 am RN-B stated R404 had not been located and an Angel Alert (facility's name for the procedure to follow in the case of a missing resident) was called around 11:00 a.m. RN-B further stated R404 was not signed out to leave the facility and had gone missing before. RN-B stated the facility's policy for missing residents directed a search of the building and grounds and then call the Angel Alert. RN-B stated they had been searching for R404 since approximately 9:45 a.m. as R404 was due to be repositioned and off-loaded every 2 hours. RN-B further stated R404 was getting better with complying with signing out before leaving the building. RN-J stated she could not recall the incident on 5/30/14, but stated an assessment/discussion of risks versus benefits related to leaving the building alone was not completed. On 6/24/14, at 11:40 a.m. RN-I stated she was working on 5/30/14, when R404 left the building without signing out. RN-I stated R404 was brought back by paramedics after the wheelchair got stuck on a curb outside. R404 was not injured. On 6/24/14, at 1:48 p.m. social worker (SW)-A stated R404 was able to leave the facility alone, needed to sign out, have a safe plan and have an estimated time of return to the facility. SW-A further stated the risks versus benefits of R404 leaving the facility alone were not discussed.	F 323	by the Clinical Manager for that unit with the resident, and/or their primary contact and documented in the medical record. 7-31-14 A communication was sent to primary contacts and all residents regarding the sign out procedure and the importance of using the sign out books. 7-21-14 MONITORING MECHANISM: 10% random care plan audits will be conducted for the next 90 days for residents who participate in outdoor activity to assure their safety has been assessed, and proper interventions are in place. Audits will be reviewed for the next 90 days by the Quality Improvement Committee for effectiveness in providing a safe environment for residents who go outdoors 7/31/14 8/31/14 9/30/14 RESPONSIBLE PRESON/S Director of Therapeutic Programs Director of Social Services Director of Quality Improvement Clinical Managers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	R 06/26/2014

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F 323	Continued From page 3 On 6/24/14, at 2:20 p.m. the director of nursing (DON) stated residents that were cognitively intact could come and go from the facility as the wished. Residents were expected to sign out and back in. The DON further stated the safety risks of leaving the facility had not been discussed with R404.	F 323		
{F 329} SS=D	discuss 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 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	{F 329}		8/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(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 329}	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to document indications for use and to evaluate effectiveness of PRN medications for 3 of 4 residents (R519, R454, R404) reviewed for unnecessary medications. Findings include: R519 had a lumbar laminectomy for spinal stenosis on 6/9/14. The diagnosis listing dated 6/25/14, indicated further diagnoses to include osteoarthrosis, depressive disorder, and mononeuritis. The admission Minimum Data Set (MDS) dated 6/12/14, indicated R519 had short term memory deficits and experienced signs and symptoms of delirium, but long term memory was intact. The MDS dated 6/20/14, indicated R519 was cognitively intact and the delirium had cleared. R519's care plan dated 6/23/14, identified pain related to the laminectomy and indicated she was receiving narcotic pain medications as needed as well as nonpharmacological interventions for pain relief. The care plan also identified R519 as alert, oriented and able to make decisions on her own behalf. R519 had physician's orders dated 6/13/14 and 6/16/14, for Hydromorphone HCl (Dilaudid) (narcotic analgesic) 4-8 milligrams (mg) by mouth every four hours as needed for pain. The physician order lacked parameters for specific doses of of Dilaudid related to the level of pain being treated.	{F 329}	R454's orders have been clarified related to diagnosis for tylenol or ibuprofen, and all prn's have been linked to monitoring. All licensed staff and TMAs will review policy and procedure, and TMAs will report to the nurse before administration of prn meds. Current prn orders will be reviewed by 5/30/14. 10% of monthly chart audits of new admissions will be completed over the next 90 days. New POC / 7/18/14 It is the policy of Augustana Health Care Center that each resident's drug regimen will be free from unnecessary drugs. CORRECTIVE ACTION: Resident #404 - Following chart review and observation, it was determined that there were no adverse effects from the missing documentation related to the prn medications that were administered. Resident expired related to his terminal illness on 7/2/14. Resident #519 - Following chart review and observation, it was determined that there were no adverse effects from the lack of specific orders for parameters on her pain medication, or the missing documentation of assessment following the administration of the same medication. Resident was successfully discharged home on 7/2/14 Resident #454 - Following chart review and observation, it was determined that there were no adverse effects related to	

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	245242	A. BUILDING _____ B. WING _____	R 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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{F 329}	Continued From page 5 R519's medical record lacked assessment/documentation of effectiveness of pain medication administered. The medications administration record (MAR) from 6/13/14 through 6/24/14, indicated R519 received Dilaudid 41 times; however, the effectiveness of the medication was documented only 11 times. During an interview on 6/25/14, at 9:21 a.m. licensed practical nurse (LPN)-A stated she administered 4 mg of Dilaudid for pain rated 5 and under, and 8 mg of Dilaudid for a pain rating over 5. LPN-A further stated she would return 30 minutes after administering the pain medication, assess the pain level and effectiveness of medication, and document the results in the progress notes. On 6/25/14, at 9:37 a.m., registered nurse (RN)-G stated there should be progress notes indicating the effectiveness of PRN pain medication. R454's Physician's Orders dated 6/9/14, included the following medication orders: Zolpidem Tartrate (hypnotic medication) 5 milligrams (mg), one tablet PRN (as needed). EQ Ibuprofen (a mild pain relieving medication) 400 mg, take one tablet every eight hours PRN. The MAR dated 6/1/14, to 6/30/14, indicated R454 received EQ Ibuprofen once on 4/12/14, once on 4/16/14, and twice on 4/24/14. The MAR also indicated R454 received Zolpidem Tartrate on 4/11/14, 4/12/14, 4/15/14, 4/17/14, and 4/19/14. The electronic progress notes dated 4/10/14, through 4/24/14, lacked documentation of the indications for use or for the effectiveness of the	{F 329}	the lack of documentation prior to and following the adminstration of ordered pain medication, and hypnotic. Resident is currently stable in long term care. IDENTIFICATION OF OTHER RESIDENTS: It was determined by the IDT that all residents could potentially be affected by the identified deficient practice. MEASURES PUT IN PLACE: In addition to previous training on PRN use and Unnecessary Drug regime's, the clinical managers and supervisors will review all prn's for appropriate assessment and documentation for both usage and effectiveness daily using the "PRN Analysis Reports" out of the ERH software to review all prn medications administered as well as all associated documentation. Any errors or incomplete documentation are reviewed with the nurse to ensure that practice is immediately improved, and corrected if appropriate. As a standard of practice, nurses who do not improve following due process and re-education will be subject to the appropriate progressive disciplinary action. 8/1/14 Afer 8/1/14 prn analysis will be done 3 times a week for 1 month and 2 times a week for the following month and once a month on-going. DON / ADON will review any corrections to ensure that errors are not repeated 8/31/14 9/30/14 MONITORING MECHANISM: Outcomes of the analysis of the	

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{F 329}	Continued From page 6 PRN Ibuprofen and PRN Zolpidem Tartrate. On 6/24/15, at 1:55 p.m. RN-D stated the reason for giving PRN medications and the PRN results were to be charted in the progress notes. The RN verified there was nothing documented in the progress notes regarding the indications or effectiveness of the PRN Ibuprofen or Zolpidem Tartrate from 4/10/14, through 4/24/14 for R454. The facility's Administration of PRN Medications policy revised 1/14, directed nurses to evaluate a resident's need for a PRN medication upon a resident's request for medication and/or when signs/symptoms of pain were noted. Nurses were to check the resident's medication administration record or computer care path for a physician order, then document the PRN medication was given. Trained medication administrators (TMA) were to obtain authorization from a licensed nurse prior to the administration of PRN medications. Nurses were to observe for the resident's response to the medication and document the response in the medical record. R404 was given Lorazepam (anti-anxiety medication) with no documented target behaviors, and the medication effectiveness was not documented. A computer-generated Diagnosis Listing by Client form dated 6/24/14, indicated R404's diagnoses included malignant neoplasm of the larynx. A significant change Minimum Data Set (MDS) dated 5/29/14, indicated R404 had no short or long-term memory deficits, displayed no symptoms of depression, had occasional verbal behaviors directed towards others, and frequently	{F 329}	assessment and documentation surrounding the prn administration will be reviewed at the monthly Quality Improvement meetings where it will be determined whether corrective action has been sustained and practice remains satisfactory. It will be determined at that time whether to conitnue process, or if adjustments are neeeded. DON / ADON will be responsible for ensuring that analysis and any other audits are completed and reviewed on an on-going basis. 7/30/14 8/31/14 9/30/14 RESPONSIBLE PERSON/S Director of Nursing Assistant Director of Nursing	

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{F 329}	Continued From page 7 rejected cares. R404's Physician Orders signed and dated 5/20/14, directed Lorazepam 0.5 mg oral tablet every 4 fours as needed for anxiety. R404's Plan of Care (POC) dated 6/3/14, indicated for mood a diagnosis of anxiety and for behavior being resistive to cares and treatments and being verbally abusive towards staff. The POC lacked target behaviors for use of the Lorazepam. An electronic Medications Administration Record (EMAR) dated 6/1/14, through 6/30/14, indicated R404 had received Lorazepam 0.5 mg oral on 6/6/14, 6/7/14, 6/8/14, 6/11/14, 6/12/14, 6/16/14, and 6/17/14. R404's Progress Notes lacked documented indications for use or effectiveness of Lorazapam. R404, observed on 6/24/14, at 8:00 a.m. was resistive to cares, was reapproached, and again refused. RN-A was interviewed on 6/24/14, at 2:00 p.m., and stated that Lorazepam was given by a trained medication aid (TMA) on 6/11/14, 6/12/14, 6/16/14, and 6/17/14, with no documented evidence of why the medication was administered, if non-pharmacological interventions were attempted, or effectiveness. RN-A stated the TMA was required to consult with a licensed nurse prior to administration of PRN medications. RN-A further stated the nurse was to check and document effectiveness of PRN medications 30 minutes after administration.	{F 329}		

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{F 329}	Continued From page 8 On 6/24/14, at 2:20 p.m. the director of nursing (DON) verified the TMA's needed to ask a licensed nurse before administering PRN medication. The DON confirmed the nurse would then be responsible to assess the effectiveness of the PRN medication and document the assessment in a progress notes. On 6/25/14, at 9:40 a.m. RN-J stated R404's refusal of cares would not be an appropriate reason to administer Lorazepam.	{F 329}		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		8/1/14

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F 441	Continued From page 9 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove changes were completed during dressing changes for 2 of 3 residents (R87, R404) who were observed for infection control practice. Findings include: R87's Diagnosis List dated 6/25/14, indicated quadriplegia, supra pubic catheter, stage four (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcers on the sacral (large triangular bone at the base of the spine) area and right trochanteric (hip) area, sepsis, osteomyelitis in the sacral and right trochanteric areas, debridement of sacral pressure ulcer with wound vac placement and a history of urinary tract infections (UTI). The most recent UTI was on 6/4/14. Wound care orders on the Treatment/Procedure Administration Record dated 6/1/14 to 6/30/14, directed cleansing to the sacral and right trochanteric pressure ulcers, pat dry, apply skin sealant and negative pressure	F 441	It is the policy of the Augustana Health Care Center to maintain an Infection Control Program that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. CORRECTIVE ACTION Staff who provided wound care for identified residents were re-educated on proper procedure and facility policy for hand wahing 7/19/14 IDENTIFICATION OF OTHER RESIDENTS: All residents are at risk for transmission of disease and infection if proper hand washing procedures are not followed. 7/19/14 MEASURES PUT IN PLACE: All licensed staff received one to one return skills demonstration education on "Dressing Change Clean Technique Audit," with a focus on hand washing and	

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F 441	Continued From page 10 wound therapy (wound vac) at 175 mmHg (millimeters of mercury) on Monday, Wednesday and Friday. Pressure ulcer wound care was observed on 6/25/14, at 9:30 a.m. Registered nurses (RN)-D and RN-F washed their hands in R87's bathroom and applied gloves. R87 was assisted onto the left side to access the pressure ulcers. RN-F removed the clear cover dressing and foam packing dressing from both pressure ulcers. Both RNs changed gloves without hand sanitization. RN-D used wound cleanser on both ulcers, patted the areas with a gauze dressing, removed gloves and washed hands. RN-D did not change gloves or sanitize hands between cleaning the separate ulcers. RN-F also cleansed both ulcers while wearing the same gloves. RN-D applied skin prep to the area around the wounds and changed gloves without hand sanitization. RN-F changed gloves and washed hands before placing a foam dressing into the sacral ulcer. RN-F changed gloves without hand sanitization before applying the clean foam dressing into the right hip ulcer and placing the clear adhesive cover sheet over the foam dressings on each ulcer. RN-F applied the wound vac tubing and foam and held it into place while RN-D covered it with the clear adhesive dressing. On 6/25/14, at 10:00 a.m. RN-D and RN-F stated they wash or sanitized their hands when going from dirty areas to clean areas. RN-F stated they change if they get "sticky or something" but do not wash or sanitize hands at those times. On 6/25/14, at 10:40 a.m. during an interview with the director of nursing (DON), the DON stated she would expect staff to wash or sanitize their	F 441	glove use. 7/20/14 All Nursing Assistants were educated on hand washing and glove use. 7/23/14 MONITORING MECHANISM: Nurses providing wound treatments will be audited on a regular basis through 7-31-14 to ensure substantial compliance with infection control policies and procedures 7/31/14 10% random audits of wound treatments will be conducted for the folowing 60 days to continue to provide substantial compliance 8/31/14 9/30/14 20% random audits of all nursing staff will be conducted for various procedures to ensure proper continued infection control protocols are being observed. All audits will be reviewed and monitored for compliance with facility infection control policies and procedures by the Quality Improvement committee 8/31/14 9/30/14 RESPONSIBLE PERSON/S Infection Control Nurse Director of Nursing and/or their designee	

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F 441	Continued From page 11 hands when going from dirty areas to clean areas and it would depend on what was touched prior to removing the gloves. The DON would not expect staff to wash or sanitize their hands between glove changes if they did not touch anything dirty during the procedure. The facility's Hand Washing/Sanitizing policy/procedure revised on 12/08 indicated hands washing or sanitizing was necessary after removing gloves. The Infection Control Dressing Change policy revised on 3/09, directed staff to wash or sanitize their hand after removing their gloves and reapplying new gloves. An computer-generated Diagnostic Listing by Client form indicated R404's diagnoses included stage 4 pressure ulcer. A significant change Minimum Data Set (MDS) dated 5/29/14, indicated R404 had no short-or long-term memory deficits, was at risk for the development of pressure ulcers, and was admitted with 1 stage 4 pressure ulcer. R404's Plan of Care dated 6/4/14, indicated a history of pressure ulcers, and directed interventions and preventative skin care every shift. R404's Physician Orders signed and dated 5/20/14, directed wound care every 2 days and PRN [as needed] to the sacrum; cleanse with NS [normal saline], pat dry, apply skin sealant to wound edges, and cover with Mepilex border dressing. R404's sacral ulcer dressing change was observed on 6/24/14, at 3:05 p.m.. RN-A removed	F 441		

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F 441	Continued From page 12 R404's old dressing from the sacral area and removed the gloves before leaving the room without washing hands. In less than a minute, RN-A returned to R404's room with a disposable ruler to measure the sacral ulcer. RN-A applied a new pair of disposable gloves, assisted nursing assistant (NA)-B with peritoneal cleansing and measured the sacral ulcer. RN-A cleansed R404's sacral ulcer area with normal saline solution, applied the skin barrier to the skin surrounding the sacral ulcer, and then applied the Mepilex dressing. RN-A removed the gloves and washed her hands in R404's bathroom sink. On 6/24/14, at 3:15 p.m. RN-A stated she should have washed her hands after removing the soiled gloves after removing R404's sacral ulcer dressing. On 6/25/14, at 10:37 a.m. the director of nursing (DON) stated hand washing or hand sanitizing should be conducted after removing gloves when old dressing are removed from wounds or ulcers. The DON confirmed handwashing was required with glove removal and upon entering/exiting a resident room.	F 441		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GU16

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF MPLS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **05/02/2014** (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 **268** (L18)

13.Total Certified Beds **268** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	268			
(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 :
Chris Elmgren, HFE NEII 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: MPM
Mark Meath, Enforcement Specialist 06/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(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: 24-5242

On May 2, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. In addition, a the time of the standard survey, an investigation of complaint number H5242091 was conducted and found to be unsubstantiated. The facility has been given an opportunity to correct before remedies would be imposed.

Life Safety Code (LSC) deficiency cited at K067 has been recommended for approval for a continuing waiver due to the unreasonable hardship financially and period of time it would displace residents. The facility is complying with the LSC requirements as the facility"s corridors are being used as a plenum.

Refer to the CMS 2567 for both health and life safety code along with the plan of correction and additional documentation related to the K067 continuing waiver.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 10, 2014

Ms. Jean Cole, Administrator
Augustana Health Care Center of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

RE: Project Number S5242024, H524209

Dear Ms. Cole:

On May 2, 2014, 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 2, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5242091.

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 May 2, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5242091 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;

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:

Patricia Halverson, Supervisor
Duluth Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 340-6623

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 11, 2014, 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 11, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (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 2, 2014 (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 2, 2014 (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
Division of Compliance Monitoring
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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

5242s14.rtf

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
	245242	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

(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 #H5242091 was completed. The complaint was unsubstantiated. Census = 254	F 000		6/11/14
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/201

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

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F 156	Continued From page 1 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State	F 156		

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F 156	Continued From page 2 ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notification for termination of skilled rehabilitation services within the required timeframe, for 1 of 3 residents (R3) reviewed for liability notice and appeal rights. Findings include: R3's admission Minimum Data Set (MDS) dated 3/6/14, indicated he had a hip fracture and was receiving skilled rehabilitation services. A Notice of Medicare Non-Coverage dated 3/19/14, indicated R3's skilled rehabilitation	F 156	It is the policy of Augustana Health Care Center to inform residents both orally and in writing in a language that the resident understands of his or her rights and all rules, services, charges and regulations regarding that information Corrective Action: The staff members responsible for the timely informing of residents re; notification for termination of skilled rehabilitatin services have been educated to the absolute compliance needed with this procedure. The identified resident (R3) was requesting discharge at the time	

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F 156	Continued From page 3 services were to end on 3/19/14. R3's signature was obtained to reflect the notification was received and understood, with a signature date of 3/18/14. On 5/1/14, at 1:12 p.m. registered nurse (RN)-C stated R3 was given the Notice of Medicare Non-Coverage on 3/18/14, based on when the group home could transport him. RN-C verified R3's notice of non-coverage was not provided two days prior to skilled rehabilitation services ending, as per the requirement.	F 156	this notice was given thus requiring or requesting no additional services Identification of Other Residents: All residents receiving skilled rehabilitation services will be considered at risk for timely notification of termination of services. This will be audited by a 10% random monthly audit of all residents receiving skilled rehabilitatin services for the next 90 days. Audits will be completed on or before June 10, July 10, and August 10, 2014 Measures put in Place: Staff education completed by June 10, 2014 Monthly random audits for the next 90 days will be completed to ensure compliance Monitoring Mechanism: Compliance audits will be conducted by the Director of Clinical Reimbursement for the next 90 days. Compliance audits will be reviewed for the next 90 days by the Quality Improvement Committee for effectiveness and on-going sustainability of standard of practice for timely notification of notice of termination of skilled rehabilitation services Responsible Person/s: Director of Clinical Reimbursement / Director of Quality Improvement	6/11/14
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both	F 242		

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F 242	Continued From page 4 inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing services at a frequency consistent with each resident's preference, for 1 of 3 residents (R326) reviewed for choices. Findings include: R326's admission Minimum Data Set (MDS) dated 4/19/14, indicated her cognition was intact. The MDS identified R326 required limited assistance with personal hygiene activities and physical help for some bathing activities. A Care Planning Report dated 4/22/14, indicated R326 was unable to bathe herself independently, due to a recent hospitalization for congestive heart failure (CHF) and exacerbation, with shortness of breath. The care plan indicated R326 required physical assistance of one staff for parts of her bathing activities. During interview on 4/28/14, at 12:41 p.m. R326 stated she was not asked of her preference for bathing frequency during the facility's admission process. R326 added, a bath was provided one time per week, but she preferred to take baths three times per week. Review of the One Main Team 1 (one) Bath Schedule (undated), indicated R326 was to receive one bath per week, on Sunday evenings.	F 242	It is the policy of Augustana Health Care Center that the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care: and make choices about aspects of his or her life in the facility that are significant to the resident. Corrective Action: Identified resident was interviewed re; bath preferences, selected bath time and frequency was added to the care plan to ensure residents preferences are and continue to be honored (5/17/14) Identification of Other residents: All new admits will be interviewed by the admitting nurse re: their bathing preferences to include day, time and frequency. (5/20/14) All current residents will be audited for their bathing prederences. (6/10/14) Measures put in place: Review of resident choice re: bathing preferences was done at the regularly scheduled Resident council meeting on May 12, 2014. All staff education will be conducted on the importance of identifying, and observing resident choice that is consistent with the resident's interests, assessments, and plans of care. Random audits of 10% of all residents will	

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F 242	Continued From page 5 On 5/1/14, at 11:30 a.m. nursing assistant (NA)-B stated R326 had asked if therapy could assist her with a bath today. NA-B further stated R326 was scheduled to receive a bath one time per week, on Sunday. NA-B reported that if a resident requested an extra bath or shower, the staff would try to give them one. On 5/1/14, at 11:40 a.m. registered nurse (RN)-E stated the nurse who admitted a resident was to inform them of their one time per week bath. RN-E further stated residents were not asked how frequently they preferred to receive a bath. RN-E reported that if a resident wanted more than one bath per week, they needed to make the request and then the facility would make accommodations. RN-E added, sometimes residents requested a change in bathing frequency during care conferences. However, residents were not asked about bathing frequency and had to request a change if they wanted a bath more than one time per week. On 5/1/14, at 11:45 a.m. RN-F stated she was not aware that R326 wanted more than one bath per week and confirmed her medical record lacked documentation to indicate she was asked on admission about her preferences for bathing frequency. A Care Plan Policy revised 1/14, indicated residents were to be provided individualization through choices and preferences in their plan of care in order to be assisted to meet their activities of daily living, health care, and psychosocial needs.	F 242	be conducted to ensure bathing preferences are being observed for the next 90 days. (6/10/14, 7/10/14 8/10/14) Monitoring Mechanism Compliance sudits will be conducted by the unit Clinical Manager for the next 90 days Compliance audits will be reviewed for the next 90 days by the Quality Improvemet Committee for effectiveness and on-going sustainability of standard of practice for observing resident preferences Person Responsible: DOn / ADON	
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE	F 247		6/11/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 247 SS=D	Continued From page 6 ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notice for change of roommate assignments, prior to the change occurring, for 1 of 1 resident (R326) who had a recent roommate change. Findings include: R326's admission Minimum Data Set (MDS) dated 4/19/14, indicated her cognition was intact. During interview on 4/29/14, at 12:50 p.m. R326 denied having received notification from the facility, prior to her current roommate moving into her shared resident room. R326 stated she received a new roommate approximately six days prior, but was never informed that a new roommate was going to be moving in. On 5/1/14, at 2:00 p.m. social services (SS)-B stated that since R326 was admitted into a double room in the facility's transitional care unit (TCU), she should have known she was going to receive a roommate. SS-B verified R326's medical record lacked any documentation to evidence notification for the roommate change was provided. SS-B stated she did not know what the facility's policy was for the TCU residents being informed of roommate changes and needed to talk to her supervisor.	F 247	It is the policy of Augustana Health Care Center that resident's will receive notice before the resident's room or roommate in the faciity is changed. Corrective Action: All Social Workers were immediately reminded of the reguirement to notify all residents of a new roommate, and that efective immediately they were required to document that notification had occurred (5/2/14 All Social Workers were asked to do a read and sign of their understadning of the policy to verbally inform and document in the medical record that notification of a change of roommate for all residents has been completed. Identification of Other Residents at Risk All residents would be identified as at risk for not being iformed of a change of roommate Random audits of 10% of residents receiving new roommates will be conducted be the Director of social Services for the next 90 days 6/10/14 7/10/14 8/10/14 Measures Put in Plan Education for all social Workers was completed on 5/20/14. Monthly random audits will be completed for the next 90	

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F 247	Continued From page 7 On 5/1/14, at 2:15 p.m. SS-A (director of social services) verified there was nothing documented to evidence R326 was informed she was getting a new roommate. SS-A added, on the TCU, they assumed that people knew they would be getting a roommate, since residents were coming and going so frequently on the unit. SS-A stated the facility staff did document notification of roommate changes for residents who lived on the long term care units, but did not do this for residents who lived on the TCU. The facility's policy for notification of roommate changes reviewed 7/08, indicated that social service staff were to verbally inform all residents of changes in roommates or of changes to their room assignments.	F 247	days to ensure compliance. Monitoring Mechanism Compliance audits will be conducted by the Director of Social Services for the next 90 days	6/11/14
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reposition residents as per the written plan of care, for 1 of 3 residents (R190) reviewed who was at risk for the development of pressure ulcers. Findings include: R190's Care Planning Report dated 11/1/13,	F 282	It is the policy of the Augustana Health Care Center that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Corrective Action: Per observation and medical record review resident (R190) has not developed any skin issues. The Care plan has been	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8 indicated she was at risk for skin impairment due to her impaired mobility, bowel and bladder incontinence, cerebrovascular accident (CVA) with left-sided weakness, chronic steroid use, and lower extremity edema. The care plan further indicated R190 required the head of her bed to be elevated for more comfortable breathing, which resulted in an increased potential for friction or sheer. Care plan interventions were added on 12/5/13, including a perimeter/pressure redistribution mattress, turning and repositioning every two hours, and application of a moisture barrier cream. A Group Sheet/ nursing assistant care sheet (undated) indicated R190 was at risk for skin breakdown and directed she be turned and repositioned with the assistance of one staff, every two hours and as needed. R190's quarterly Minimum Data Set (MDS) dated 4/9/14, indicated she had a moderate cognitive impairment, required extensive assistance with bed mobility and transfers, and was at risk for the development of pressure ulcers. During continuous observation on 4/30/14, from 7:15 a.m. to 10:12 a.m., R190 was noted as lying on her back, in bed, with the head of the bed raised to at least 30 degrees. At 7:45 a.m., licensed practical nurse (LPN)-A was observed to enter R190's room. R190 was observed to remain in the same position in her bed. At 8:30 a.m., nursing assistant (NA)-A was observed to enter R190's room with a breakfast meal tray. NA-A assisted R190 to eat breakfast while still in bed. At 8:40 a.m., R190 stated breakfast was done and NA-A was observed to lower the head of her bed. R190 remained on her back, in bed. At 10:12 a.m., nearly three hours from when the observation began, NA-A stated she was ready to	F 282	consistently followed related to off loading (while in chair) and re-positioning (while in bed). She was experiencing a general decline and was hospitalized on May 12, 2014, and expired while in the hospital. Identification of Other Residents All residents that are identified at risk for skin breakdown, would also be considered at risk for not following the care plan related to re-poistioning and off loading. Measures Put in Place: All Nursing department staff will be educated on the importance of following the care plan, with focus on re-positioning and off loading as part of the presention of skin breakdown, this will be completed on or before June 11, 2014. All clinical Managers and Nursing Supervisors received a list of residents identified as at risk for skin breakdown on May 2, 2014. Monthly random audits of 10% of all residents identified as requiring re-positioning will be conducted for the next 90 days to ensure re-poistioning and off loading is being followed per plan of care. 6/10/14 7/10/14 8/10/14 Monitroing Mechanism: Compliance audits will be conducted by the Clinical managers and Nursing supervisors for the next 90 days. Compliance audits will be reviewed for the next 90 days by the Quality Improvement committee for effectiveness and on-going sustainabiity of standard of practice for re-positioning and off loading of residents. 6/11/14 Responsible Person/s: DON / ADON	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	05/02/2014

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AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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F 282	Continued From page 9 provide R190 with morning cares. NA-A was observed to reposition R190 to her left side while providing a bed bath. R190's buttocks were observed as deep red in color. A separate, round and reddened area was noted on her lower back, above the coccyx. LPN-A was called to R190's room to observe the reddened areas. LPN-A stated R190 had lupus and had been having some rash issues with her skin. LPN-A stated she would report the skin issues to the wound care nurse. On 4/30/14, at 10:50 a.m. NA-A stated R190 was supposed to be turned and repositioned every two hours. NA-A stated she had last repositioned R190 at approximately 6:30 a.m., when she first came on shift to work (three hours and 42 minutes before R190 was observed to be repositioned). On 4/30/14, at 12:58 p.m. LPN-A stated R190 was to be repositioned every two hours and was to be positioned off of her back, more side-to-side, to minimize the redness noted on her buttocks. On 5/1/14, at 12:50 p.m. registered nurse (RN)-A stated the red area on R190's sacral area was not pressure related, but part of the lupus rash she had been exhibiting. However, RN-A did confirm R190 was to be repositioned every two hours due to skin risk factors. On 5/1/14, at 2:20 p.m. RN-B stated R190 should have been repositioned every two hours while in bed, which meant she was to be off of her back, with more side-to-side repositioning due to her skin risk factors.	F 282		

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F 314 F 314 SS=D	Continued From page 10 483.25(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 observation, interview, and document review, the facility failed to implement repositioning interventions to minimize the risk of skin breakdown, for 1 of 3 residents (R190) reviewed who was at risk for developing pressure ulcers. Findings include: R190's quarterly Minimum Data Set (MDS) dated 4/9/14, indicated she had a moderate cognitive impairment. Her Braden Scale/Comprehensive Skin Risk Evaluation dated 10/18/13, indicated she was at high risk for developing skin breakdown due to being chair fast, incontinent of bowel and bladder, and requiring maximum assistance with all activities of daily living (ADLs). R190's Care Area Assessment (CAA) dated 11/1/13, identified additional risk factors for skin breakdown, including the potential for friction and sheer, the use of psychotropic medication, and diagnoses of schizoaffective disorder, atrial fibrillation, cerebrovascular accident (CVA), and	F 314 F 314	It is the policy of the Augustana health Care Center to provide treatment/services for the prevention and healing of pressure sores. Corrective Action: Per observation and medical record review resident (R190) has not developed any skin isues. Care plan has been consistently followed related to off loading (while in chair) and re-positioning (while in bed). She was experiencing a general decline and was hospitalized on May 12, 2014, and expired whle in the hospital. Identification of Other Reisdents: All residents that are identified at risk for skin breakdown, would also be considered at risk for not following the care plan related to re-poistioning and off loading. Measures Put in Place All Nursing department staff will be educated on the importance of following the care plan, with focus on re-positioning	6/11/14

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F 314	Continued From page 11 glaucoma. R190's Care Planning Report dated 11/1/13, indicated she required the head of her bed to be elevated for more comfortable breathing, which resulted in an increased potential for friction or sheer. Care plan interventions were added on 12/5/13, including a perimeter/pressure redistribution mattress, turning and repositioning every two hours, and application of a moisture barrier cream. A Group Sheet/ nursing assistant care sheet (undated), directed she be turned and repositioned with the assistance of one staff, every two hours and as needed. During continuous observation on 4/30/14, from 7:15 a.m. to 10:12 a.m., R190 was noted as lying on her back, in bed, with the head of the bed raised to at least 30 degrees. At 7:45 a.m., licensed practical nurse (LPN)-A was observed to enter R190's room. R190 was observed to remain in the same position in her bed. At 8:30 a.m., nursing assistant (NA)-A was observed to enter R190's room with a breakfast meal tray. NA-A assisted R190 to eat breakfast while still in bed. At 8:40 a.m., R190 stated breakfast was done and NA-A was observed to lower the head of her bed. R190 remained on her back, in bed. At 10:12 a.m., nearly three hours from when the observation began, NA-A stated she was ready to provide R190 with morning cares. NA-A was observed to reposition R190 to her left side, while providing a bed bath. R190's buttocks were observed as deep red in color. A separate, round and reddened area was noted on her lower back, above the coccyx. LPN-A was called to R190's room to observe the reddened areas. LPN-A stated R190 had lupus and had been having some rash issues with her skin. LPN-A stated	F 314	and off loading as part of the prevention of skin breakdown, this will be completed on or before June 11, 2014. All Clinical managers and Nursing Supervisors received a list of residents identified as at risk for skin breakdown on May 2, 2014. Monthly random audits of 10% of all residents identified as requiring re-positiioning will be conducted for the next 90 days to ensure re-positioning and off loading is being followed per plan of care. 6/10/14 7/10/14 8/10/14 Monitoring Mechanism: Compliance audits will be conducted by the Clinical Managers and Nursing supervisors for the next 90 days. Compliance audits will be reviewed for the next 90 days by the Quality Improvement committee for effectiveness and on-going sustainability of standard of practice for re-positioning and off loading of residents. 6/11/14 Responsible Person/s: DON / ADON	

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F 314	Continued From page 12 she would report the skin issues to the wound care nurse. On 4/30/14, at 10:50 a.m. NA-A stated R190 was supposed to be turned and repositioned every two hours. NA-A stated she had last repositioned R190 at approximately 6:30 a.m., when she first came on shift to work (three hours and 42 minutes before R190 was observed to be repositioned). On 4/30/14, at 12:58 p.m. LPN-A stated R190 was to be repositioned every two hours and was to be positioned off of her back, more side-to-side, to minimize the redness noted on her buttocks. On 5/1/14, at 12:50 p.m. registered nurse (RN)-A stated the red area on R190's sacral area was not pressure related, but part of the lupus rash she had been exhibiting. However, RN-A did confirm R190 was to be repositioned every two hours due to skin risk factors. On 5/1/14, at 2:20 p.m. RN-B stated R190 should have been repositioned every two hours while in bed, which meant she was to be off of her back, with more side-to-side repositioning due to her skin risk factors.	F 314		
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	F 329		6/11/14

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F 329	Continued From page 13 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 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 parameters for use were identified, for 1 of 3 residents (R454) reviewed who was prescribed multiple analgesic medications. The facility also failed to assess for the necessity of as needed (PRN) medications prior to administration and to evaluate whether those medications were effective, for 1 of 5 residents (R454) reviewed who was prescribed an a PRN medication. Findings include: R454's Physician Orders dated 4/17/14, included the following medication orders: . Acetaminophen (a mild pain relieving medication) 325 milligrams (mg), two tablets (650	F 329	It is the policy of the Augustana Health Care Center that each resident's drug regimen is free from unnecessary drugs. Corrective Action: Per observation, resident interview, and chart review, identified resident (R454) has had his pain managed, and also his sleep related to the prn Zolpidem. His orders have been clarified related to diagnosis for Tylenol or Ibuprofen, and all prn's have been linked to monitoring. Identification of Other Residents: All residents with orders for any prn medication would be considered at risk in terms of diagnosis / parameters and also monitoring of effectiveness. Measures Put in Place:	

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F 329	Continued From page 14 mg) every four hours PRN for pain. · EQ Ibuprofen (a mild pain relieving medication) 400 mg, one tablet every eight hours PRN for pain. · Zolpidem Tartrate (a hypnotic medication) 5 mg, one tablet at bedtime PRN. A Comprehensive Pain Data Collection and Assessment dated 4/19/14, indicated R454's pain-related diagnoses included arthritis and a recent cerebrovascular accident (CVA). The assessment identified R454 occasionally displayed non-verbal pain indicators including sounds, facial expressions, restlessness, and rubbing of affected areas. However, his pain was well managed with prescribed PRN pain medications. The assessment noted R454's pain was to be monitored every shift, using a one-to-ten pain scale, including monitoring prior to administration of PRN pain medications. The Care Planning Report dated 4/29/14, indicated R454 was able to report pain to staff most of the time, via vocal complaints and protective body movements. The care plan further indicated R454's goals for pain management were to verbalize relief from the interventions and to maintain the highest possible level of comfort, with the following interventions: Offering a warm blanket, warm pack, cold pack, or repositioning; Offering PRN pain medications; and Offering sleep medications at bedtime if ordered/appropriate. The care plan also indicated R454 had a PRN medication available for sleep. R454's goals for sleep management were to report changes in sleep pattern or difficulties sleeping to staff as needed, with the following interventions: A dark room was to be provided when getting ready for sleep; Sleep	F 329	All licensed staff will review policy and procedure for transcribing prn orders and administration/follow-up on or before 6/10/14 All TMA's will review policy and procedure for administration, and reporting to licensed nurse for any prn's on or before 6/10/14 All Health Unit coordnators will review policy and procedure for transcribing prn orders on or before 6/10/14 Current prn orders are being reviewed by Clinical Managers to determine compliance with policy and procedure on or before 5/30/14 10% or more of all new prn orders will be reviewed for accuracy for the next 90 days 6/10/14 7/10/14 8/10/14 Monthly random chart audits of 10% of new admissions will be conducted for follow-up after administration of prn medication for the next 90 days. 6/10/14 7/10/14 8/10/14 Monitoring Mechanism: Results of audits will be reviewed at the monthly Quality Improvement committee meetings for the next 90 days for effectiveness and on-going sustainability of standard of practice for prn medication monitoring. 6/11/14 Responsible Person/s DON / ADON	

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F 329	Continued From page 15 medication (hypnotic) was to be administered as ordered; Pain medication was to be offered as needed; A bedtime snack and/or drink, repositioning with pillows for comfort, and toileting were to be offered; Linen was to be kept clean, dry, and wrinkle free; Hallway noise and/or light was to be minimized. R454's Medication Administration Record (MAR) dated 4/1/14, to 4/30/14, indicated he received Acetaminophen once on 4/22/14, twice on 4/23/14, once on 4/26/14, twice on 4/27/14, and once on 4/28/14. The MAR further indicated R454 received EQ Ibuprofen twice on 4/18/14, once on 4/20/14, and once on 4/21/14. The MAR indicated R454 had received Zolpidem Tartrate at bedtime on 4/22/14, 4/23/14, 4/26/14, and 4/28/14. Review of R454's electronic progress notes dated 4/17/14, through 4/28/14, lacked documentation for the effectiveness of the PRN Acetaminophen and for the effectiveness of the 4/26/14, and 4/28/14, PRN Zolpidem Tartrate. During numerous, intermittent observations from 4/28/14, through 5/1/14, R454 was noted both in and out of his resident room, with no remarkable signs/symptoms of pain/discomfort. On 4/29/14, at 1:54 p.m. R454 explained his pain was in the left shoulder and arm. R454 reported he received pain medication upon request, with relief. On 4/30/14, at 1:23 p.m. licensed practical nurse (LPN)-H stated R454 let staff know when a pain medication was needed. LPN-H further stated nursing staff assessed his pain level, documented which medication was given in the electronic record, and followed-up to determine if the medication was effective. LPN-H reported nursing staff used their professional judgment to	F 329		

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F 329	Continued From page 16 determine which pain medication to administer for R454's pain, the Acetaminophen for mild pain or fever, and the Ibuprofen for muscle or joint pain. On 4/30/14, at 1:30 p.m. registered nurse (RN)-D stated both R454's Acetaminophen and Ibuprofen were indicated for pain and did not differentiate which medication to administer for which type of pain. RN-D confirmed nursing staff were to use a pain scale to document both pain assessment, prior to administration of the medication and medication effectiveness, post administration. RN-D further stated PRN medication effectiveness was to be documented in the electronic progress notes and confirmed R454's Acetaminophen and Zolpidem results were not documented. On 4/30/14, at 2:05 p.m. LPN-B stated R454's pain medication orders needed clarification as to which pain medication was to be administered for which type or level of pain. The facility's Administration of PRN Medications policy revised 1/14, directed nurses were to evaluate a resident's need for a PRN medication upon a resident's request for medication and/or when signs/symptoms of pain were noted. Nurses were to check the resident's medication administration record or computer care path for a physician order, then document the PRN medication was given. Nurses were to observe for the resident's response to the medication and document the response in the medical record.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		6/11/14

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F 356	Continued From page 17 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the daily nursing hours posting included the number of licensed and unlicensed nursing staff, and the actual hours worked on each shift. This had the potential to affect all 254 residents who resided in the facility.	F 356	It is the policy of the Augustana Health Care Center of Minneapolis to post the daily nurse staffing information. Corrective Action: Upon discussion with the surveyor during our annual survey the daily nurse staffing information posting was changed to	

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F 356	Continued From page 18 Findings include: On 4/28/14, at 4:00 p.m. during the initial tour, the daily nurse staff posting was observed on the facility's ground floor. The staff posting lacked the actual hours worked and number of registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants (NAs) who worked, for each of the identified shift times. The nurse staff posting also lacked this information when observed on 4/29/14, at 8:30 a.m. and on 4/30/14, at 11:30 a.m. On 4/30/14, at 12:50 p.m. the director of nursing (DON) was interviewed and verified the nursing hours posting lacked the actual hours worked and number of RNs, LPNs, and NAs working each shift. The facility policy and procedure for posting staffing information dated 10/13, directed staffing information be posted by shift, daily, with regulatory directives.	F 356	include all required information, with specific reference to actual hours worked and number of registered nurses, licensed practical nurses, TMA's and nursing assistants who worked for each identified shift. Measures Put in Place: Facility will ensure daily nurse staffing information continues to be posted in the required format through daily review by staffing office personnel. 5/2/14 Monitoring Meachanism: Nursing staffing hours are reviewed on a on-going basis by teh Director of Nursing or her disignee for compliance. 6/11/14 Responsible Person/s: DON / ADON	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF MPLS	**1007 EAST 14TH STREET** **MINNEAPOLIS, MN 55404**

(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. At the time of this survey, Augustana Home of Mpls 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 TO: Healthcare Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/2014

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
	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF MPLS	**1007 EAST 14TH STREET** **MINNEAPOLIS, MN 55404**

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K 000	Continued From page 1 Marian.Whitney@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. Augustana Home of Mpls is a 5-story building with a basement. The building was constructed at 3 different times. The original building was constructed in 1945 and was determined to be of Type II(222) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1974, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 290 beds and had a census of 257 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 05/01/2014, observation revealed that the exterior sidewalk slab at the ground floor east north exit door has subsided approximately 4 inches. This deficient practice was verified by the maintenance director at the time of the inspection.	K 038	It is the policy of the Augustana Health Care Center to provide appropriate means of egress that are readily accessible at all times. Corrective Action: Vendors were contracted and bids were obtained to repair identified sidewalk slabs. Contract has been secured and executed for sidewalk repair. 6/11/14 Monitoring Mechanism: director of Maintenance will routinely monitor egress at all entrances, and log compliance on a monthly basis. These rounds will be presentd at the quarterly Quality Assurance meeting for on-going review of sustainability of standard of practice for compliance with codes for means of egress. 6/11/14 Responsible Person/s: Director of Mainatenance / Director of Quality Improvement	6/11/14
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		6/11/14

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K 050	Continued From page 3 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide quarterly drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 05/01/2014, record review revealed that: 1. There was no AM shift drill for the first quarter of 2014, 2. There was no night shift drill for the third quarter of 2013, 3. There was no PM shift drill for the fourth quarter of 2013. These deficient practices were verified by the maintenance director at the time of the inspection.	K 050	It is the policy of the Augustana Health Care Center to implement fire drills at unexpected times under varying conditions at least one time on all shifts every quarter. Corrective Action: Fire Drill schedule was revised to be in compliance with standard of a least one drill per quarter on every shift. 6/1/14 Monitoring Mechanism: The fire Drill schedule will be reviewed on a monthly basis by the faciity Safety Officer, and Director of Quality Improvement to ensure compliance with schedule of at least one drill on each shift per quarter. The Fire Drill schedule will be a standing agenda item at the monthly Safety committee meetings to ensure compliance with specified schedule. 5/6/14 Responsible Person/s: Director of Maintenance / Facility Safety Officer	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed	K 067		6/11/14

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K 067	Continued From page 4 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 observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect the residents. Findings include: During the facility tour between 9:30 AM and 11:30 AM on 05/01/2014, observation revealed that the ventilation system for the main building appears to be utilizing the egress corridor as an air plenum for the resident rooms. This deficient practice was verified by the maintenance director at the time of the inspection.	K 067	See attached waiver for K067 See attached bid for K067	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GU16

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF MPLS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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 **05/02/2014** (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 **268** (L18)

13.Total Certified Beds **268** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	268			
(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 :
Chris Elmgren, HFE NEII 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: MPM
Mark Meath, Enforcement Specialist 06/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(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: 24-5242

On May 2, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. In addition, a the time of the standard survey, an investigation of complaint number H5242091 was conducted and found to be unsubstantiated. The facility has been given an opportunity to correct before remedies would be imposed.

Life Safety Code (LSC) deficiency cited at K067 has been recommended for approval for a continuing waiver due to the unreasonable hardship financially and period of time it would displace residents. The facility is complying with the LSC requirements as the facility"s corridors are being used as a plenum.

Refer to the CMS 2567 for both health and life safety code along with the plan of correction and additional documentation related to the K067 continuing waiver.

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K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed	K 067		6/11/14

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

F5242022

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245242	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	A. BUILDING 1 B. WING C. FLOOR K3	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	A. (•) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✓] MEDICARE [✓] MEDICAID	K4 05/01/2014	K6	5. [✓] 2000 EXISTING 6. [ ] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (•) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. [ ] ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (•) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 290	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ___	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 290	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 290	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID ___

7. A. (•) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (•) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) FSES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
ROBERT REXEISEN	DEPUTY STATE FIRE MARSHAL	STATE FIRE MARSHAL	05/01/2014
SURVEYOR ID 28120 K10			
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE	DATE
	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	5-5-14

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES				K12- 5-story building with a basement. The building was constructed at 3 different times. The original building was constructed in 1945 and was determined to be of Type II (222) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1974, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. In 1974, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.
	BUILDING CONSTRUCTION				
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2	○	○	◉	
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	◉	○	○	
	1 ◉ I (443), I (332), II (222) — Any Height				
	2 ○ II (111) — One story only (non-sprinklered).				
	3 ○ II (111) — Not over three stories with complete automatic sprinkler system.				
	4 ○ III (211) — Not over two stories with complete automatic sprinkler system.				
	5 ○ V (111) — Not over two stories with complete automatic sprinkler system.				
	6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system.				
	7 ○ II (000) — Not over two stories with complete automatic sprinkler system.				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000) — Not over one story with complete automatic sprinkler system.				
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*				

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.							
	1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2		II (111)	Not over three stories with complete automatic sprinkler system				
	3		III (211)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)				◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s*_____				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s*_____				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.	◉	○	○	
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 *If the walls have a fire resistance rating, give rating _____ if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*	◉	○		
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3	◉	○		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.^{2} and the opening is installed in bottom half of the wall (80 in.^{2} in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: ☐ (a) The required manual fire alarm system and ☐ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Describe method used in REMARKS				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	◉	○	○	
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2				
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	◉	○	○	
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				
K25	2000 EXISTING 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	◉	○	○	
	2000 NEW Smoke barriers shall be constructed to provide at least a one 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 in approved frames. 8.3, 18.3.7.3, 18.3.7.5				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	◉	○	○	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: Provider Type / Swinging Doors / Horizontal Sliding Doors Hospitals and Nursing Facilities: 41.5 inches (105 cm) / 83 inches (211 cm) Psychiatric Hospitals and Limited Care Facilities: 32 inches (81 cm) / 64 inches (163 cm) 18.3.7.7				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	◉	○	○	
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREAS				
K29	2000 EXISTING One hour fire rated construction (with ¾ 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 shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be 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	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	✔	✔	
c. Laundries (greater than 100 sq feet)	✔	✔	
d. Repair Shops and Paint Shops	✔	✔	
e. Laboratories (if classified a Severe Hazard - see K31)			✔
f. Combustible Storage Rooms/Spaces (over 50 sq feet)	✔	✔	
g. Trash Collection Rooms	✔	✔	
i. Soiled Linen Rooms	✔	✔	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair, Maintenance and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			
m. Combustible Storage Rooms/Spaces (over 100 sq feet)			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles	✔	✔	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ☐ The corridor is at least 6 feet wide ☐ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ☐ The dispensers shall have a minimum spacing of 4 ft from each other ☐ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ☐ Dispensers are not installed over or adjacent to an ignition source. ☐ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623	◉	○	○	
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating “No Exit”. 7.10, 18.2.10.1, 19.2.10.1	◉	○	○	
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	◉	○		
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3				K38 observation revealed that the exterior sidewalk slab at the ground floor east north exit door has subsided approximately 4 inches.
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	◉	○	○	
K35	The capacity of required mean of egress is based on its width, in accordance with 7.3.	◉	○		
K36	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	◉	○		
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	◉	○	○	
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	○	◉		
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5	◉	○		
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 *If doors lead directly to grade from each room, check this box.* ☐	◉	○		
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	◉	○		
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5	◉	○	○	
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2	○	○	◉	
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	◉	○		K50 record review revealed that: 1. There was no AM shift drill for the first quarter of 2014, 2. There was no night shift drill for the third quarter of 2013, 3. There was no PM shift drill for the fourth quarter of 2013.
	ILLUMINATION				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	◉	○		
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	◉	○		
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			☑	
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	◉	○	○	
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	○	◉	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	◉	○		
K52	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,	◉	○		
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	◉	○	○	
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ☐ Corridors ☐ Rooms ☐ Bath	○	○	◉	
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	◉	○		
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8	◉	○		
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
K60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1	◉	○		
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13	◉	○	○	
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	◉	○	○	
	A. Date sprinkler system last checked and necessary maintenance provided. 06/04/2013				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. OLSEN				
	C. Note the source of water supply for the automatic sprinkler system. CITY WATER				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	◉	○	○	
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	◉	○	○	
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	◉	○		
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	○	○	○	K67 observation revealed that the ventilation system for the main building appears to be utilizing the egress corridor as an air plenum for the resident rooms.
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	○	◉	○	
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	◉	○	○	
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	◉	○	○	
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	◉	○	○	
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.	○	○	◉	
K160	2000 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators & Escalators*. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	◉	○	○	
	2000 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)	○	○	●	
	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All escalators and conveyors comply with ASME/ANSI A17.1, *Safety Code for Elevators and Escalators.* 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	●	○	○	
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 ☐ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. ☐ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 ☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	●	○	○	
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A	●	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5	◉	○	○	
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)	○	○	◉	
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1	○	○	◉	
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)	○	○	◉	
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).	○	○	◉	
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).	○	○	◉	
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).	○	○	◉	
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	○	○	◉	
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	◉	○	○	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3	○	○	◉	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99)	○	○	◉	
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	◉	○	○	
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	○	○	◉	
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	◉	○		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2			☑	
K144	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)	◉	○	○	
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	◉	○	○	
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	◉	○		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	○	○	○	

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	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245242	**AUGUSTANA HCC OF MPLS**	*K4 **05/01/2014**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[X]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

Augustanna HCC

An annual/continuing waiver is being requested for K067.

K 067

The building heating, ventilation and 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.

A. Compliance with this provision will cause an unreasonable hardship because:

1. The most recent cost estimate dated May 9, 2014 for a complying ducted HVAC system is $1,900,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work)
2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 94% as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases
3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too:
    a. The building electrical system would need to be upgraded to support a new ducted system.
    b. The system would also require a new meter at additional costs to the ducted HVAC bid.
    c. Installation of a ducted system would require asbestos abatement which would also increase the cost.

   Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.
4. Due to these extensive costs, disruption and possible relocation of residents there are no immediate plans to implement the above major physical plant renovation. In addition to the extra associated projects an costs, the ducted system would need to penetrate l load bearing walls decreasing building structural integrity.
5. The building is currently 53 years old and not slated for replacement in the foreseeable future. The building has a useful life of an additional 75+ years and meets all LSC to ensure a safe physical environment for residents and staff, which in turn allows the existing non-complying HVAC to remain in use..

B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because:

1. The facility is Type II with an interior finish rating of Class A.
2. The walls, floors, ceiling and vertical opening resist the passage of smoke
3. The following safety features are installed:
    a. Fire Alarm EST-3 addressable, transmission type SD4 Version 5.2
    b. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1199 Ed. As of January 2008. (Fully (sprinkled, wetpipe quick response)
    c. Fire extinguishers – Dry chemical 4-A 60-BC
    d. The building is equipped with an approved, addressable fire alarm/smoke detector system, and all resident rooms are equipped with automatic smoke detection tied into the nurses call station.
4. In accordance with LSC 19.7.2.2, the facility has a compliant fire safety plan which included fire plans for all departments and employees, training on plans is conducted upon hire, and annually for all employees. Fire drills are conducted at least quarterly on each shift.
5. Operational plans include: Plans for all departments, and all office areas, Fire Out, Fire Drills, Fire Watch Alarms Out, Fire Watch Sprinkler systems out.
6. The facility sets a staff ratio at 3.69 nursing hours per day per resident.
7. There are 5 smoke compartments on Ground Floor, 1st, 2nd, and 3rd floor, 4 smoke compartments on 4th floor, and 3 on 5th floor Main which is currently closed
8. TCU residents are located on the first floor of both the East and Main building and houses 52 residents, the dementia care unit is located on 4th floor Main and houses 28 residents
9. The closest fire department is 1 mile away and has an average of 5 minutes or less response time.

5/2014

Fire Safety Supervisor

State Fire Marshal

5-21-14

MMC

May 9, 2014

Clark Worden
Augustana Apartments
1007 East 14th Street
Minneapolis, MN 55404

RE: Bldg A Ventilation Budget

Dear Mr. Worden:

Per your request the following budget proposal is to provide 100% outside air ventilation to all floors of the main building.

Included items in this proposal:

- Demo and relocate existing exhaust fans and roof vents to accommodate new air handler.
- Furnish and install one (1) 100% outside air rooftop complete with desiccant wheel, roof curb and controls.
- Structural engineering design for new rooftop and core drilling for new shafts.
- Necessary new ductwork and diffusers.
- Necessary new gas piping. New meter required and provided by others.
- Necessary new fire smoke dampers.
- Temperature controls
- Rigging
- Equipment rental
- Power wiring
- Insulation
- Air balance
- Check, Test, Start

The following items are not included:

- Overtime labor
- Painting
- Condition of existing systems.
- Dumpsters
- Structural Work Required
- General Construction

The budget cost to complete this scope of work is.....$1,900,000.00

Thank you for the opportunity! Please contact me with any questions.

Metropolitan **M**echanical **C**ontractors, Inc.
7340 Washington Avenue South ♦ Eden Prairie, Minnesota 55344
Phone: 952-941-7010 ♦ Fax: 952-941-9118

Sincerely,

Metropolitan Mechanical Contractors, Inc.

Accepted By:_____
Augustana

Apartments

Date:_____

Dale Haupert
Service Sales Manager
612-919-4701
dale.haupert@metromech.com

From:	Sheehan, Pat (DPS)
To:	rochi_lsc@cms.hhs.gov
Cc:	Rexeisen, Robert (DPS); jmcole@augustanacare.org; Dietrich, Shellae (MDH); Fiske-Downing, Kamala (MDH); Henderson, Mary (MDH); Johnston, Kate (MDH); Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	Augustana HCC of Minneapolis (245242) 2014 K67 Annual Waiver Request - Previously Approved - No changes
Date:	Thursday, May 22, 2014 9:14:08 AM

This is to inform you that Augustana HCC is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 5-1-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Augustanna HCC

An annual/continuing waiver is being requested for K067.

K 067

The building heating, ventilation and 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.

A. Compliance with this provision will cause an unreasonable hardship because:

1. The most recent cost estimate dated May 9, 2014 for a complying ducted HVAC system is $1,900,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work)
2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 94% as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases
3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too:
    a. The building electrical system would need to be upgraded to support a new ducted system.
    b. The system would also require a new meter at additional costs to the ducted HVAC bid.
    c. Installation of a ducted system would require asbestos abatement which would also increase the cost.

   Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.
4. Due to these extensive costs, disruption and possible relocation of residents there are no immediate plans to implement the above major physical plant renovation. In addition to the extra associated projects an costs, the ducted system would need to penetrate l load bearing walls decreasing building structural integrity.
5. The building is currently 53 years old and not slated for replacement in the foreseeable future. The building has a useful life of an additional 75+ years and meets all LSC to ensure a safe physical environment for residents and staff, which in turn allows the existing non-complying HVAC to remain in use..

B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because:

1. The facility is Type II with an interior finish rating of Class A.
2. The walls, floors, ceiling and vertical opening resist the passage of smoke
3. The following safety features are installed:
    a. Fire Alarm EST-3 addressable, transmission type SD4 Version 5.2
    b. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1199 Ed. As of January 2008. (Fully (sprinkled, wetpipe quick response)
    c. Fire extinguishers – Dry chemical 4-A 60-BC
    d. The building is equipped with an approved, addressable fire alarm/smoke detector system, and all resident rooms are equipped with automatic smoke detection tied into the nurses call station.
4. In accordance with LSC 19.7.2.2, the facility has a compliant fire safety plan which included fire plans for all departments and employees, training on plans is conducted upon hire, and annually for all employees. Fire drills are conducted at least quarterly on each shift.
5. Operational plans include: Plans for all departments, and all office areas, Fire Out, Fire Drills, Fire Watch Alarms Out, Fire Watch Sprinkler systems out.
6. The facility sets a staff ratio at 3.69 nursing hours per day per resident.
7. There are 5 smoke compartments on Ground Floor, 1st, 2nd, and 3rd floor, 4 smoke compartments on 4th floor, and 3 on 5th floor Main which is currently closed
8. TCU residents are located on the first floor of both the East and Main building and houses 52 residents, the dementia care unit is located on 4th floor Main and houses 28 residents
9. The closest fire department is 1 mile away and has an average of 5 minutes or less response time.

5/2014

Fire Safety Supervisor

State Fire Marshal

5-21-14

MMC

May 9, 2014

Clark Worden
Augustana Apartments
1007 East 14th Street
Minneapolis, MN 55404

RE: Bldg A Ventilation Budget

Dear Mr. Worden:

Per your request the following budget proposal is to provide 100% outside air ventilation to all floors of the main building.

Included items in this proposal:

- Demo and relocate existing exhaust fans and roof vents to accommodate new air handler.
- Furnish and install one (1) 100% outside air rooftop complete with desiccant wheel, roof curb and controls.
- Structural engineering design for new rooftop and core drilling for new shafts.
- Necessary new ductwork and diffusers.
- Necessary new gas piping. New meter required and provided by others.
- Necessary new fire smoke dampers.
- Temperature controls
- Rigging
- Equipment rental
- Power wiring
- Insulation
- Air balance
- Check, Test, Start

The following items are not included:

- Overtime labor
- Painting
- Condition of existing systems.
- Dumpsters
- Structural Work Required
- General Construction

The budget cost to complete this scope of work is.....$1,900,000.00

Thank you for the opportunity! Please contact me with any questions.

Metropolitan **M**echanical **C**ontractors, Inc.
7340 Washington Avenue South ♦ Eden Prairie, Minnesota 55344
Phone: 952-941-7010 ♦ Fax: 952-941-9118

Sincerely,

Metropolitan Mechanical Contractors, Inc.

Accepted By:_____
Augustana

Apartments

Date:_____

Dale Haupert
Service Sales Manager
612-919-4701
dale.haupert@metromech.com