DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL 'E SURVEY AGENCY	ID: GU16 Facility ID: 00164		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245242 2.STATE VENDOR OR MEDICAID NO. (L2) 159540700).	3. NAME AND ADI (L3) AUGUSTAN (L4) 1007 EAST 1 (L5) MINNEAPO	A HCC OF MPLS 4TH STREET		(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		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	7 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
 6. DATE OF SURVEY 08/11/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 	268 (L18)268 (L17)	B. Not in Com Requireme	ce With quirements Based On: cceptable POC pliance with Program nts and/or Applied V		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) X 5. Life Safety Code * Code: A,5 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)		
18 SNF 18/19 SNF 268 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARK			ATION DATE):					
See Attached Remarks	5 (IF ATTEICABLE 5	now lie cancele	ATION DATE).					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:		
Sue Miller, HFE NEII			08/21/2014	(L19)	Enforcement Specialist 09/23/2014 (L20)			
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	LOFFICE OR SINGLE STAT	TE AGENCY		
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22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 01/01/1982	BEGINNING	DATE	ENDING DATE	Ξ	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety		
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25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of		(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active		
(L27)	B. Rescind Sus	pension Date:						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45)		30. REMARKS			
20. TERMINATION DATE.	2)		indulia ito.		Jo. REMITING			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (06/24/2014	OF APPROVAL DAT	ΓE				
	(L32)			(L33)	DETERMINATION APPRO	VAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: GU16 Facility ID: 00164

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 determined 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, effective 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

General Information: (651) 201-5000 * TDD/TTY: (651) 201-5797 * Minnesota Relay Service: (800) 627-3529 * www.health.state.mn.us For directions to any of the MDH locations, call (651) 201-5000 * An Equal Opportunity Employer



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.

Augustana Heathcare Center of Minneapolis August 21, 2014 Page 2

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,

Mart meeth

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

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 245242	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/11/2014
Name	e of Facility		Street Address, City, State, Zip Code	
AL	IGUSTANA 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	(Y	′5)	Date
ID Prefix	F0323	Correction Completed 08/01/2014	ID Prefix	F0329	Correction Completed 08/01/2014	ID Prefix	F0441		Correction Completed 08/01/2014
	483.25(h)			483.25(1)	-		483.65		_
D.a. #			Bog #		Correction Completed	Dec. #			Correction Completed
Reg. #			Reg. #		Correction Completed	Reg. #			Correction Completed
Reg. #			_		Correction Completed				Correction Completed
_			_			D //			
Reviewed E		•	Date:	Signature of Sur	•		1	Date:	
State Agen	cy PHL	/mm	08/21/201	14 03	3023			08	8/01/2014
Reviewed E CMS RO	3y Review	ved By	Date:	Signature of Sur	rveyor:		1	Date:	
Followup t	o Survey Completed 5/2/2014	on:		Check for any Unco Uncorrected Defic				YES	NO

DEPARTMENT OF HEALT						DICARE & MEDICAID SERVICES	
					AND TRANSMITTAL	ID: GU16	
1. MEDICARE/MEDICAID PROVII		3. NAME AND A	DDRESS OF FAC	CILITY	TE SURVEY AGENCY	Facility ID: 00164 4. TYPE OF ACTION: 7 (L8)	
(L1) 245242 2.STATE VENDOR OR MEDICAID (L2) 159540700	NO.	(L3) AUGUSTAN (L4) 1007 EAST (L5) MINNEAPO	14TH STREET		(L6) 55404	1. Intial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
 5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 06/2 8. ACCREDITATION STATUS: 	6/2014 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray	09 ESRD 10 NF 11 ICF/III	<u>(12)</u> (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	07/30	
 11. LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 	DN 268 (L18)	Complianc	ance With equirements the Based On: acceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN X 5. Life Safety Code	7. Medical Director	
13.Total Certified Beds	268 (L17)	X B. Not in Cor Requirem	npliance with Pro- ents and/or Appli	gram ed Waivers:	* Code: B ,5	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN	1			15. FACILITY MEETS		
18 SNF 18/19 SNF 268	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REA See Attached Remarks	MARKS (IF APPLICA	ABLE SHOW LTC C	CANCELLATION	UDATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Teresa Ament, HFE	NEII	(05/21/2014	(L19)	Mark Meath, Program Specialist 08/26/2014 (L20)		
PA	RT II - TO BE	COMPLETED	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY	
 DETERMINATION OF ELIGIB <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	H CIVIL		uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :	
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25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER	
(L27)	-	n of Admissions: 1spension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)	Posted 09/03/201	4 Co.	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAI	L DATE			
	(L32)	06/24/2014		(L33)	DETERMINATION APP	ROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL 'E SURVEY AGENCY	ID: GU16 Facility ID: 00164		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: GU16 Facility ID: 00164

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

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Mark Meath

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Electronically delivered August 21, 2014

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RE: Project Number S5242024

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Augustana Heathcare Center of Minneapolis August 21, 2014 Page 2

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

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Mart meeth

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

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Post-Certification Revisit Report

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(Y1)	Provider / Supplier / CLIA / Identification Number 245242	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/11/2014
Name	e of Facility		Street Address, City, State, Zip Code	
AL	IGUSTANA 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	(Y	′5)	Date
ID Prefix	F0323	Correction Completed 08/01/2014	ID Prefix	F0329	Correction Completed 08/01/2014	ID Prefix	F0441		Correction Completed 08/01/2014
	483.25(h)			483.25(1)	-		483.65		_
D.a. #			Bog #		Correction Completed	Dec. #			Correction Completed
Reg. #			Reg. #		Correction Completed	Reg. #			Correction Completed
Reg. #			_		Correction Completed				Correction Completed
_			_			D //			
Reviewed E		•	Date:	Signature of Sur	•		1	Date:	
State Agen	cy PHL	/mm	08/21/201	14 03	3023			08	8/01/2014
Reviewed E CMS RO	3y Review	ved By	Date:	Signature of Sur	rveyor:		1	Date:	
Followup t	o Survey Completed 5/2/2014	on:		Check for any Unco Uncorrected Defic				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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Meeth

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

5242r1_14.rtf

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 245242	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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 (Y	4) Item	(Y5)	Date
	F0156 483.10(b)(5) - (10), 483.10(Correction Completed _06/11/2014 b)(1)	-	F0242 483.15(b)	Correction Completed 06/11/2014	ID Prefix Reg. #	F0247 483.15(e)(2)		Correction Completed 06/11/2014
LSC		-	LSC			LSC			_
	F0282 483.20(k)(3)(ii)	Correction Completed 06/11/2014		F0314 483.25(c)	Correction Completed 06/11/2014	-	F0356 483.30(e)		Correction Completed 06/11/2014
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Reg. #			Correction Completed
ID Prefix Reg. # LSC		-	ID Prefix Reg. # LSC			Reg. #			Correction Completed
ID Prefix Reg. # LSC		-	ID Prefix Reg. # LSC						
Reviewed B	y Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
State Agenc	y MM/P	Н	07/09/20	14 2	9433			06/2	6/2014
Reviewed B	y Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
Followup to	Survey Completed on: 5/2/2014			•	Uncorrected Def d Deficiencies (C		-	YES	NO

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 245242	(Y2) Multiple Construction A. Building B. Wing 01 - MAII	Building 01 - MAIN BUILDING 01		
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
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		06/11/2014	ID Prefix		06/11/2014	ID Prefix		
-	NFPA 101	-	-	NFPA 101		Reg. #		
LSC	K0038		LSC	K0050		LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix			ID Prefix		
Reg. #			Reg. #			Reg. #		
LSC			LSC			LSC		_
		0			o "			
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		-	Reg. #		-			
LSC								
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		-	ID Prefix		-			
Reg. #		-	Reg. #			Reg. #		
LSC			LSC					
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		-	ID Prefix			ID Prefix		
Reg. #		_	Reg. #			Reg. #		
LSC			LSC			LSC		
Reviewed By	Reviewed I	Ву	Date:	Signature of Surve	yor:	1	Date:	
State Agency	/ MM/F	PS	07/09/202	28	3120		06/23	3/2014
Reviewed By	Reviewed I	Ву	Date:	Signature of Surve			Date:	
CMS RO								
Followup to	Survey Completed on:			Check for any	Uncorrected De	eficiencies. Was a Su	Immary of	
	5/1/2014			Uncorrecte	d Deficiencies (CMS-2567) Sent to th	e Facility? YES	NO

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A OMB NO.	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	
		245242	B. WING_		F 06/2	₹ 26/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
AUGUST	ANA HCC OF MPLS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	TS	{F 00	00}		
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the form. Your electron be used as verifica Upon receipt of an on-site revisit of yo validate that substa regulations has be	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility will be conducted to antial compliance with the en attained in accordance with				
F 323 SS=D	The facility must environment rema as is possible; and	F ACCIDENT RVISION/DEVICES Insure that the resident ins as free of accident hazards l each resident receives ion and assistance devices to	F3	323		8/1/14
	by: Based on observa review, the facility risks associated w	ENT is not met as evidenced ation, interview, and document failed to discuss the safety vith leaving the facility without f 1 residents (R404) reviewed		It is the policy of Augustana I Center to ensure that the resi environment remains as free hazards as is possible: and e receives adequate supervisio assistance devices to preven CORRECTIVE ACTION: Resident expired on 7/2/14.	ident of accident ach resident in and t accidents	
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	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.

PRINTED: 08/04/2014

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R B. WING 06/26/2014 245242 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1007 EAST 14TH STREET AUGUSTANA HCC OF MPLS MINNEAPOLIS, MN 55404 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 323 F 323 Continued From page 1 survey exit however the unit Clinical A computer-generated Diagnosis Listing by Client Manager and Social Worker completed a form dated 6/24/14, indicated R404's diagnoses risk to benefits discussion and form with included malignant neoplasm of the larynx and the resident re: the importance of signing stage 4 pressure ulcer. out upon his return on June 24, 2014. The resident acknowledged the A cognitive/dementia Care Area Assessment importance of signing out and agreed he dated 6/3/14, indicated R404 had an independent would do that in the future. There were no routine, went out into the community from time to further incidences of this resident not time, was reminded to sign out first, got around in signing out during his stay at Augustana. the wheelchair, and had intact cognition with 6/24/14 minimal symptoms of depression. **IDENTIFICATION OF OTHER** RESIDENTS: The Plan of Care (POC) dated 3/13/14, indicated All residents identified at risk for R404 was alert and oriented times 3, and was elopement and whose normal routine own decision maker but did not always make safe includes going outside were assessed choices. The POC did not address the safety and evaluated for their safety outside. risks of leaving the facility without signing out. Outdoor activity was added to the care plan for these residents by the Activity An electronic Progress Note dated 5/30/14, staff. If any resident was identified to indicated R404 left the facility without signing out. have safety or elopement risks, the The Progress Note also indicated R404 would be individuals care plan was reviewed, monitored every 30 to 60 minutes as R404 was a updated as needed for any appropriate flight risk. Additional notes on 5/30/14, indicated interventions and if necessary a specific R404 was allowed to leave the facility per the risk to benefits of noncompliance of care plan. There was no indication of R404 being informed of the risks of leaving the facility without proper procedure was completed. 7-31-14 signing out. MEASURES PUT IN PLACE: Upon admission residents will be informed The electronic Progress Note dated 6/6/14, by their Social Worker about the sign out indicated R404 left the facility without signing out procedures at the facility. The activity and fell over in the wheelchair while trying to get staff person will assess for their interest in up onto the cement curb. The Progress Note outdoor activity. If outdoor activity is lacked documentation to indicate R404's risks desired, activity staff will determine type, versus benefits of leaving the facility were duration, and any assistance needed to discussed. be safe when outside, outdoor activity will be documented in a progress note and On 6/24/14, R404 was observed from 7:24 a.m. added to the plan of care. If a risk to until 8:48 a.m., when went to the smoking room in benefits is required this will by completed the wheelchair. At 9:45 a.m. R404 was no longer

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00164

If continuation sheet Page 2 of 13

PRINTED: 08/04/2014

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING R B, WING 06/26/2014 245242 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1007 EAST 14TH STREET AUGUSTANA HCC OF MPLS **MINNEAPOLIS, MN 55404** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 2 F 323 by the Clinical Manager for that unit with observed in the smoking room and had not the resident, and/or their primary contact returned to the floor or to the room. At 10:30 a.m. and documented in the medical record. the surveyor alerted registered nurse (RN)-A as 7-31-14 to R404's absence. A communication was sent to primary contacts and all residents regarding the On 6/24/14, at 11:15 am RN-B stated R404 had sign out procedure and the importance of not been located and an Angel Alert (facility's using the sign out books. name for the procedure to follow in the case of a 7-21-14 missing resident) was called around 11:00 a.m. MONITORING MECHANISM: RN-B further stated R404 was not signed out to 10% random care plan audits will be leave the facility and had gone missing before. conducted for the next 90 days for RN-B stated the facility's policy for missing residents who participate in outdoor residents directed a search of the building and activity to assure their safety has been grounds and then call the Angel Alert. RN-B assessed, and proper interventions are in stated they had been searching for R404 since place. Audits will be reviewed for the next approximately 9:45 a.m. as R404 was due to be 90 days by the Quality Improvement repositioned and off-loaded every 2 hours. RN-B Committee for effectiveness in providing a further stated R404 was getting better with safe environment for residents who go complying with signing out before leaving the outdoors building. RN-J stated she could not recall the 7/31/14 incident on 5/30/14, but stated an 8/31/14 assessment/discussion of risks versus benefits 9/30/14 related to leaving the building alone was not **RESPONSIBLE PRESON/S** completed. **Director of Therapeutic Programs Director of Social Services** On 6/24/14, at 11:40 a.m. RN-I stated she was **Director of Quality Improvement** working on 5/30/14, when R404 left the building **Clinical Managers** 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00164

If continuation sheet Page 3 of 13

PRINTED: 08/04/2014

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

PRINTED: 08/04/2014 FORM APPROVED OMB NO 0938-0391

CENTER	SFOR MEDICARE	& MEDICAID SERVICES	_			NUD NO.	0930-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		245242	B. WING			R 06/26/2014	
	PROVIDER OR SUPPLIER	243242			REET ADDRESS, CITY, STATE, ZIP CODE	00/2	.0/2014
	ROVIDER OR SUFFLIER				07 EAST 14TH STREET		
AUGUST	ANA HCC OF MPLS			М	INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	On 6/24/14, at 2:20 (DON) stated resid intact could come wished. Residents back in. The DON	age 3 0 p.m. the director of nursing lents that were cognitively and go from the facility as the were expected to sign out and further stated the safety risks ty had not been discussed with	F	323			
{F 329} SS=D	UNNECESSARY I Each resident's dr unnecessary drug drug when used ir duplicate therapy) without adequate indications for its adverse conseque	ug regimen must be free from s. An unnecessary drug is any excessive dose (including ; or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose d or discontinued; or any		329}			8/1/14
	resident, the facili who have not use given these drugs therapy is necess as diagnosed and record; and reside drugs receive gra behavioral interve	rehensive assessment of a ty must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical ents who use antipsychotic dual dose reductions, and intions, unless clinically in an effort to discontinue these					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GU1612

Facility ID: 00164

If continuation sheet Page 4 of 13

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	08/04/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMP	PLETED
		245242	B. WING			6/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA HCC OF MPLS				1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 329}	Continued From pa	age 4	{F 32	29}		
	by: Based on observa review, the facility if for use and to eval medications for 3 of R404) reviewed for Findings include: R519 had a lumba stenosis on 6/9/14 6/25/14, indicated osteoarthrosis, de mononeuritis. The (MDS) dated 6/12/ term memory defic symptoms of deliri intact. The MDS of was cognitively int cleared. R519's care plan of related to the lami receiving narcotic well as nonpharm relief. The care p oriented and able behalf. R519 had physicia 6/16/14, for Hydro (narcotic analgesi every four hours a physician order la	NT is not met as evidenced tion, interview and document failed to document indications uate effectiveness of PRN of 4 residents (R519, R454, r unnecessary medications. r laminectomy for spinal . The diagnosis listing dated further diagnoses to include pressive disorder, and e admission Minimum Data Set (14, indicated R519 had short cits and experienced signs and um, but long term memory was dated 6/20/14, indicated R519 act and the delirium had dated 6/23/14, identified pain nectomy and indicated she was pain medications as needed as acological interventions for pain lan also identified R519 as alert to make decisions on her own an's orders dated 6/13/14 and pmorphone HCI (Dilaudid) ic) 4-8 milligrams (mg) by mouth as needed for pain. The icked parameters for specific did related to the level of pain		R454's orders have been clarifie to diagnosis for tylenol or ibuprofe all prn's have been linked to mon All licensed staff and TMAs will re policy and procedure, and TMAs report to the nurse before admini of prn meds. Current prn orders of reviewed by 5/30/14. 10% of mor chart audits of new admissions w completed over the next 90 days New POC / 7/18/14 It is the policy of Augustana Heal Center that each resident's drug will be free from unnecessary dru CORRECTIVE ACTION: Resident #404 - Following chart and observation, it was determin there were no adverse effects from missing documentation related to medications that were administe Resident expired related to his te illness on 7/2/14. Resident #519 - Following chart and observation, it was determin there were no adverse effects from lack of specific orders for param her pain medication, or the miss documentation of assessment for the administration of the same medication. Resident was succo discharged home on 7/2/14 Resident #454 - Following chart and observation, it was determin there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects from and observation, it was determing there were no adverse effects resident was succe	en, and itoring. eview will stration will be othly vill be th Care regimen ugs. review red that or the or the prn red. erminal review hed that om the neters on sing ollowing essfully	

Facility ID: 00164

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PRINTED: 08/04/2014 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COMPLI	
	I GORREOHON		A, BUILDI	NG	R	
		245242	B. WING			/2014
	PROVIDER OR SUPPLIER	240242		STREET ADDRESS, CITY, STATE, ZIP COD		
	ROWDER OR SUFFLIER			1007 EAST 14TH STREET		
AUGUST	ANA HCC OF MPLS			MINNEAPOLIS, MN 55404		
(() 15	SUMMARY ST	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETIO
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		DATE
{F 329}	Continued From pa	aa 5	{F 32	201		
{i 528}	Continued From pa	ige 5	1 02	the lack of documentation prio	r to and	
	R519's medical rec	ord lacked		following the administration of		
		nentation of effectiveness of		pain medication, and hypnotic		
		ministered. The medications		is currently stable in long term		
		ord (MAR) from 6/13/14		IDENTIFICATION OF OTHER		
		dicated R519 received		RESIDENTS:		
	Dilaudid 41 times;	however, the effectiveness of		It was determined by the IDT		
	the medication was	s documented only 11 times.		residents could potentially be		
				the identified deficient practice	e.	
	During an interview	v on 6/25/14, at 9:21 a.m.		MEASURES PUT IN PLACE:	on DPN	
	licensed practical i	hurse (LPN)-A stated she		In addition to previous training use and Unnecessary Drug re	aime's the	
	administered 4 mg	of Dilaudid for pain rated 5		clinical managers and supervi		
	and under, and 8 r	ng of Dilaudid for a pain rating her stated she would return 30		review all prn's for appropriate		
	minutes after adm	inistering the pain medication,		assessment and documentati		
	assess the nain le	vel and effectiveness of		usage and effectiveness daily		
	medication and de	ocument the results in the		"PRN Analysis Reports" out o	f the ERH	
	progress notes.		1	software to review all prn med	lications	
	p. 03. 000			administered as well as all as		
		7 a.m., registered nurse		documentation. Any errors of		
	(RN)-G stated the	re should be progress notes		documentation are reviewed		
		ctiveness of PRN pain		nurse to ensure that practice		
	medication.			immediately improved, and co		
		s Orders dated 6/9/14, included		appropriate. As a standard o		
	the following medi			nurses who do not improve for process and re-education will	he subject	
		(hypnotic medication) 5		to the appropriate progressive		
	milligrams (mg), c	ne tablet PRN (as needed). EQ pain relieving medication) 400		action.	alooipiiriasy	
		et every eight hours PRN.		8/1/14		
		scovery eight hours i rate.		Afer 8/1/14 prn analysis will b	e done 3	
	The MAR dated 6	/1/14, to 6/30/14, indicated		times a week for 1 month and	1 2 times a	
	R454 received EC) Ibuprofen once on $4/12/14$,		week for the following month		
	once on 4/16/14,	and twice on 4/24/14. The MAR		month on-going. DON / ADC		
	also indicated R4	54 received Zolpidem Tartrate		any corrections to ensure that	t errors are	
	on 4/11/14, 4/12/1	4, 4/15/14, 4/17/14, and		not repeated		
	4/19/14.			8/31/14		
		ogress notes dated 4/10/14,				
	through 4/24/14, I	acked documentation of the		MONITORING MECHANISM		
	indications for use	e or for the effectiveness of the		Outcomes of the analysis of		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM / MB NO.	08/04/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
	245242		B. WING			R 06/26/2014	
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA HCC OF MPLS					107 EAST 14TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 329}	PRN Ibuprofen and On 6/24/15, at 1:55 for giving PRN mer- were to be charted verified there was in progress notes reg effectiveness of the Tartrate from 4/10/ The facility's Admin policy revised 1/14 resident's need for resident's need for resident's request signs/symptoms of were to check the administration reco- physician order, the medication was given administrators (TM from a licensed nu- of PRN medication the resident's resp document the resp R404 was given L medication) with m behaviors, and the not documented. A computer-gener form dated 6/24/1 included malignar A significant chan- dated 5/29/14, ind long-term memory symptoms of deput	age 6 d PRN Zolpidem Tartrate. 5 p.m. RN-D stated the reason dications and the PRN results in the progress notes. The RN nothing documented in the garding the indications or e PRN Ibuprofen or Zolpidem 14, through 4/24/14 for R454. histration of PRN Medications , directed nurses to evaluate a a PRN medication upon a for medication and/or when f pain were noted. Nurses resident's medication ord or computer care path for a en document the PRN ven. Trained medication MA) were to obtain authorization inse prior to the administration hs. Nurses were to observe for bonse to the medical record. orazepam (anti-anxiety to documented target e medication effectiveness was rated Diagnosis Listing by Client 4, indicated R404's diagnoses at neoplasm of the larynx. ge Minimum Data Set (MDS) licated R404 had no short or y deficits, displayed no ression, had occasional verbal d towards others, and frequently		29}	assessment and documentation surrounding the prn administration reviewed at the monthly Quality Improvement meetings where it wi determined whether corrective acti- been sustained and practice remai satisfactory. It will be determined at time whether to conitnue process, adjustments are neeeded. DON / will be responsible for ensuring that analysis and any other audits are completed and reviewed on an on- basis. 7/30/14 8/31/14 9/30/14 RESPONSIBLE PERSON/S Director of Nursing Assistant Director of Nursing	ll be on has ins at that or if ADON at	

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		AND HUMAN SERVICES & MEDICAID SERVICES			0		PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	LETED
		245242	B. WING	_			6/2014
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA HCC OF MPLS				07 EAST 14TH STREET INNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 329}	Continued From parejected cares. R404's Physician C 5/20/14, directed L every 4 fours as new R404's Plan of Car indicated for mood behavior being res and being verbally POC lacked target Lorazepam. An electronic Medi (EMAR) dated 6/1/ R404 had received 6/6/14, 6/7/14, 6/8 and 6/17/14. R404's Progress N indications for use R404, observed o resistive to cares, refused. RN-A was intervie and stated that Lo medication aid (Th 6/16/14, and 6/17, evidence of why th administered, if no interventions were RN-A stated the T a licensed nurse p medications. RN- to check and doc	age 7 Orders signed and dated orazepam 0.5 mg oral tablet	{F 3				

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		AND HUMAN SERVICES & MEDICAID SERVICES			ON		PPROVED)938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245242	B. WING				6/2014	
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, 1007 EAST 14TH STRE				
AUGUST	ANA HCC OF MPLS			MINNEAPOLIS, MN	55404			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 329}	On 6/24/14, at 2:20 (DON) verified the licensed nurse befor medication. The D then be responsible of the PRN medica assessment in a pr On 6/25/14, at 9:40 refusal of cares wo reason to administ 483.65 INFECTIO SPREAD, LINENS The facility must e Infection Control F safe, sanitary and to help prevent the of disease and infe (a) Infection Contr The facility must e Program under wh (1) Investigates, c in the facility; (2) Decides what should be applied (3) Maintains a re actions related to (b) Preventing Sp (1) When the Infe determines that a prevent the sprea- isolate the resider (2) The facility must communicable di	 p.m. the director of nursing TMA's needed to ask a ore administering PRN ON confirmed the nurse would e to assess the effectiveness ation and document the rogress notes. O.a.m. RN-J stated R404's build not be an appropriate ter Lorazepam. N CONTROL, PREVENT Stablish and maintain an Program designed to provide a comfortable environment and e development and transmission ection. Fol Program establish an Infection Control nich it - controls, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. pread of Infection ection Control Program a resident needs isolation to ad of infection, the facility must 	F	441			8/1/14	

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PRINTED: 08/04/2014

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X3) D C	ATE SURVEY OMPLETED R
		245242	B. WING			6/26/2014
IAME OF F	ROVIDER OR SUPPLIEF	2			REET ADDRESS, CITY, STATE, ZIP CODE	
UGUST	ANA HCC OF MPLS	6			07 EAST 14TH STREET INNEAPOLIS, MN 55404	
	STIMMADY S	TATEMENT OF DEFICIENCIES	I		PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETI
(X4) ID PREFIX TAG	(EACH DEFICIEN)	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 441	Continued From	hade 9	F4	441		
1 441		transmit the disease.				
	(3) The facility m	ust require staff to wash their				
	hands after each	direct resident contact for which				
	hand washing is i	indicated by accepted				
	professional prac	tice.				
	(c) Linens	andle store process and				
	Personnei must r	nandle, store, process and so as to prevent the spread of				
	infection.	as to prevent the spread of				
		IENT is not met as evidenced				
	by:	votion interview and document			It is the policy of the Augustana Health	n I
	Based on obser	vation, interview and document y failed to ensure proper hand			Care Center to maintain an Infection	
	bygiene and glov	e changes were completed			Control Program that is designed to	
	during dressing	changes for 2 of 3 residents			provide a safe, sanitary and comfortab	le
	(R87, R404) who	o were observed for infection			environment and to help prevent the	
	control practice.				development and transmission of dise	ase
					and infection. CORRECTIVE ACTION	
	Findings include	::			Staff who provided wound care for	
		List dated 6/25/14 indicated			identified residents were re-educated	on
	R87's Diagnosis	List dated 6/25/14, indicated pra pubic catheter, stage four (ful	u		proper procedure and facility policy for	
	quadriplegia, su	loss with exposed bone, tendon			hand wahing	
	or muscle) pres	sure ulcers on the sacral (large			7/19/14	
	triangular bone	at the base of the spine) area and	d		IDENTIFICATION OF OTHER	
	right trochanteri	c (hip) area, sepsis, osteomyelitis	6		RESIDENTS:	on of
	in the sacral and	d right trochanteric areas,			All residents are at risk for transmissio	
	debridement of	sacral pressure ulcer with wound			disease and infection if proper hand washing procedures are not followed.	
	vac placement a	and a history of urinary tract			7/19/14	
	infections (UTI).	. The most recent UTI was on			MEASURES PUT IN PLACE:	
	6/4/14. Wound	care orders on the edure Administration Record			All licensed staff received one to one	
	dated 6/1/1/ to	6/30/14, directed cleansing to the	e		return skills demonstration education	on
	sacral and right	trochanteric pressure ulcers, pat			"Dressing Change Clean Technique	
	dry apply skin s	sealant and negative pressure			Audit," with a focus on hand washing	and

Facility ID: 00164

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ENTER	S FOR MEDICARE	& MEDICAID SERVICES					938-0391
TEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R	
		245242	B. WING			06/26/2014	
	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	ANA HCC OF MPLS				07 EAST 14TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	wound therapy (wo (millimeters of me and Friday. Pressure ulcer wo 6/25/14, at 9:30 a. and RN-F washed and applied glove left side to access removed the clear packing dressing RNs changed glov RN-D used wound patted the areas w gloves and washe gloves or sanitize separate ulcers. while wearing the skin prep to the a changed gloves w changed gloves w cover sheet over ulcer. RN-F appl foam and held it with the clear ad On 6/25/14, at 1 they wash or sam from dirty areas change if they g not wash or sam	bund vac) at 175 mmHg rcury) on Monday, Wednesday and care was observed on .m. Registered nurses (RN)-D it their hands in R87's bathroom s. R87 was assisted onto the sthe pressure ulcers. RN-F r cover dressing and foam from both pressure ulcers. Both ves without hand sanitization. d cleanser on both ulcers, with a gauze dressing, removed ed hands. RN-D did not change hands between cleaning the RN-F also cleansed both ulcers e same gloves. RN-D applied area around the wounds and without hand sanitization. RN-F and washed hands before ressing into the sacral ulcer. loves without hand sanitization he clean foam dressing into the d placing the clear adhesive the foam dressings on each ied the wound vac tubing and into place while RN-D.covered it		441	glove use. 7/20/14 All Nursing Assistants were educa hand washing and glove use. 7/23/14 MONITORING MECHANISM: Nurses providing wound treatmer audited on a regular basis throug 7-31-14 to ensure substantial cor with infection control policies and procedures 7/31/14 10% random audits of wound tre will be conducted for the folowing to continue to provide substantial compliance 8/31/14 9/30/14 20% random audits of all nursing be conducted for various proced ensure proper continued infection protocols are being observed. A will be reviewed and monitored for compliance with facility infection policies and procedures by the 0 Improvement committee 8/31/14 9/30/14 RESPONSIBLE PERSON/S Infection Control Nurse Director of Nursing and/or their	nts will be h mpliance atments 60 days l g staff will ures to in control ul audits for control Quality	

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391	
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	Сом	E SURVEY PLETED	
		245242	B. WING			R 06/26/2014		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET			
AUGUST	ANA HCC OF MPLS				MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 441	hands when going and it would depen removing the glove staff to wash or sar glove changes if th during the procedu The facility's Hand policy/procedure re- hands washing or removing gloves. The Infection Cont revised on 3/09, di their hand after rer reapplying new glo An computer-gene Client form indicat stage 4 pressure u A significant chang dated 5/29/14, ind long-term memory development of pr admitted with 1 sta R404's Plan of Ca history of pressure interventions and shift. R404's Phys 5/20/14, directed of PRN [as needed] [normal saline], pa wound edges, and dressing. R404's sacral ulco	from dirty areas to clean areas d on what was touched prior to es. The DON would not expect nitize their hands between ey did not touch anything dirty re. Washing/Sanitizing evised on 12/08 indicated sanitizing was necessary after rol Dressing Change policy rected staff to wash or sanitize moving their gloves and oves. erated Diagnostic Listing by ed R404's diagnoses included		44				

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PRINTED: 08/04/2014

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	-		FOF	D: 08/04/2014 MAPPROVED O. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED		
		245242	B. WING	i		R 6/26/2014		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		0/20/2014		
AUGUST	ANA HCC OF MPLS		1007 EAST 14TH STREET MINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE		
F 441	removed the glove without washing ha RN-A returned to F ruler to measure the new pair of disposa assistant (NA)-B w measured the sacr R404's sacral ulcer solution, applied the surrounding the sa Mepilex dressing. washed her hands On 6/24/14, at 3:16 have washed her he gloves after removed dressing. On 6/25/14, at 10:3 (DON) stated hand should be conducted old dressing are re The DON confirme with glove removal resident room.	g from the sacral area and s before leaving the room ands. In less than a minute, A04's room with a disposable he sacral ulcer. RN-A applied a able gloves, assisted nursing ith peritoneal cleansing and ral ulcer. RN-A cleansed r area with normal saline e skin barrier to the skin cral ulcer, and then applied the RN-A removed the gloves and in R404's bathroom sink. 5 p.m. RN-A stated she should hands after removing the soiled ing R404's sacral ulcer 87 a.m. the director of nursing washing or hand sanitizing ed after removing gloves when moved from wounds or ulcers. ed handwashing was required and upon entering/exiting a	F	441				
ORM CMS-25	67(02-99) Previous Versions	s Obsolete Event ID: GU1612	2	Facility ID: 00164	If continuation she	et Page 13 of 1'		

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DEPARTMENT OF HEALT					CENTERS FOR MEI	DICARE & MED	CAID SERVICES	
					AND TRANSMITTAL		ID: GU16	
1. MEDICARE/MEDICAID PROVID		3. NAME AND AI			FE SURVEY AGENCY	4. TYPE OF ACT	Facility ID: 00164 ION: 2 (L8)	
(L1) 245242	EK NO.	(L3) AUGUSTAN						
2.STATE VENDOR OR MEDICAID	NO.	(L4) 1007 EAST	14TH STREE	Г		1. Initial2. Recertification3. Termination4. CHOW		
(L2) 159540700		(L5) MINNEAPO	DLIS, MN		(L6) 55404	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey Af		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Al	ter Comprant	
	2/2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENI	DING DATE: (L35)	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	09/30		
2 AOA 3 Other		04.014	00 01 1/01	12 Mile	IT HOST ICE			
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia			And/Or Approved Waivers Of			
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of		
12. Total Facility Beds	268 (L18)	-	cceptable POC		4. 7-Day RN (Rural SN			
					<u>x</u> 5. Life Safety Code	9. Beds/Roo	m	
13.Total Certified Beds	268 (L17)	X B. Not in Con Requirement	npliance with Prog ents and/or Appli	ram ed Waivers:	* Code: B , 5	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
268								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date: MPM	
Chris Elmgren, HFE	NEII	0	5/21/2014	(L19)	Mark Meath, Enforcement Specialist 06/20/2014			
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITH	I CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
1. Facility is Eligible to	Participate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Sti e :	nt (HCFA-1513)	
2. Facility is not Eligible								
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22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNINC	J DATE	ENDING DAT	ΓЕ	<u>VOLUNTARY</u> 00) INVOL	UNTARY	
01/01/1982					01-Merger, Closure		o Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		o Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(L44)		of other reason for windrawa	07-Prov 00-Acti	ider Status Change	
(L27)	B. Rescind Su	spension Date:	(L++)					
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28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
		DETEDMINIATION		DATE				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPKUVAL	DALE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		

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:

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

<u>Informal Dispute Resolution</u> - 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 Augustana Health Care Center Minneapolis May 10, 2014 Page 4

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Augustana Health Care Center Minneapolis May 10, 2014 Page 6

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

(X3) DATE SURVEY

CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 05/02/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245242 1007 EAST 14TH STREET NAME OF PROVIDER OR SUPPLIER MINNEAPOLIS, MN 55404 AUGUSTANA HCC OF MPLS (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG PRÉFIX TAG F 000 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. 6/11/14 Census = 254 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF F 156 F 156 RIGHTS, RULES, SERVICES, CHARGES SS=D 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 (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PREFIX	REGULATORY OF	CY MUST BE PRECEDED BY TON LSC IDENTIFYING INFORMATION)					
TAG							
			F	= 242			
F 242	Continued From	page 4					
1 2 1 2	inside and outsid	bage 4 Ie the facility; and make choices this or her life in the facility that					
	about aspects of are significant to	the resident.					
		MENT is not met as evidenced				loalth Care	
	This REQUIRE				It is the policy of Augustana I	he right to	
	by:	view and document review, the			Center that the resident has	and health	
	facility failed to	provide bathing services at a					
	frequency cons	sistent with each resident's	ed				
	preference, for	istent with each residence 1 of 3 residents (R326) review			assessments, and plans of o make choices about aspects	, of his or he	r
	for choices.				make choices about aspects life in the facility that are sign	nificant to the	e
					resident.		
·	Findings incluc					viewed re:	
	D326's admis	sion Minimum Data Set (MDS)	tact		Corrective Action. Identified resident was inter bath preferences, selected		nd
			laor.				5
	The MDS ider	ntified R326 required limited	nd				
	assistance wi	htified R326 required militors th personal hygiene activities a far some bathing activities.					
	physical help	TOI SOITTE Datations			Identification of Other resid	ents:	
		ing Report dated 4/22/14, indic	ated			10110000	
	A Care Plan	able to bathe herself independent	ently,				
	due to a rece	nable to battle nerson interpent ent hospitalization for congestive (OUE) and exacerbation, with	e		preferences to include day	,	
	heart failure	(CHF) and exacerbation, with	be		frequency. (5/20/14) All current residents will be	e audited for	•
	shortness of	breath. The care plan indicate	taff for		All current residents will st their bathing prederences	. (6/10/14)	
	DOOG roguir	an nivsical assistance					
	parts of her	pathing activities.				re: bathing	
		view on 4/28/14, at 12:41 p.m.	R326		Review of resident choice preferences was done at	the regularly	on
	During inter	view on 4/28/14, at 12.4 performed was not asked of her preference was adving the facility's admi	e tor		scheduled Resident court	CII meeting	
	stated sile	was not asked of her preference quency during the facility's admi upper added, a bath was provide	ission				
	process R	auency during the facility of during 326 added, a bath was provide the but she preferred to take b	aths		All staff education will be		
	time per W6	Bek, but she proton			All staff education will be the importance of identify observing resident choic	e that is	
	three times	s per week.					ts,
		Main Team 1 (one) Ba	ith				
	Review of	the One Main Team 1 (one) Ba (undated), indicated R326 was	to		assessments, and plans Random audits of 10%		nts Will
	Schedule	(undated), indicated Rozo was he bath per week, on Sunday ev	enings.			If continuati	ion sheet '
	receive on		ent ID: GU16	511	Facility ID: 00164		
L		Eve					

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5 of

		AND HUMAN SERVICES				(X3) DATE S	SURVEY
EPARTME	ENT OF HEALIN	AND HUMAN SERVICES <u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRU	UCTION	COMPL	LETED
ENTERS	FOR MEDIO	INTERIOURPLIER/CLIA	A BUILDI	ING			
TEMENT OF	DEFICIENCIES	(X1) PROVIDER/SOFT LLE.			_	05/0	2/2014
PLANON	-	245242	B. WING		DDRESS, CITY, STATE, ZIP C	ODE	
				STREET AD	T 14TH STREET		
ANE OF PR	OVIDER OR SUPPLIER	R		1007 EAS	DOI 16 MN 53404		
ANEOT	NOC OF MPLS	\$		MINNEA	PROVIDER'S PLAN OF CO	RRECTION	(X5) COMPLETION
LUGUSTA	NA HCC OF MPLS		ID PREF	EIV	(EACH CORRECTIVE TO THE	EAPPROPRIATE	DATE
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TA	G CF	ROSS-REFERENCED DEFICIENCY)		
PREFIX	(EACH DEFICIEI REGULATORY O	NCY MUST BE PRECEDED BT 100 R LSC IDENTIFYING INFORMATION)					
TAG	NEGOT						
		_	F	= 242	conducted to ensure b	athing	
E 242	Continued From	ı page 5		be c	conducted to ensure b ferences are being ob (6/10/14, 7)	served for the	
F 242		· · · · · · · · · · · · · · · · · · ·	.)-B		I DU DAVS TOULOU ST	10/14 8/10/14)	
	On 5/1/14, at 11	1:30 a.m. nursing assistant (her	Mo	nitoring Mechanism	- and ucted by	
	Latated K320 lia	u uono a unatotod R320 W	vas	Co	nitoring Mechanism mpliance sudits will be	for the next 90	
	with a bath loud	ay. I and time her wee	К,	the	a unit Clinical Manage		
	I scheduled to re	such that if a resident		l da	IVS	- roviewed for t	ne
	on Sunday.	extra bath or shower, the stan		Cc	ompliance audits will b ext 90 days by the Qua	ality Improvement	t
	would try to give	ve them one.		ne	ommittee for effective	ness and on-gol	ing
		: Land purse (KI	N)-E		ommittee for effective ustainability of standar	d of practice for	
	On 5/1/14, at	11:40 a.m. registered nurse (Ri rse who admitted a resident wa of their one time per week bath.	is to		ustainability of standar bserving resident prefi		
	Latated the nul	Se who ar week bath.	. 1	P	bserving resident pren Person Responsible: D		
	inform them (of the strengt aske	ea i				
	RN-E further	stated residents were not defined by they preferred to receive a back that if a resident wanted mor	atn.				
	how frequent	tly they preferred to record and that if a resident wanted mor and per week, they needed to ma	ke the				
	than one bat	ed that if a resident wanted more h per week, they needed to ma then the facility would make					
	request and	then the facility would make	S				
		1000 in hathing					
	residents re	quested a conferences. Howe	ver,				
	frequency a	uning our of the heathing					
	I residents W	ele not dotte	they				
	frequency a	and had to request a change we ath more than one time per we	eĸ.				
		The stated she	washou				
	On 5/1/14,	at 11:45 a.m. RN-F stated she t R326 wanted more than one b confirmed her medical record l	bath per				
	aware that	NJ20 Warter adical record	ackeu				
	week and	communed in the abo was asked	d on				
	document	confirmed her medical receiver ation to indicate she was asked about her preferences for bath	ning				
	admission	about her pro-					
	frequency		ed				
	A Care P	lan Policy revised 1/14, indicate	ization				-
	Incoidents	Wele in their	ir nian ui				
	through (choices and provide meet the	ar activities	s			-
	care in 0	order to be assisted to meet the iving, health care, and psychos	ocial	-			6/
	of daily I	Wing, nearth our s		F 24	47		
	needs.	e)(2) RIGHT TO NOTICE BEF(ORE	12	-	If contin	nuation sheet P
l l	F 247 483.15(e)(2) NGTT 10 11			Facility ID: 00164	It count	1
		obsolete	Event ID: GU	1611	· · ·		

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		AND HUMAN SERVICES				OND TO TE CURVEY
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				(X3) DATE SURVEY COMPLETED
CENTERS	FOR MEDICARE	& MEDICAID SERVICES	(X2) MULT	IPLE CONS	TRUCTION	50m
UENTLINO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG		
AND PLAN OF	CORRECTION	IDENTIFICATION				05/02/2014
ANDPLANO	: -		B. WING			
		245242		STREET	ADDRESS, CITY, STATE, ZIP CODE	1
				STREET	AST 14TH STREET	
NAME OF PR	OVIDER OR SUPPLIER			1007 EA	APOLIS, MN 55404	
				MINNE		CTION (X5) COMPLETION
AUGUSTA	NA HCC OF MPLS		ID		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH	
		- DEFICIENCIES	PREF	IX		PROPRIATE
(X4) ID	SUMMART S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL DI SC IDENTIFYING INFORMATION)	TAC	G	CROSS-REFERENCED	
PREFIX	REGULATORY OR	CY MUST BE PRECEDED 51 TO A STATION (LSC IDENTIFYING INFORMATION)				
TAG	(m +					
				247		
	I From	nage 6		4 -11		
F 247	Continued From	ATE OHANGE				
SS=D	ROOM/ROOMM	ALECHANCE				
		successive notice before	e			
	A resident has th	he right to receive notice zality	is			
1	the resident's ro	om or roommate in the facility				
	changed.				• •	
	Gildingo.					
		·	d			
	This REOUIRE	MENT is not met as evidence	~		It is the policy of Augustana	a Health Care
		the second se	<u> </u>		It is the policy of Augustante Center that resident's will re-	eceive notice
	by:	rview and document review, the			Center that resident's win re before the resident's room	or roommate in
	Based on inter	provide notice for change of ignments, prior to the change			before the resident's room	
	tacility falled to	ignments, prior to the change			the facility is changed.	
1	roommate ass	ignments, prior to the original 1 of 1 resident (R326) who had	a		Corrective Action.	mediately
	occurring, for	ate change.			All Social Workers were im	ant to notify all
	recent roomm	ale onange.			reminded of the reguliering	ato and that
					reminded of the regulierne residents of a new roomm	worp required to
	Findings inclu				residents of a new roomin efective immediately they	weie iegunod
		Data Sot (MDS))		efective immediately they document that notification	nau occurred
	R326's admis	sion Minimum Data Set (MDS 4, indicated her cognition was i	ntact.		(5/2/14	the do 2
	dated 4/19/14	4, 110100100			(5/2/14 All Social Workers were a	asked to up a
		100/14 at 12.50 p.m.	326		All Social Workers were a read and sign of their und	derstadning of
	During interv	iew on 4/29/14, at 12.00 pints	e		read and sign of their und the policy to verbally info	rm and document
	denied havin	iew on 4/29/14, at 12.00 pm the ig received notification from the to her current roommate moving	na into		the policy to verbally info in the medical record that	t notification of a
	facility prior	to her current roommate moving scident room, R326 stated sh	e		in the medical record the change of roommate for	all residents has
	hor shared r	to her current foormitate management room. R326 stated sh	ix davs		change of foormated	
	received a n	esident room. R320 states and new roommate approximately s new roommate approximately s	in days		been completed. Identification of Other Re	esidents at Risk
1	received a fi	as never informed that a new				
	prior, but we	was going to be moving in.			All residents would be it	a change of
l	roommate	Wao 90			for not being normed of	
		st 2:00 n m social services (St	5)-в		roommate	of residents
	On 5/1/14,	at 2:00 p.m. social services (S since R326 was admitted into	a .			on residence
	stated that	Since Rozo us transitional Ca	are unit			
	double rool	m in the facility of the was (going to		conducted be the Direct	COL 01 SOCIAL
	(TCU), she	should have a verified R326	5'S		Services for the next of	U days of tor the
	receive a f	00mmato. e -	n to		7/10/14	
	medical re	commate. SS-B vernice reation cord lacked any documentation notification for the roommate cl notification for the roommate cl not ss-B stated she did not k	hange			
	evidence I	notification for the roominate of	noW		Measures Put in Plan Education for all socia	Workers was
	was provid	notification for the roominate ded. SS-B stated she did not k with the policy was for the TCU	(101)		Education for all social completed on 5/20/14	Monthly random
1	was provide	acility's policy was for the TCU	handes		completed on 5/20/14 audits will be complete	ed for the next 90
			nanyes		audits will be complete	If continuation sheet F
	residents				Facility ID: 00164	If continuation sheet
	and need		vent ID: GU16	511	Faunty ID. Com	

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		AND HUMAN SERVICES			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
DEPARTME	NT OF HEALTH	* MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	
ACNITERS		(X1) PROVIDER/SUPPLIER/CLIA	A BUILDING		
STATEMENT OF	DEFICIENCIES	IDENTIFICATION NOMBER			05/02/2014
AND PLAN OF C	ORRECTION		B. WING	DESS CITY, STATE, ZIP	CODE
		245242	1	STREET ADDRESS, OTH	
	245242 STREET ADDRESS, CIT, EXAMPLESS, CIT, EXAM		(X5)		
NAME OF PRO	WIDER OR SOLUTION	-			CORRECTION (X5) COMPLETION DATE
AUGUSTA	NA HCC OF MPL	5	ID	(EACH CORRECTION TO T	HEAPPROPRIATE
Auces		ATATEMENI OF DELLE PO DV EUII	PREFIX TAG	CROSS-REFERENCED DEFICIENC	(Y)
(X4) ID	(EACH DEFICIE	NCY MUST BE PRECEDENTION			
PRÉFIX	REGULATORY	JR 130 12			
			F2	247	nce.
	In the From	n nade 7		days to ensure comp	histod by
F 247	Continued FIO	it page	al	Monitoring Mounts will	be conducted by
	- 444 at 2	o-15 p.m. SS-A (director of social	ted	the Director of Social S	Services for the sa
	On 5/1/14, at 2	ied there was nothing document	ng a	90 days	
	to evidence R	326 was informed she the TCU, the	ey		
	new roommat	e. SS-A added, of the would be get	tting		
	assumed that	people knew and were coming ar	id the		
	a roominate,	wonthy on the unit. 55-A states			
	going so free	id document notification of	on the		
	long term ca	are units, but did not do the			
	residents wi	no lived on the 100.	1		
			nate		
	The facility	viewed 7/08, indicated that soci	idents		
	changes le	ff were to verbally inform all les	their		6/11/14
			1	F 292	
	room assi	nments.	D	F 202	
	282 483.20(k)	(3)(ii) SERVICES BI GOIN			
	S-D PERSON	S/PER CARE FLAN	facility		
			efacility		
	The servi	revided by qualified persons in	nlan of		
	must be	be with each resident's whiteh	pian		
	accoruar				
	1				
		is not met as evi	denced		of the Augustana Health
	This RE	QUIREMENT	Loument	It is the policy of	at the services provided
1	by:	abcervation, interview, and	acidents as	cafe Center the	e facility must be provided
	Based	the facility failed to reposition f	residents	by qualified per	sons in accolutation the
	review	written plan of care, for 1 0131	he		
		reviewed who was at risk for a			VIII I I record
	develo	pment of pressure uicers.		Der observatio	and developeu
				review resider	The Care plan has been
1	Findir	ngs include:		any skin issue	
		L Coro Planning Report dated	11/1/13,		If continuation sheet Page
	R190	's Cale Flamme	Event ID: GU	1611 Facility ID: 00164	
	1	99) Previous Versions Obsolete			

		WINDON CEPVICES			(DMB NO. 0930-03
	ENT OF HEALTH	AND HUMAN SERVICES				(X3) DATE SURVEY COMPLETED
	FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPLE C	ONSTRUCTION	COMPLETED
-NIERO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	NG		
TEMENT OF	CORRECTION	IDEN IFICATION NO.				05/02/2014
PLANO			B. WING			
		245242		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
		2		400	7 FAST 14TH STREET	
AME OF PR	OVIDER OR SUPPLIEF	`		млін	INEADOLIS, MN 55404	(75)
	NA HCC OF MPLS	6				TION (X5)
UGUSTA			ID	-12	PROVIDER'S PLAN OF CONTEN (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OPRIATE DATE
	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL 2 L SC IDENTIFYING INFORMATION)	PREI TA		CROSS-REFERENCED TO THE A	
(X4) ID PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FORMATION) R LSC IDENTIFYING INFORMATION)		-		
TAG	REGULATOR					
			-	282		ff leading
-	. –			- 202	consistently followed related to	
F 282	Continued From	page o as at risk for skin impairment du mobility, bowel and bladder	Je		consistently followed related to (while in chair) and re-position	
	indicated she wa	mobility, bowel and bladder mobility, bowel and bladder		1	(while in chair) and re-position bed). She was experiencing a	general
	to her impaired	(100 ling), we have accident (CVA)			bed). She was experiencing a decline and was hospitalized of the decline and was hospitalized of the decline and while in the	on May 12,
	incontinence, ce	elebronic steroid use, a	and			
	with left-slaeu w	reakiness, and plan further			2014, and expired while as identification of Other Resider	nts
	lower extremity	evenia.	bbe		i i i i i i i i i i i i i i i i i i i	
	indicated R190	required the breathing which	n i		All residents that are the last b skin breakdown, would also b	e .
	elevated for mo	required the head of her solution ore comfortable breathing, whic ncreased potential for friction o lan interventions were added of	r		skin breakdown, would also a considered at risk for not follo	owing the
	resulted in an i	ncreased potential for measure lan interventions were added or ling a perimeter/pressure	n		considered at risk for not lond care plan related to re-poistic	oning and on
	cheer Cale P	all interestire				
	12/5/13, includ	ing a point and reposition	ing		loading. Measures Put in Place:	
	redistribution r	namess, raining of a moistur	e		Measures Put in Place. All Nursing department staff	will be
	every two nou	15, and approved pursing assis	tant		All Nursing department stan educated on the importance	of following
	harrier cream	D100 was at	risk		educated on the importance the care plan, with focus on	re-positioning
	care sheet (ui	Jualed) manual che he turn	ed		the care plan, with focus on and off loading as part of the	e presention of
	for skin break	down and directed she be the	staff,		- Lin brook(IOWII, UIO T	completed on
					or before June 11, 2014.	
1	every two not	uis and do not			All clinical Managers and N	ursing
			dated		All clinical Managers and N Supervisors received a list	of residents
	R190's quart	ated she had a moderate cogni ated she had a moderate cogni	tive		Supervisors received a list identified as at risk for skin	breakdown on
	$\Delta/9/14$ indice	aleu ono mana accistance	with		May 2, 2014.	
	impairment,	required extensive assistance	for the			10% of all
					Monthly random addies en residents identified as requ	uiring
	developmen	and transience, and transience, and transience, and transience, and the second se			residents identified as require re-positioning will be cond	ucted for the
		1: on 1/30/14	from		re-positioning will be cond next 90 days to ensure re-	-poistioning and
	Durina cont	inuous observation on 4/30/14, o 10:12 a.m., R190 was noted a c in bed, with the head of the b	as lying			
	7.15 a.m. to	10:12 a.m., R190 was noted of	ed		off loading is being long is care. 6/10/14 7/10/14 8/1	0/14
	on her back	A+7.45 a m			Monitroing Mechanism:	
	raised to at	c, in bed, with the fields of a.m. t least 30 degrees. At 7:45 a.m. estical purse (LPN)-A was obse	erved to			e conducted by
	licensed Dr	actical nurse (LPN)-A was observed to the second se	0			
	onter R190	s room. R190 was observed to be agent position in her bed. A	at 8:30		supervisors for the next supervisors for the n	90 days.
	remain in t	b's room. R190 was observed the same position in her bed. A ing aggistant (NA)-A was obser	ved to		supervisors for the next s Compliance audits will b	e reviewed for the
	a m nurs	ing assistant (NA)-A was obser	trav.		Compliance audits will be next 90 days by the Qua	lity Improvement
	onter R19	o's room with a breakfast meal	le still in		next 90 days by the Qua committee for effectiven	ess and on-going
	NIA A acci	0's room with a breakfast mean sted R190 to eat breakfast whi 10 c m R190 stated breakfas	twas		committee for effectiven sustainability of standard	l of practice for
	had At 8	sted R190 to eat bleaklast mini- :40 a.m., R190 stated breakfas	head		sustainability of standard re-positioning and off lo	ading of residents.
	done and	An A was observed to lower the NA-A was observed to lower the NA-A was observed to lower the NA-A was observed on her back	in hed		re-positioning and on to	-
	of hor her	NA-A was observed to lower a d. R190 remained on her back	then the		6/11/14 Responsible Person/s:	DON / ADON
		d. R190 remained off field buck a.m., nearly three hours from w is a bogan NA-A stated she wa	o roady tr		Responsible Personas	If continuation she
	AL 10.12	ion began, NA-A stated she wa	51000 1		Facility ID: 00164	IT COnunuation one
	observat	a.m., nearly three hours from a ion began, NA-A stated she wa	vent ID: GU1	611	Facility ID: 00164	

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		AND HUMAN SERVICES					E SURVEY
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES			NSTRUCTION	COM	IPLETED
CENTERS	FOR MEDICANE	(X1) PROVIDER/SUPPLIER/CLIA					
	= DEFICIENCIES	(X1) PROVIDER/SOLF ELEMBER:	A. BUILDI	ING		05	/02/2014
AND PLAN OF	CORRECTION						10212014
		245242	B. WING		T ADDRESS, CITY, STATE, ZIP	CODE	
				STREE			
DE DE PR	OVIDER OR SUPPLIER	L .		1007 E	EAST 14TH STREET		
				MINN	EAPOLIS, MN 55404	OBRECTION	(X5) COMPLETION
AUGUSTA	NA HCC OF MPLS				PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO	ON SHOULD BE	DATE
			ID PREI				
(X4) ID	SUMMART S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL DI SC IDENTIFYING INFORMATION)	TA	G	CROSS-REFERENCED	()	
PREFIX	REGULATORY OF	CY MUST BE PRECEDED DI TOUR LSC IDENTIFYING INFORMATION)					
TAG							
			F	282			
	Continued From	page 9					
F 282	Continued From	th morning cares. NA-A was acition B190 to her left side whi					
	provide R190 Wil	th morning cares. NAP tube osition R190 to her left side whi hoth R190's buttocks were	lle				
	observed to repu	both B190's buttocks were	-1				
	providing a bed	Daun. A congrate rou	ina				
	observed as det	ep led in the on her lower bar	ск,				
	and reddened a	yx. LPN-A was called to R190's	s				
	above the cocc	e the reddened areas. LPN-A					
	room to observ	e the reddened alous having ad lupus and had been having was with her skin. LPN-A stated					
	stated R190 na	id lupus and had been have a les with her skin. LPN-A stated and the skin issues to the wound					
	some rash issu	ort the skin issues to the wound					
	she would repu						
	care nurse.						
		t 10:50 a.m. NA-A stated R190	was				
	On 4/30/14, at	turned and repositioned ever	У				
	SUDDOSED TO D	e turned and had lost renosit	onea				
1	two hours. IN	A-A stated she had last report oximately 6:30 a.m., when she to work (three hours and 42	first				
	R190 at appro	to work (three hours and 42					
	came on shift	re R190 was observed to be					
	minutes bero						
	repositioned)						
		at 12:58 p.m. LPN-A stated R19	90				
	On 4/30/14,	at 12.50 pint every two hours and	was				
	was to be re	positioned and more	1				
	to be positio	ned off of her back, more , to minimize the redness noted	on				
	side-to-side.						
	her huttocks	5.	1				
		140.50 nm registered nurse	(RN)-A				
	On 5/1/14, a	at 12:50 p.m. registered nurse ed area on R190's sacral area related but part of the lupus	was				
	stated the r	ed area of the lubus	rasn				
	I not pressur	e leialeu, but par	did				
l	she had be	een exhibiting. However, RN-A 90 was to be repositioned ever a ckin risk factors.	ry two				
	hours due	to skill hok last					
		DN D stated R19	0 should				
	On 5/1/14	, at 2:20 p.m. two hours	while in				
	have beer	Treposition is a to be off of he	er back,				
1	bed, whic	h repositioned every two hours h meant she was to be off of he ride to side repositioning due	to her				
	with more	SIDE-ID-SIDE I OF					
	skin risk f	actors				If continu	uation sheet Page
			vent ID: GU1	611	Facility ID: 00164		

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		AND HUMAN SERVICES				(X3) DATE	SURVEY
EPARTM	ENT OF HEALT	AND HUMAN SERVICES	(Y2) MUI-	TIPLE CONS	TRUCTION	COMP	PLETED
ENTERS	FOR MEDION	(X1) PROVIDER/SUPPLIER/CLIA	A BUILD	ING			
TEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUFF LILINGER: IDENTIFICATION NUMBER:	1.2-1			05/0	02/2014
) PLAN OF V		- 15042	B. WING		ADDRESS, CITY, STATE, ZIP CC	DE	
		245242		STREET	ADDRESS, CITY, STATE, E		1
DE OF PR	OVIDER OR SUPPLIE	R		1007 EA	AST 14TH STREET		
				MINNE	PROVIDER'S PLAN OF COF	RECTION	(X5) COMPLETION
AUGUSTA	NA HCC OF MPL		ID		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULD BE	DATE
	SUMMARY S	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R L SC IDENTIFYING INFORMATION)	PREI TA	FIX G	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	AIT 1101	
(X4) ID PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED D11 D11 R LSC IDENTIFYING INFORMATION)					
TAG	REGULATOR						
			F	= 314			6/11/14
E 014	Continued From	n page 10	1	F 314			
F 314	402 25(c) TREA	ATMENT/SVCS TO AL PRESSURE SORES					
F 314	PREVENT/HEA	ATMENT/SV03 10 AL PRESSURE SORES					
SS=D		· · · · · · · · · · · · · · · · · · ·	a				
l	Based on the c	comprehensive assessment of a ficility must ensure that a reside facility without pressure sores	nt				
	resident, the la	Clincy model in and procedure sores					
	who enters the	hading the					
	does not deve	lop pressure soles unless and nical condition demonstrates the weidable: and a resident having	at				
	individual's cin	voidable; and a resident having receives necessary treatmen	t and				
	they were and	voidable; and a resident name is receives necessary treatment mote healing, prevent infectio	n and				
	services to pr	omote healing, prevent infection omote healing, prevent infection pores from developing.					
	prevent new	sores from developing.					
	1.						
		REMENT is not met as eviden	ced		A.	auctana healt	h
	This REQUI	REMENT IS NOT			It is the policy of the Au	treatment/ser	vices
	by:	bservation, interview, and docu	imeni		It is the policy of the AU Care Center to provide for the prevention and	healing of pres	ssure
	Based on 0	acility failed to implement	rick of		for the prevention and		
	review, inc i	acility failed to implement g interventions to minimize the oun for 1 of 3 residents (R190	11310 01		sores. Corrective Action:		
	skin breakd	g interventions to minimum own, for 1 of 3 residents (R190 owns at risk for developing p	ressure		Corrective Action. Per observation and m	iedical record	laned
	reviewed W	own, for 1 of 3 residents (Refe ho was at risk for developing p			Per observation and m review resident (R190) has not deve	lioped
	ulcers.				any skin isues. Care	plan has been	ading
					any skin isues. Care consistently followed r	elated to on ic	vhile in
	Findings in	clude:	a) I had		(while in chair) and re	innoing a dene	eral
		arterly Minimum Data Set (MDS	S) dated		bed). She was experi	italized on Ma	ay 12,
	R190's qu	arterly Minimum Data Set (inc licated she had a moderate cos Luce Braden Scale/Compret	gnilive		decline and was host 2014, and expired wh	he in the hosp	ital.
	4/9/14, 110	licated she had a moderate of t. Her Braden Scale/Compreh Evaluation dated 10/18/13, ind	licated		2014, and expired will Identification of Othe	r Reisdents:	
	Skin RISK	Evaluation					ISK TOP
	she was a	Evaluation dated for her her her her her her her her her he	ntinent of		All residents that are skin breakdown, wo	uld also be	the
	hroakd0W	In que lo being -	um		skin breakdown, wol considered at risk fo	r not following	and off
	howel and	Diauuci, and daily livin	a (AULS)		considered at risk fo care plan related to	re-poistioning	
	l accistanc	$e_{\text{WIII}} a_{\text{III}} a_{\text{IIII}} a_{\text{III}} a_{\text{IIII}} a_{\text{IIIII}} a_{\text{IIII}} a_{\text{IIII}} a_{\text{IIII}} a_{\text{IIII}} a_{\text{IIII}} a$	ated		landing		
	1 P 190'S U	ale nicul local in the factors	s for SKILL	1	Measures Put in Pla	ace	be
	11/1/13.	action for t	riction and	1	All Nursing departs	ternen of fo	llowing
	hreakdo	Wh, including thetropic medicat	ion, and		educated on the im the care plan, with	focus on re-po	ositioning
	sheer, u	es of schizoaffective disorder, a schizoaffective disorder	$\gamma(\Delta)$ and			If continu	uation sheet Pa
	diagnos	es of schizoaffective disorder, on, cerebrovascular accident (C			Facility ID: 00164	n contaite	
	Tipfillatic		Event ID: GU	10.11	-		

FORM CMS-2567(02-99) Previous Versions Obsolete

		- THIMAN SERVICES		_	OMB NO. 08	
	NT OF HEALTH	AND HUMAN SERVICES			(X3) DATE S COMPLE	ETED
-NTEDS	FOR MEDICARE	AND HOMPILY SERVICES AMEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	COMIT -	
NIERO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			
TEMENT OF	ORRECTION	IDENTIFICATION			05/02	/2014
) F LNI (O.		0.450.42	B. WING	REET ADDRESS, CITY, STATE,	ZIP CODE	
		245242	ST	REET ADDRESS, CHT, STATE,	-	1
	UPER OR SUPPLIEF	<u>}</u>	10	07 EAST 14TH STREET		
	OVIDER OR SUPPLIEF		M	INNEAPOLIS, MN 55404	ORDECTION	(X5)
ATZUGUSTA	NA HCC OF MPLS			PROVIDER'S PLAN C	OF CORRECTION D BE	COMPLETION
100001/1			ID PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL STATES IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED	NCY)	
PREFIX	(EACH DELIVIE)	ICY MUST BE PRECEDED BY TODA R LSC IDENTIFYING INFORMATION)				
TAG						
			F 314	and off loading as par	t of the prevention of	
	Continued From	page 11	•	and off loading as par skin breakdown, this	will be completed on	
F 314		F-0				
	glaucoma.			or before Julie 11, 2-	and Nursing	
		anning Report dated 11/1/13, anuired the head of her bed to b	0	All Clinical managers	is list of residents	
	R190's Care Pla	anning Report dated 117116, equired the head of her bed to b ore comfortable breathing, which	0	Supervisors received identified as at risk for	or skin breakdown or	1
	indicated she re	Squillow a Lable breathing, WNICI		identified as at tisk the	0, 0, 0, 0	
	L Devated IOLIUS	tantial for friction 0	1	May 2, 2014. Monthly random auc	tits of 10% of all	
	resulted in an i	an interventions were added on interventions were added on interventions were added on		Monthly random autoritied residents identified	as requiring	
	sheer. Calle p	an interventione areasure ing a perimeter/pressure nattress, turning and repositioni	na	residents identined	adjusted for the	
	12/5/13, Includ	nattress, turning and repositioni anteress, turning and repositioni	ng	re-positioning will b	sure re-positioning an followed per plan of	d
	redistribution	nattress, turning and reposition rs, and application of a moisture A Group Sheet/ nursing assist	ant	next 90 days to end	followed per plan of	
	every two nou	A Group Sheet/ nursing assist adated) directed she be turned	and	off loading is being care. 6/10/14 7/10	114 8/10/14	
	barrier cream	A Group Sheet/ huising assist ndated), directed she be turned with the assistance of one staff,	anu	care. 6/10/14 //10	nism.	
	care sheet (u	ndated), directed she be taken with the assistance of one staff, with and as needed.		Monitoring Mechar	will be conducted by vers and Nursing	
	repositioned	urs and as needed.		Compliance audits the Clinical Manag	ers and Nursing	
	every two not	4:00/14 fr	om	the Clinical Managers supervisors for the	next 90 days.	
	During contin	uous observation on 4/30/14, fr 10:12 a.m., R190 was noted as	lvina	supervisors for the	s will be reviewed for	the
	During contain	10:12 a.m., R190 was noted as	1	- Compliance audit	e Quality Improvement activeness and on-go	ent
	7 15 a.m. to	in bed, with the head of the bed		next 90 days by the	ectiveness and on-go tandard of practice fo	ling
	on her buerd	in bed, with the nead of an, east 30 degrees. At 7:45 a.m., otical nurse (LPN)-A was observed to room R190 was observed to	ved to	committee for one	tandard of practice for	
	liconsed pra	ctical nurse (LPN)-A was observed to		sustainability of a	d off loading of reside	ents.
	antor B190'	s room. R190 was observed to	8·30	re-positioning and		
	enter rete	s room. R190 was observed to le same position in her bed. At a assistant (NA)-A was observe	ad to	6/11/14	son/s: DON / ADON	
		e same position in her boar was ng assistant (NA)-A was observe a room with a breakfast meal tr	av.	Responsible r		
	anter R190	ng assistant (NA)-A was exercise 's room with a breakfast meal tr is a p100 to eat breakfast while	still in			
	NA-A assis	ted R190 to eat breakfast mode while R190 to eat breakfast while	Nas			
	hod At 8:4	to a.m., it to over the	head			
	done and	40 a.m., R190 stated bleakdown NA-A was observed to lower the R190 remained on her back, i poarly three hours from wh	n bed.			
	of her hed	RIGUICING from wh	entne			
	At 10:12 a	R190 remained on her back, m, nearly three hours from wh bagan NA-A stated she was	ready to			
	L abcorvatic		Nas			
	provide R	on began, NA-A stated she way 190 with morning cares. NA-A to reposition R190 to her left sid a bod bath_R190's buttocks w	te, while			
	observed	to repusition - huttocks W	ere			
	l providing	a beu buun in a annara	te rounu i			
	cheerved	a bed bath. R190's buttocks w as deep red in color. A separa ened area was noted on her low	ver back,			
	and redd	ened area was noted on her low	R190's			
١	and redu	ened area was noted of the lot e coccyx. LPN-A was called to	PN-A			
	above in	e coccyx. LPN-A was called a observe the reddened areas. Ll	wing			
1	room to	observe the reddened areas. – 190 had lupus and had been ha biseus with her skin. LPN-A	atated		if continua	tion sheet Pag
1						
	stated R	190 had lupus and had been to sh issues with her skin. LPN-A	vent ID: GU1611	Facility ID: 00164	II CONTINUES	

1:

				C	MB NO. (1930-000
DEPARTMENT OF HEALTH	AND HUMAN SERVICES				(X3) DATE	SURVEY
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HOUSE SERVICES			ONSTRUCTION	COMP	PLETED
DEPARTIES FOR MEDICARE	T == = = = P(UIDPLIER/ULIA	(X2) MULT	IPLE CC			
CENTERSTOT	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	NG		OF!	02/2014
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	DENTITION				05/	<u>JZ/2011</u>
AND PLAN OF COLUMN		B. WING		STATE, ZIP CODE		
	245242	1	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				FACT 14TH SIRCE		
NAME OF PROVIDER OR SUPPLIE	R		MIN			(X5)
NUME OF MPI	6			DROVIDER'S PLAN OF COLOR	ULD BE	COMPLETION
AUGUSTANA HCC OF MPLS	- INCIES	ID	-17/	(EACH CORRECTIVE TO THE APPE	OPRIATE	
	STATEMENT OF DEFICIENCIES	PREF		CROSS-REFERENCED DEFICIENCY)		
(X4) ID (FACH DEFICIEI	NCY MUST BE PRECEDED AND NOT THE PRECED AND NOT THE PRECEDED AND NOT THE PRECED AND NOT THE PRECED AND NOT THE PRECED AND NOT THE PRECE		_			
REGULATORY	NCY MUST BE PRECEDED BTT OLD NCY MUST BE PRECEDED BTT OLD R LSC IDENTIFYING INFORMATION)					
TAG						
		F	: 314			
F 314 Continued From	page 12					
F 314 Continued From	n page 12 In the skin issues to the wound					
she would repo			1			
		26				
	10:50 a.m. NA-A stated R190 w	a5				
On 4/30/14, at	10:50 a.m. NA-A stated the e turned and repositioned every A stated she had last reposition	nod				
two hours. INF	when she in	SL				
	All the bours and 44					
came on shift	to work (three hours and 42 re R190 was observed to be					
minutes beto	EICIGO					
(increasitioned)		~				
	and A stated B191	5				
On 4/30/14, a	at 12:58 p.m. LPN-A stated refer positioned every two hours and y ned off of her back, more	Nas				
	0031001101					
to be positio	positioned every two more ned off of her back, more , to minimize the redness noted of	on				
side-to-side	, to manner					
Lease buttock?		1				
	tuned purse ()	RN)-A				
On 5/1/14, 5	at 12:50 p.m. registered hurse (red area on R190's sacral area v re related, but part of the lupus r	vas				
I lotated the I	eu al cu ou	asin				
l ant prossu	IE CIGICO, IL INCE BIL-AU	Ju I				
she had be	een exhibiting. However, rice very 190 was to be repositioned every to ckin risk factors.	/ two				
confirm R ¹	190 was to be repusitioned					
	- Lated B190) should	1			
0n5/1/14	n at 2:20 p.m. RN-B stated Kind n repositioned every two hours v h meant she was to be off of he	vhile in				
have bee		1 Daois				
had which	the meant she was to be on of the she was to be on of the she side to side repositioning due to the states	to her				6/11/14
1 Linith more						
skin risk	factors.	OM		F 329		
		0				
	ESSARY DRUGS					
00 -	the first he first	ree from				
	sident's drug regimen must be fi	nin is anv	1			
Eachite	sident's drug regimen must be in ssary drugs. An unnecessary dr used in excessive dose (incl	uding				
unnece	ssary drugs. An unnecessary drugs nen used in excessive dose (incl the rany) or for excessive dur	ation: Or				
drug wi	hen used in excessive dose (inclusion to the therapy); or for excessive durities therapy); or for excessive durities adopted to the monitoring; or without	t adequat	te			
duplica	te therapy); or for excessive during t adequate monitoring; or without t adequate suse; or in the presence	na of				i Dara /
without	adequate monitoring, of where ions for its use; or in the presence	10.01			If conti	nuation sheet Page 1
indicat	10113 101 112		11611	Facility ID: 00164		
		Event ID: GL	ווסונ			

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	(X2) MUL	TIPLE CONS	ON	FORM APF <u>IB NO. 09</u> (X3) DATE SU COMPLE	38-0391 IRVEY
CENTERS FOR MEDIO	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING		05/02	/2014
TATEMENT OF DEFICIENTS		B. WING			00/01	
	245242		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			1007 EA	AST 14TH STREET EAPOLIS, MN 55404		(X5)
NAME OF PROVIDENCE			1	PROVIDER'S PLAN OF CONTRACT	D BE	COMPLETION
AUGUSTANA HCC OF MPLS	TATEMENT OF DEFICIENCIES	ID PRE	FIX	(EACH CORRECTIVE TO THE APPRO	PRIATE	
(X4) ID SUMMARY S PREFIX (EACH DEFICIEN TAG REGULATORY OF	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	TA	.G	CROSS-REFERENCED DEFICIENCY)		
F 329 Continued From	page 13	1	F 329			
adverse conseq	uences which have discontinued; or any					
combinations of Based on a corresident, the far who have not of given these dr therapy is nec as diagnosed record; and re	the reasons above. The reasons above. The reasons above. The reasons above. The reasons above. The reasons above. The reasons and the residents the reasons and the residents and documented in the clinical residents who use antipsychotic gradual dose reductions, and erventions, unless clinically ed, in an effort to discontinue the	ion				
by: Based on review, the use were i reviewed v medicatio the neces prior to ac those me residents an a PRI	IREMENT is not met as evider observation, interview and docu- facility failed to ensure parame dentified, for 1 of 3 residents (F vho was prescribed multiple an ns. The facility also failed to as sity of as needed (PRN) medic dications were effective, for 1 of (R454) reviewed who was pre- N medication. include: Physician Orders dated 4/17/14 wing medication orders:	eters for (454) (algesic (seess for ations (hether of 5 (scribed)		It is the policy of the Augus Care Center that each resir regimen is free from unner Corrective Action: Per observation, resident i chart review, identified res has had his pain manager sleep related to the prn Z orders have been clarified diagnosis for Tylenol or II prn's have been linked to Identification of Other Res All residents with orders medication would be con terms of diagnosis / par	cessary dr interview, sident (R44 d, and also olpidem. I d related to puprofen, i o monitorin esidents: for any pr	ugs. and 54) 5 his His o and all ng. n

DEPARTMENT OF HEALTH AND HUMAN SERVICES DICAID SERVICES

		AND HUMAN SERVICES				
DEPARTN	MENT OF HEALTH	AND HUMAN SERVICES			(X3) DATE :	SURVEY
CENTERS	S FOR MEDICARE		(X2) MULT	TIPLE CONSTRUCTION	COMPL	EIEU
		(X1) PROVIDER/SUPPLIER/CLIA		NG		1
STATEMENT	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			
AND PLAN OF	CONNECTION		1		05/0	2/2014
		045242	B. WING			
ł		245242		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
				1007 EAST 14TH STREET		
NAME OF P	ROVIDER OR SUPPLIER			1007 EAST 1411 OT 10 AND 55404		
				MINNEAPOLIS, MN 55404		(X5)
AUGUST	ANA HCC OF MPLS				FCORRECTION	COMPLETION
		THE REPERCIENCIES	ID	PROVIDER'S PLAN O (EACH CORRECTIVE AC (EACH CORRECTIVE AC		DATE
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREF		/ 111 4 / 0	
PREFIX	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	TAC	G CROSS-RELEXTENDEFICIEN	NCT)	
TAG	REGULATORY OR	EGG (BEITT				
			-	220		
		nogo 14	F F	All licensed staff will re	view policy and	
F 329	Continued From	page 14		All licensed start will re procedure for transcrib	ing pro orders and	
	5 he	auro PRN for balli.				
	Ling) every loan in	n (a mild pain relieving		administration/follow-u	ip on or before	
		mg, one tablet every eight hour	S			
	medication) 400	ing, one tablet brenty to		A HAR A LA MULL ROVIEW/ D	policy and procedure	2
	Zalnidom Ta	rtrate (a hypnotic medication) 5		for administration, and	a reporting to	
	mg, one tablet a	t bedtime PRN.		for administration, and licensed nurse for any	y pris on or before	
		ve Pain Data Collection and		us that according	nators will review	
	A Comprehensiv	ted 4/19/14, indicated R454's		All Health Unit coold policy and procedure	for transcribing prn	
1	Assessment dat	ted 4/19/14, indicated it ord a		policy and procedure	10/11/	
				o want orders a	re being reviewere	y
	recent cerebiov	entified R454 occasionally				
1	assessment lde	verbal pain indicators including		Clinical Managers to compliance with poli	cy and procedure of	n
1	displayed non-	verbal pain indicators molecumy		compliance with poin	oy and t	
	counds facial e	expressions, restlessness, and	NOC	or before 5/30/14	and one will b	e
			was		iew prn olders will b	
	rubbing of ane	with prescribed PRN pain		10% or more of all reviewed for accura	cy for the next 90 u	ays
	well manageo	with prescribed PRN pain	pain {			
				6/10/14 //10/14 6/1	art audits of 10% of	
	was to be mon	itored every shift, using a	ior	6/10/14 7/10/14 8/16 Monthly random cha	the conducted for	
	One-to-terr par	on of PRN pain medications.	1			4.4
	to administrati			follow-up after adm medication for the r	next 90 days. 6/10/	14
		$D_{\rm exact}$ datad $4/29/14$				
	The Care Plan	nning Report dated 4/29/14,	ff	7/10/14 8/10/14	iem:	
				Monitoring Mechar	ill he reviewed at th	e
				I waanthiy Ouality III	DIOVEILLEILLOOLLIN	
1	protective boo	by Individuals for pain				
	further indica	ted R454's goals for pain twere to verbalize relief from the work to maintain the highest po	e			lity
	management	t were to verbalize relier normal	ssible	effectiveness and	ctice for prn medica	tion
1	interventions	and to maintain the highest po	00,010	of standard of pra	clice for printing and	
	Interventione	ort, with the following interventi	0115.			
1	level of com	arm blanket, warm pack, cold p	ack,	Personsible Pers	on/s DON / ADON	
	Offering a Wa	ing; Offering PRN pain medical	tions;	Leshousing Lett		
	ardorod/ann	ropriate. The care plan also	1-ble			
		154 had a PRN medication avail 154 had a prn medication avail	lable			
l	indicated R4	454's goals for sleep manager	nent			
ł	for sleep. R	(454 S guais ior sloop nattern or				
	were to repo	ort changes in sleep pattern or	the			
l	difficulties	leeping to staff as needed, with				
1	umounes o	terventions: A dark room was t	u ne			
	tollowing in	hen getting ready for sleep; Sle	ер		If continuatio	n sheet Page
	provided wi	nen geuing roudy for the th		Facility ID: 00164	n contandado	
L		Les Versions Obsolete Even	nt ID: GU1611	1		

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PRINTED: 05/20/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DD PLAN OF CORRECTION Definition Definition Definition NAME OF PROVIDER OR SUPPLIER 3 STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET AUGUSTANA HCC OF MPLS SIMMARY STATEMENT OF DEFICIENCIES INNEAPOLIS, MN 55404 (2000) VM ID SUMMARY STATEMENT OF DEFICIENCIES INNEAPOLIS, MN 55404 (2000) VM ID SUMMARY STATEMENT OF DEFICIENCIES INNEAPOLIS, MN 55404 (2000) VM ID SUMMARY STATEMENT OF DEFICIENCIES INNEAPOLIS, MN 55404 (2000) F 329 Continued From page 15 PREFIX PREFIX (2000) F 329 Continued From page 15 F 329 F 329 medication (hyprotic) was to be administered as needed; A bedtime snack and/or drink, repositioning with pillows for comfort, and toileting were to be offered. Linew as to be kept clean, dry, and wrinkle free; Hallway noise and/or light was to be enhimitized. F 329 R464'S Medication Administration Record (MAR) dated 41/14, to 4/30/14, indicated he received Acetaminophen once on 4/22/14, Wice on 4/27/14, and once on 4/22/14, Wice on 4/27/14, and once on 4/26/14, and once on 4/21/14, three indicated as noted on 4/26/14, and once on 4/21/14, three indicated at a the date on 4/26/14, and ORC on 4/21/14, three indicated at a three indicated at 1/26/14, and or cain 4/28/14, lacked documentation for the effectiveness of the PRN Acetaminophen and for the effectiveness of	ATEMENT OF	= DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		COMF	PLETED
245242 B.WINS STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MUGUSTANA HCC OF MPLS SURMARY STATEMENT OF DEFICIENCES PROVIDER PLAN OF CORRECTION REAL DEFICIENCES PROVIDER PLAN OF CORRECTION (CAL DEFICIENCES PRETX PROVIDER PLAN OF CORRECTION (CAL OF MPLS PROVIDER PLAN OF CORRECTION (CAL OF MPLS PROVIDER PLAN OF CORRECTION (CAL OF MPLS PRETX PROVIDER PLAN OF CORRECTION (CAL OF MPLS PROVIDER PLAN OF CORRECTION (CAL OF MPLS PROVIDER PLAN OF CORRECTION (CAL OF MPLS PRETX PRET	D PLAN OF (CORRECTION	IDENTIFICATION NOMBERS	A. BUILD	NO		05/	12/2014
UIGUSTANA HCC OF MPLS MINNEAPOLIS, MN 55404 X41 ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOLL BE (EACH CORRECTIVE ACTION SHOLL BE (EACH CORRECTIVE ACTION SHOLL BE (EACH CORRECTIVE ACTION SHOLL BE (EACH CORRECTIVE ACTION SHOLL BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY USE IDENTIFYING INFORMATION) PREVIX TAG PREVIX (EACH CORRECTIVE ACTION SHOLL BE (EACH CORRECTIVE ACTION SHOLL BE	AME OF PR	OVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CIT		05/0	<u>JZIZO 14</u>
DAY ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY YULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX					MINNEAPOLIS, MN	55404		
 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 winkle 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 4/21/14, and once on 4/26/14. The MAR further indicated R454 received EQ lbuprofen twice 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, RFN 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 bed mediate and arm. R454 reported he received 	(X4) ID PREFIX	SUMMARY ST		PREF	IX (EACH CORR	ECTIVE ACTION SHOU ENCED TO THE APPR		COMPLETION
Definition of the analysis of the state of t	F 329	Continued From p medication (hypno ordered; Pain me needed; A bedtim repositioning with were to be offered dry, and wrinkle f was to be minimi R454's Medication dated 4/1/14, to 4 Acetaminophen 4/23/14, once or once on 4/28/14 R454 received E once on 4/28/14 indicated R454 I bedtime on 4/22 4/28/14. Review notes dated 4/1 documentation Acetaminophen 4/26/14, and 4/2 During numero 4/28/14, throug and out of his r signs/symptom at 1:54 p.m. R4 left shoulder an pain medication On 4/30/14, at (LPN)-H stated medication wa nursing staffa	bage 15 bitic) was to be administered as dication was to be offered as e snack and/or drink, pillows for comfort, and toiletin d; Linen was to be kept clean, ree; Hallway noise and/or light zed. an Administration Record (MAR) 4/30/14, indicated he received once on 4/22/14, twice on a 4/26/14, twice on 4/27/14, and The MAR further indicated 20 Ibuprofen twice on 4/18/14, and once on 4/21/14. The MA had received Zolpidem Tartrate 2/14, 4/23/14, 4/26/14, and wof R454's electronic progress 7/14, through 4/28/14, lacked for the effectiveness of the PRN and for the effectiveness of the 28/14, PRN Zolpidem Tartrate. us, intermittent observations from h 5/1/14, R454 was noted both esident room, with no remarkat is of pain/discomfort. On 4/29/ 454 explained his pain was in the darm. R454 reported he rece n upon request, with relief. 1:23 p.m. licensed practical nud ch454 let staff know when a pain is needed. LPN-H further state issessed his pain level, which medication was given in the	g Rat J min ble I4, ived rse ain d	329			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PRINTED: 0 FORM AI DMB NO. 0	PPROVED
	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y Z		NSTRUCTION	(X3) DATE S COMPL	SURVEY _ETED
		245242	B. WING _		· · · · · · · · · · · · · · · · · · ·	05/0	2/2014
	ROVIDER OR SUPPLIER	245242			ET ADDRESS, CITY, STATE, ZIP CODE		
1					EAST 14TH STREET IEAPOLIS, MN 55404		
AUGUST	ANA HCC OF MPLS				DROV/DER'S PLAN OF CORRECT	ION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 329	determine which p R454's pain, the A fever, and the Ibu On 4/30/14, at 1:3 stated both R454' were indicated for which medication pain. RN-D confi pain scale to doc prior to administr medication effect RN-D further stat effectiveness wa electronic progre Acetaminophen documented.	pain medication to administer for acetaminophen for mild pain or profen for muscle or joint pain. 30 p.m. registered nurse (RN)-D s Acetaminophen and Ibuprofer r pain and did not differentiate to administer for which type of rmed nursing staff were to use a ument both pain assessment, ation of the medication and tiveness, post administration. ted PRN medication s to be documented in the ess notes and confirmed R454's and Zolpidem results were not	a	29			
	pain medication which pain medi which type or lev The facility's Ad policy revised 1, evaluate a resid upon a resident when signs/sym Nurses were to administration r physician order medication was for the resident document the r 483.30(e) POS =C INFORMATION	ministration of PRN Medications (14, directed nurses were to lent's need for a PRN medication 's request for medication and/or optoms of pain were noted. check the resident's medication record or computer care path for then document the PRN s given. Nurses were to observe 's response to the medication a response in the medical record. TED NURSE STAFFING	s n r a e nd	F 356			6/11/14
		Event ID:		F	acility ID: 00164 If co	ontinuation sh	neet Page 17

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DEPARTMENT OF HEA CENTERS FOR MEDIC/

LTH AND HUMAN SERVICES ARE & MEDICAID SERVICES		PRINTED: 05/20/2014 FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245242	B. WING		05/02/2014
	PROVIDER OR SUPPLIER	· · ·		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 356	a daily basis: o Facility name. o The current date o The total number by the following ca unlicensed nursing resident care per s - Registered nu- - Licensed pra- vocational nurses - Certified nurse o Resident census The facility must p specified above or of each shift. Data o Clear and reada o In a prominent p residents and visit The facility must, n make nurse staffir for review at a cos standard. The facility must r staffing data for a required by State This REQUIREMI by: Based on observ review, the facility nursing hours pos licensed and unlic actual hours work	r and the actual hours worked tegories of licensed and staff directly responsible for shift: urses. ctical nurses or licensed (as defined under State law). se aides. s. ost the nurse staffing data in a daily basis at the beginning a must be posted as follows: ble format. dace readily accessible to	F 350	It is the policy of the Augustana Care Center of Minneapolis to po daily nurse staffing information. Corrective Action: Upon discussion with the survey our annual survey the daily nurse information posting was changed	ost the or during e staffing

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00164

If continuation sheet Page 18 of 19

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

PRINTED: 05/20/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	PLETED
245242 B. WING 05/02	2/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUGUSTANA HCC OF MPLS 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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, ILPNs), and nursing assistants (NAs) who worked for each identified shift times. The nurses (LPNs), and nursing assistants (NAs) who worked for each of the identified shift times. The nurses (LPNs), and nursing assistants (NAs) who worked on 4/29/14, at 8:30 a.m. and on 4/30/14, at 11:30 a.m. 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 0/4/20/14, at 11:30 a.m. and 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. Nursing staffing hours are reviewed on a number of RNs, LPNs, and NAs working each shift. The facility policy and procedure for posting information be posted by shift, daily, with regulatory directives. Finduction shift, daily, with regulatory directives. F08M CWS-287/02-99/ Previous Versions Obsolete Event ID: GUIST Facility D: SUIST Monture of the clause the formation continues to the posted of the observed on the required information continues to the posted of the posted staffing information be posted by shift, daily, with regulatory directives.	

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		AND HUMAN SERVICES & MEDICAID SERVICES	7	5	242022		APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
		245242	B. WING			05/	/01/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF MPLS				007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	К 0	00			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE					
	REGULATIONS HA	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
K.	Minnesota Departm time of this survey, found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					ž
	DEFICIENCIES TO	R THE FIRE SAFETY			EPOC	1	
	Healthcare Fire Ins State Fire Marshal 444 Cedar St., Suit St. Paul, MN 55101	Division e 145			LFUG]	
	By email to:				TITLE		(X6) DATE
		DER/SUPPLIER REPRESENTATIVE'S SIGM	NATURE		TITLE		05/20/2014
Electron	ically Signed						00/20/2014

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.

PRINTED: 05/28/2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/28/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245242	B. WING	_		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF MPLS				1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Marian.Whitney@s	•	K	000			
a N	to correct the defici	vhat has been, or will be, done					
		title of the person ection and monitoring to nce of the deficiency.			E.		
	with a basement. T 3 different times. The constructed in 1945 Type II(222) constru- was constructed to that was determined construction. In 197 constructed to the W was determined to construction. Beca the additions meet	Vest side of the building that					
	facility has a comple smoke detection in open to the corridor automatic fire depa has a licensed capa census of 257 at the	fire sprinkler protected. The ete fire alarm system with the corridors and spaces t, that is monitored for rtment notification. The facility acity of 290 beds and had a e time of the survey.					
	i ne requirement at	42 CFR Subpart 483.70(a) is		_			

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Facility ID: 00164

If continuation sheet Page 2 of 5

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			B NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	X3) DATE SURVEY COMPLETED
	(A)	245242	B. WING		05/01/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUST	ANA HCC OF MPLS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K 000		-	K 000		
K 038	NOT MET as evide NFPA 101 LIFE SA	enced by: FETY CODE STANDARD	K 038		6/11/14
SS=D	Exit access is arran accessible at all tin 7.1. 19.2.1	nged so that exits are readily nes in accordance with section			
Based failed t with the 101, Se	Based on observa failed to provide mo with the following re	is not met as evidenced by: tion and interview, the facility eans of egress in accordance equirements of 2000 NFPA 5.4. The deficient practice residents.		It is the policy of the Augustana Hea Care Center to provide appropriate r of egress that are readily accessible times. Corrective Action: Vendors were contracted and bids w	neans at all
	Findings include:			obtained to repair identified sidewalk slabs. Contract has been secured a	nd
	on 05/01/2014, obs exterior sidewalk s	ween 9:30 AM and 11:30 AM servation revealed that the lab at the ground floor east subsided approximately 4		executed for sidewalk repair. 6/11/1 Monitoring Mechanism: director of Maintenance will routinely monitor egress at all entrances, and compliance on a monthly basis. The rounds will be presentd at the quarter	log ese
		tice was verified by the tor at the time of the		Quality Assurance meeting for on-go 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	ning f or
K 050 SS=F		FETY CODE STANDARD	K 050		6/11/14
	varying conditions,	at least quarterly on each shift.		8	

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Facility ID: 00164

If continuation sheet Page 3 of 5

PRINTED: 05/28/2014

		AND HUMAN SERVICES			FORM APPRC IB NO. 0938-0	
		& MEDICAID SERVICES			X3) DATE SURVE	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	COMPLETED	.,
		245242	B. WING		05/01/201	4
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF MPLS			1007 EAST 14TH STREET		
700001				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TION
K 050	that drills are part o Responsibility for pl assigned only to co qualified to exercise conducted between	ge 3 f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are 9 PM and 6 AM a coded y be used instead of audible	K 05	0		
K 067	Based on record red determined that the quarterly drills for e period in accordance Section 19.7.1.2. The affect how staff read Improper reaction be residents. Findings include: On facility tour betwo on 05/01/2014, record 1. There was no AM of 2014, 2. There was no nig quarter of 2013, 3. There was no PM quarter of 2013. These deficient pra maintenance direct inspection.	s not met as evidenced by: eview and interview, it was a facility failed to provide ach shift in the last 12-month we with NFPA 101 LSC (00) his deficient practice could ct in the event of a fire. by staff would affect all ween 9:30 AM and 11:30 AM ord review revealed that: A shift drill for the first quarter ght shift drill for the third A shift drill for the third A shift drill for the fourth ctices were verified by the or at the time of the FETY CODE STANDARD	К 06	It is the policy of the Augustana Hea Care Center to implement fire drills unexpected times under varying conditions at least one time on all sh every quarter. Corrective Action: Fire Drill schedule was revised to be compliance with standard of a least drill per quarter on every shift. 6/1/1 Monitoring Mechanism: The fire Drill schedule will be review a monthly basis by the faciity Safety Officer, and Director of Quality Improvement to ensure compliance schedule of at least one drill on each per quarter. The Fire Drill schedule will be a star 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	at hifts one 4 ed on with n shift hding	4
SS=F		, and air conditioning comply of section 9.2 and are installed				

Facility ID: 00164

If continuation sheet Page 4 of 5

PRINTED: 05/28/2014 FORM APPROVED

		AND HUMAN SERVICES				FORM	05/28/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245242	B, WING	_	s	05/	01/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUS	TANA HCC OF MPLS				007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 067	in accordance with specifications. 19 19.5.2.2 This STANDARD is Based on observat not be verified that and air conditioning accordance with the NFPA 90A, Section system could affect Findings include: During the facility to 11:30 AM on 05/01/ that the ventilation s appears to be utilizi air plenum for the re This deficient practi	the manufacturer's 5.5.2.1, 9.2, NFPA 90A, s not met as evidenced by: tions and interviews, it could the facility's general ventilating y system (HVAC) is installed in a LSC, Section 19.5.2.1 and 2-3.11. A noncompliant HVAC the residents. bur between 9:30 AM and (2014, observation revealed system for the main building ing the egress corridor as an	K	067	See attached waiver for K067 See attached bid for K067		

Facility ID: 00164

If continuation sheet Page 5 of 5

DEPARTMENT OF HEALT					CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES	
					AND TRANSMITTAL		ID: GU16	
1. MEDICARE/MEDICAID PROVID		3. NAME AND AD			TE SURVEY AGENCY	4 TYPE OF ACT	Facility ID: 00164	
(L1) 245242	LICINO.	(L3) AUGUSTAN				4. TYPE OF ACTION: $2(L8)$		
2.STATE VENDOR OR MEDICAID	NO.	(L4) 1007 EAST	14TH STREET	Г		1. Initial 3. Termination	 Recertification CHOW 	
(L2) 159540700		(L5) MINNEAPO	DLIS, MN		(L6) 55404	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey Aft		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. Fui Sui vey Ait	er comprant	
	2/2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	DING DATE: (L35)	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	09/30		
2 AOA 3 Other		015112	00 01 1/01	121010	1011051102			
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia			And/Or Approved Waivers Of			
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of S 7. Medical D		
12. Total Facility Beds	268 (L18)	-	cceptable POC		4. 7-Day RN (Rural SN			
					<u>X</u> 5. Life Safety Code	9. Beds/Roo	m	
13.Total Certified Beds	268 (L17)	X B. Not in Con Requirement	pliance with Prog ents and/or Appli	ram ed Waivers:	* Code: B , 5	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
268								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date: MPM	
Chris Elmgren, HFE	NEII	0	5/21/2014	(L19)	Mark Meath, Enforcement Specialist 06/20/2014			
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBII	LITY	20. COM	IPLIANCE WITH	I CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-2:	572)	
 Facility is Eligible to I 	Participate	RIGH	ITS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	e							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNING	J DATE	ENDING DAT	ΓE	VOLUNTARY 00	<u>INVOLU</u>	JNTARY	
01/01/1982					01-Merger, Closure		Meet Health/Safety	
(L24)	(L41)	(L25)			02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(1.44)		04-Other Reason for windrawar	07-Provi 00-Activ	der Status Change	
(L27)	B. Rescind Su	spension Date:	(L44)			0011011		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
03001								
	(L28)			(L31)				
				D. 1975				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32) (L33)				DETERMINATION APP	ROVAL		

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.

		AND HUMAN SERVICES & MEDICAID SERVICES	7	:5	242022		APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245242	B. WING			05/	/01/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF MPLS			-	007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	К 0	00			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE					
	REGULATIONS HA	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
K	Minnesota Departm time of this survey, found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					ð.
	DEFICIENCIES TO	R THE FIRE SAFETY			EPOC	1	
	Healthcare Fire Ins State Fire Marshal 444 Cedar St., Suit St. Paul, MN 55101 By email to:	Division e 145					
	· · · · · · · · · · · · · · · · · · ·				TITLE		(X6) DATE
	ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN					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.

PRINTED: 05/28/2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/28/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245242	B. WING	_		05/	01/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA HCC OF MPLS				I .	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Marian.Whitney@s	•	ĸ	000			
8	to correct the defici	vhat has been, or will be, done					
	prevent a reoccurre	ection and monitoring to nce of the deficiency.			к.		
	with a basement. T 3 different times. The constructed in 1945 Type II(222) constru- was constructed to that was determined construction. In 197 constructed to the W was determined to construction. Beca the additions meet	Vest side of the building that					
	facility has a comple smoke detection in open to the corridor automatic fire depa has a licensed capa census of 257 at the	fire sprinkler protected. The ete fire alarm system with the corridors and spaces that is monitored for rtment notification. The facility acity of 290 beds and had a e time of the survey. 42 CFR Subpart 483.70(a) is					

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Facility ID: 00164

If continuation sheet Page 2 of 5

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	×	245242	B. WING		05/01/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUST	ANA HCC OF MPLS			1007 EAST 14TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
K 000		-	K 000		
K 038	NOT MET as evide NFPA 101 LIFE SA	enced by: FETY CODE STANDARD	K 038		6/11/14
SS=D	Exit access is arran accessible at all tin 7.1. 19.2.1	nged so that exits are readily nes in accordance with section			
	Based on observa failed to provide mo with the following re	is not met as evidenced by: tion and interview, the facility eans of egress in accordance equirements of 2000 NFPA 5.4. The deficient practice residents.		It is the policy of the Augustana He Care Center to provide appropriate of egress that are readily accessibl times. Corrective Action: Vendors were contracted and bids	means e at all
	Findings include:			obtained to repair identified sidewa slabs. Contract has been secured	lk and
	on 05/01/2014, obs exterior sidewalk s	ween 9:30 AM and 11:30 AM servation revealed that the lab at the ground floor east subsided approximately 4		executed for sidewalk repair. 6/11/ Monitoring Mechanism: director of Maintenance will routine monitor egress at all entrances, and compliance on a monthly basis. The rounds will be presentd at the quart	ly d log nese
		tice was verified by the tor at the time of the		Quality Assurance meeting for on-g review of sustainability of standard practice for compliance with codes means of egress. 6/11/14 Responsible Person/s: Director of Mainatenance / Director of Quality Improvement	of for
K 050 SS=F		FETY CODE STANDARD	K 050		6/11/14
	varying conditions,	at least quarterly on each shift. r with procedures and is aware		4	

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Facility ID: 00164

If continuation sheet Page 3 of 5

PRINTED: 05/28/2014

		AND HUMAN SERVICES			FORM APPRO	
		& MEDICAID SERVICES			X3) DATE SURVE	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	COMPLETED	
		245242	B. WING		05/01/2014	4
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HCC OF MPLS			1007 EAST 14TH STREET		
700001				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TION
K 050	that drills are part o Responsibility for pl assigned only to co qualified to exercise conducted between	ge 3 f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are 9 PM and 6 AM a coded y be used instead of audible	K 05	0		
K 067	Based on record red determined that the quarterly drills for e period in accordance Section 19.7.1.2. The affect how staff read Improper reaction be residents. Findings include: On facility tour betwo on 05/01/2014, record 1. There was no AM of 2014, 2. There was no nig quarter of 2013, 3. There was no PM quarter of 2013. These deficient pra maintenance direct inspection.	s not met as evidenced by: eview and interview, it was a facility failed to provide ach shift in the last 12-month we with NFPA 101 LSC (00) his deficient practice could ct in the event of a fire. by staff would affect all ween 9:30 AM and 11:30 AM ord review revealed that: A shift drill for the first quarter ght shift drill for the third A shift drill for the third A shift drill for the fourth ctices were verified by the or at the time of the FETY CODE STANDARD	К 06	It is the policy of the Augustana Hea Care Center to implement fire drills unexpected times under varying conditions at least one time on all sh every quarter. Corrective Action: Fire Drill schedule was revised to be compliance with standard of a least drill per quarter on every shift. 6/1/1 Monitoring Mechanism: The fire Drill schedule will be review a monthly basis by the faciity Safety Officer, and Director of Quality Improvement to ensure compliance schedule of at least one drill on each per quarter. The Fire Drill schedule will be a star 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	at hifts e in one 4 ed on with n shift hding	4
SS=F		, and air conditioning comply of section 9.2 and are installed				

Facility ID: 00164

If continuation sheet Page 4 of 5

PRINTED: 05/28/2014 FORM APPROVED

		AND HUMAN SERVICES				FORM	05/28/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245242	B, WING	_	·	05/	01/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA HCC OF MPLS					007 EAST 14TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 067	in accordance with specifications. 19 19.5.2.2 This STANDARD is Based on observat not be verified that and air conditioning accordance with the NFPA 90A, Section system could affect Findings include: During the facility to 11:30 AM on 05/01/ that the ventilation s appears to be utilizi air plenum for the re	the manufacturer's 9.5.2.1, 9.2, NFPA 90A, s not met as evidenced by: tions and interviews, it could the facility's general ventilating y system (HVAC) is installed in a LSC, Section 19.5.2.1 and 2-3.11. A noncompliant HVAC the residents. bur between 9:30 AM and /2014, observation revealed system for the main building ing the egress corridor as an esident rooms. ice was verified by the	K	067	See attached waiver for K067 See attached bid for K067		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00164

If continuation sheet Page 5 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	F5242022		T	2000 CODE	OMB Exempt
FIRE SAFETY SURVEY REPORT 20	000 CODE - HEALTH CA			1. (B) MEDICAID I.D. NO.	
Medicare – Me	dicaid	_{к1} 245	5242	к2	
	PART I — Life Safety (PART IV — Waiver R				
Identifying information as shown in applicable reco	ords. Enter changes, if any, alo	ngside each iter	n, giving date of chang	е.	
2. NAME OF FACILITY 2. (A) MULT		2. (B) ADDRESS OF	FACILITY (STREET, CITY,	STATE, ZIP CODE) A	
CENTER OF MINNEAPOLIS	UGUSTANA HEALTH CARE A. BUILDING 1			B.C C.C	(All required areas are sprinklered) Partially Sprinklered (Not all required areas are sprinklered) None (No sprinkler system)
3. SURVEY FOR 4. DATE OF	SURVEY	DATE OF PLAN APP	PROVAL SURVEY UN	IDER	
	/2014	<6	5. 🗸 000 E	EXISTING 6. 🗌 20	000 NEW
5. SURVEY FOR CERTIFICATION OF			N		
1 HOSPITAL 2. SKILLED/NURSING FACI	LITY 4.OCF/MR UNE	DER HEALTH CARE			
IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE IT 1. DENTIRE FACILITY 2. DISTINCT PART OF (SPE				HOSPITAL, IS HOSPITAL /	ACCREDITED?
6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY 290 b. NUMBER OF HOSPITAL E CERTIFIED FOR MEDICAR		BEDS 290 d. N	UMBER OF SKILLED BEDS ERTIFIED FOR MEDICAID_	e. NUMBER OF CERTIFIED FO	NF or ICF/MR BEDS DR MEDICAID
7. A THE FACILITY MEETS, BASED UPON (CHECK ALL	APPROPRIATE BOXES)				
1. OCOMPLIANCE WITH ALL PROVISIONS 2	ACCEPTANCE OF A PLAN OF COR		COMMENDED WAIVERS	4 FSES 5 PERFO	ORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE STANDARD		J			
SURVEYOR (Signature)		OFFICE		DATE	
	EPUTY STATE FIRE ARSHAL	STATI	E FIRE MARSHAL	05/01/20	14
FIRE AUTHORITY OFFICIAL (Signature)	E FIRE SAFETY SUPERVI	SOR STAT	E FIRE MARSHAL	DATE 5-5-	14

ID REFIX				MET	NOT MET	N/A	REMARKS
	Ρ	PART I - LSC REQUIREMENTS - It	ems in italics relate to the FSES				
		BUILDING CON	STRUCTION				
(11	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						
12	Bui	00 EXISTING ilding construction type and heig 1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5					
	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)					
	5	V (111)	Not over two stories with				
	6	IV (2HH)	complete automatic sprinkler system.				
	7	II (000)					
	8	III (200)	Not over one story with complete automatic				
	9	V (000)	sprinkler system.				
	Give nun are app	Building contains fire treated woo e a brief description, in REMARKS nber of stories, including baseme located, location of smoke or fir proval. Complete sketch or attac Iding as appropriate.	S, of the construction, the ents, floors on which patients e barriers and dates of				

ID PREFIX				MET	NOT MET	N/A	REMARKS
	Buil	0 NEW ding construction type and height I.6.2, 18.1.6.3, 18.3.5.1.	meets one of the following:				
	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)					
	4	V (111)	Not over one story with complete automatic				
	5	IV (2HH)	sprinkler system.				
	6	II (000)		_			
	7	III (200)	Not Permitted				
	8	V (000)					
	Give num are app	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.					
(103	cons	rior walls and partitions in building struction shall be noncombustible erials. 18.1.6.3, 19.1.6.3	gs of Type I or Type II or limited-combustible				
	trea	icate N/A for existing buildings us ted wood studs within non-load bitions.)	ing listed fire retardant earing one-hour rated				

ID		MET	NOT	N/A	REMARKS
PREFIX			MET	N/A	
	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 $\frac{1}{28}$ 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				
	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 2000 NEW				
	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. <i>Indicate flame spread rating/s</i>				

ID		МЕТ	NOT	N/A
PREFIX			MET	19/74
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		1	
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 <i>If the walls have a fire resistance rating, give rating</i>			
	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 1 ³ / ₄ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3				
	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 <i>If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.</i>				
	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. <i>If enclosures are less than required, give a brief description and</i> <i>specific location in REMARKS.</i>				
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.				

			1	
ID PREFIX		MET	NOT MET	N/A
	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
(27	2000 EXISTING Doors in smoke barriers rating or are at least 1 ³ / ₄ Non-rated protective plat the bottom of the door a comply with 7.2.1.14. Do closing in accordance with required to swing with es	inch thick solid l tes that do not e re permitted. Ho pors shall be self ith 19.2.2.2.6. Sy gress and positiv	oonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are 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 1 ³ / ₄ 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						
28	2000 EXISTING Door openings in smoke width of 32 inches (81 cr 19.3.7.7						
	2000 NEW Door openings in smoke						
	Provider Type Hospitals and Nursing Facilities	Swinging Doors 41.5 inches (105 cm)	Horizontal Sliding Doors 83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

ID EFIX				ME	T NOT MET	N/A	REMARKS
)4	Penetrations of smoke barriers by c						
	accordance with 8.3.5. Dampers ar						
	penetrations of smoke barriers in fu			ns			
	where a sprinkler system in accord						
	provided for adjacent smoke compa						
	Hospitals may apply a 6-year damp						
	to NFPA 80 & NFPA 105. All other			ust			
	maintain a 4-year damper maintena	ince interval. 8	.3.5				
	Describe any mechanical smoke co	ontrol system ir	n REMAF	RKS.			
	HAZARD	OUS AREAS					
	2000 EXISTING						
	One hour fire rated construction (wi	th 3/4 hour fire-	rated doo	ors) or			
	an approved automatic fire extingui	shing system i	n accorda	ance			
	with 8.4.1 and/or 19.3.5.4 protects	hazardous area	as. When	n the			
	approved automatic fire extinguishing	ng system opti	on is use	d, the			
	areas shall be separated from othe						
		Suaces by Si					
	partitions and doors. Doors shall be	self-closing a	nd non-ra	ated or			
	partitions and doors. Doors shall be field-applied protective plates that c	e self-closing a lo not exceed 4	nd non-ra	ated or			
	partitions and doors. Doors shall be	e self-closing a lo not exceed 4	nd non-ra	ated or			
	partitions and doors. Doors shall be field-applied protective plates that c	e self-closing a lo not exceed 4	nd non-ra	ated or			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitte	e self-closing al lo not exceed 4 d. 19.3.2.1	nd non-ra 48 inches	ated or from			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet)	e self-closing al lo not exceed 4 d. 19.3.2.1	nd non-ra 48 inches	ated or from			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops	e self-closing al lo not exceed 4 d. 19.3.2.1	nd non-ra 48 inches	ated or from			
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	Area 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)	e self-closing al lo not exceed 4 d. 19.3.2.1	nd non-ra 48 inches	ated or from			
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	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitted Area 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	e self-closing al lo not exceed 4 d. 19.3.2.1	nd non-ra 48 inches	ated or from			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitted Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitted Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			
	partitions and doors. Doors shall be field-applied protective plates that of the bottom of the door are permitter Area 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	Automatic Sprinkler	nd non-ra	N/A			

						1	
ID				MET	NOT	N/A	REMARKS
PREFIX					MET		
	2000 NEW						
	Hazardous areas are protected in a	ccordance with	84 The				
	areas shall be enclosed with a one		,				
	³ / ₄ hour fire-rated door, without winc	lows (in accord	ance with				
	8.4). Doors shall be self-closing or	automatic closi	na in				
	accordance with 7.2.1.8. Hazardous						
	sprinkler system in accordance with	19.7, 18.3.2.1,	18.3.5.1.				
	Area	Automatic Sprinkler	Separation N/A				
	a. Boiler and Fuel-Fired Heater Rooms	Automatic Optimiler					
	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	aroas that				
		s of flazardous a	areas inal				
	are deficient in REMARKS.						
K30	Gift shops shall be protected as ha						
	storage or display of combustibles i	in quantities co	nsidered				
	hazardous. Non-rated walls may se						
	considered hazardous, have separa						
	are completely sprinkled. Gift shops						
	if they are not considered hazardou	is, have separa	te protected				
	storage, are completely sprinklered	and do not exc	ceed 500				
	square feet. 18.3.2.5, 19.3.2.5						
	390010 1001. 10.0.2.0, 10.0.2.0						
	Area	Automatic Sprinkler	Separation N/A				
	L. Gift Shop storing hazardous quantities						
	of combustibles						

			NOT		
PREFIX		MET	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. \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				
	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		MET	NOT	N/A	REMARKS
PREFIX	2000 NEW		MET		
	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 <i>If doors lead directly to grade from each room, check this box.</i>				
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
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			
	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			

			NOT		
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			NOT		
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				
<109	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				
<54	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.				
(55	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				1
	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
	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		1	
	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			

			NOT	
PREFIX		MET	NOT MET	N/A
	B. Show who provided the service			
	C. Note the source of water supply for the automatic sprinkler system.			
	(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 internationa symbol for no smoking.	I		
	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			MET	NOT MET	N/A
PREFIX	(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.			
		BUILDING SERVICE EQUIPMENT			
K67	and spec	ting, ventilating, and air conditioning shall comply with 9.2 shall be installed in accordance with the manufacturer's sifications. J.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2			
K68	roon	nbustion and ventilation air for boiler, incinerator and heater ns is taken from and discharged to the outside air. .2.2, 19.5.2.2.			
K69		king facilities shall be protected in accordance with 9.2.3. 9.2.6, 19.3.2.6, NFPA 96			
K70	care non- elem	able space heating devices shall be prohibited in all health occupancies. Except it shall be permitted to be used in esleeping staff and employee areas where the heating nents of such devices do not exceed 212°F (100°C). 2.8, 19.7.8			
K71		bish Chutes, Incinerators and Laundry Chutes. .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		MET	NOT	N/A
PREFIX	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.		MET	
K160	2000 EXISTING			
KIOO	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, <i>Safety Code for Existing Elevators & Escalators</i> . 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, <i>Safety Code for</i> <i>Existing Elevators and Escalators.</i> 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	1			1
	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				-
<73	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				
< 74	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. 				
<75	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	r			

ID		MET	NOT	N/A	REMARKS
PREFIX	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		MET		
	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				
(131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
<132	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).				
(133	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)				

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ID PREFIX		MET	NOT MET	N/A	l
K142	All occupancies containing hyperbaric facilities shall comply with				
K143	NFPA 99, Standard for Health Care Facilities, Chapter 19. Transferring of liquid oxygen from one container to another shall				
K143	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				
11177	30 minutes per month and shall be in accordance with NFPA 99				
	and NFPA 110.				
K145	3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) The Type I EES is divided into the critical branch, life safety				
K140	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			NOT		
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)	<u> </u>	Title	Office	Date
Fire Authority Official (Signature)		Title	Office	Date
Form CMS-2786R (02/2013)				Page 27

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

PROVIDER NUMBER K1 245242	FACILITY NAME AUGUSTANA HCC OF MPLS		SURVEY DATE *K4 05/01/2014
K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS NUMBER OF THIS BUILDING	1A	A BUILDING B WING C FLOOR D APARTMENT UNIT
12 2786 R 13 2786 R	Ith Care Form 2000 EXISTING 2000 NEW	COMPLETE IF ICF/MR IS SURVEYED UN SMALL (16 BEDS O 1 PROMPT K8: 2 SLOW 3 IMPRAC	R LESS)
14 2786 U 15 2786 U	ASC Form 2000 EXISTING 2000 NEW CF/MR Form X 2000 EXISTING	LARGE 4 PROMPT 5 SLOW K8: 6 IMPRACT	
17 2786 V, W, 2 *K7 12 SELECT NUMBER 0	X 2000 NEW DF FORM USED FROM ABOVE	APARTMENT HOUSE 7 PROMPT K8: 8 SLOW 9 IMPRAC	
2786 M, R, T, U, V, W, X,	marked as not applicable in the Y and Z.) K56: 3	ENTER E-SCORE HERE K5: e.g 2.5	
*K9 : FACILITY MEETS LSC A1 (COMP. WITH ALL PROVISIONS)		X A4 IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	A5 (PERFORMANCE BASED DESIGN)
FACILITY DOES NOT MEET B. *MANDATORY	LSC: K180: A. X FULLY SPRINKLE (All required areas are spin)		

Augustanne HCC

An annual/continuing waiver is being requested for K067.

- 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 I 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

Sheehan

Fire Safety Supervisor State Firə Marshal

5-21-14

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.



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 Mechanical Contractors, Inc. 7340 Washington Avenue South ◆ Eden Prairie, Minnesota 55344 Phone: 952-941-7010 ◆ Fax: 952-941-9118



Sincerely,

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Metropolitan Mechanical Contractors, Inc. Accepted By:.

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Apartments

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

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Date:

Augustana

Metropolitan Mechanical Contractors, Inc. 7340 Washington Avenue South ◆ Eden Prairie, Minnesota 55344 Phone: 952-941-7010 ◆ Fax: 952-941-9118

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a.

From:	Sheehan, Pat (DPS)
То:	rochi Isc@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

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5/2014

Sheehan

Fire Safety Supervisor State Firə Marshal

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Apartments

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

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