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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HGLC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00750

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245423**

2. STATE VENDOR OR MEDICAID NO. (L2) **925340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **CHOSEN VALLEY CARE CENTER**
(L4) **1102 LIBERTY STREET SOUTHEAST**
(L5) **CHATFIELD, MN** (L6) **55923**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 08/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/09/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245423 August 9, 2017

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

Dear Mr. Backen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 24, 2017 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 9, 2017

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

RE: Project Number S5423027

Dear Mr. Backen:

On June 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 17, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 5, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 24, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 17, 2017, effective June 24, 2017 and therefore remedies outlined in our letter to you dated June 1, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HGLC

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(L3) **CHOSEN VALLEY CARE CENTER**
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(L5) **CHATFIELD, MN** (L6) **55923**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 06/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/17/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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02/01/1987
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2017

Mr. Craig Backen, Administrator
Chosen Valley Care Center
1102 Liberty Street Southeast
Chatfield, MN 55923

RE: Project Number S5423027

Dear Mr. Backen:

On May 17, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 26, 2017, 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 26, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 17, 2017 (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 17, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Please contact me if you have questions related to this eNotice.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On May15 through May 17 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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.	F 000		
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notice of a new roommate was provided for 1 of 3 residents (R35) reviewed for facility admission, transfer and discharge practices.	F 247	This plan and response to CMS-2567 regarding Tag F247, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these	6/24/17

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

Electronically Signed | 06/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 1 Findings include: R35's quarterly Minimum Data Set (MDS) dated 4/17/17, identified R35 had severe cognitive impairment. R35's medical record was reviewed and lacked any evidence that R35 or family member (FM)-D had been notified of the new roommate prior to the arrival at the facility. Review of R35's progress notes dated from 5/2/17 to 5/17/17, identified there was no documented information regarding a roommate change. During a family interview on 5/15/17, at 10:38 a.m., FM-D stated that R35 had a new roommate a week and a half ago and she was never told about it. On 5/17/17, at 4:56 p.m., social worker (SW)-A stated that when a resident has a roommate change she notifies the resident or family member verbally and then documents this in the resident's medical record. SW-A stated she did verbally notify (FM)-D of the new roommate change the day the new roommate would be arriving, but SW-A stated she did not document this in R35's medical record. SW-A further stated she typically gives notice for a roommate change the day before or the day of and that she documents the information in the resident's medical record. The facility Transfer, Room to Room policy revised December 2016, directed staff to "6. A roommate will be informed of any new transfer into his/her room. Such information will include why the transfer is being made and any	F 247	findings in their entirely should any remedies be imposed. Chosen Valley Care Center ensures that each resident receives proper notice before the resident□s room or roommate in the facility is changed. Chosen Valley Care Center is sensitive to the trauma a move or change of roommate causes some residents, and attempts to be as accommodating as possible. Chosen Valley Care Center will give a resident as much notice as possible that they are getting a new roommate. The policy and procedure for notification of room transfer were reviewed and found appropriate. R35 has not recently changed rooms or has not gotten a new roommate. All residents have the potential to be affected by this deficient practice. All licensed and unlicensed staff will be re-educated on the room change policy at our mandatory in-services on June 19th, 20th, 21st, and 23rd, 2017. The Licensed Social Worker or her designee will monitor compliance by completing the Room Change Monitor form quarterly for one year and it will be presented at the Quality Improvement meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 2 information that will assist the roommate in becoming acquainted with his or her roommate," and 7. ..."Documentation of a room transfer is recorded in the resident's medical record."	F 247		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure the resident's comprehensive care plan was followed for toileting for 1 of 3 residents (R61) reviewed for urinary incontinence Findings include: R61's care plan dated last review 3/27/17, included: I am sometimes incontinent of bladder, I am on a toileting program. Interventions included A/Remind/help me to the toilet: 0500 (5:00 a.m.), upon rising, every 3 hours, at bedtime and prn (as needed). NOCS (nights) to check/ toilet on rounds, and change if wet. R61's nursing assistant (NA) care plan dated 4/3/17, identified bowel and bladder: occasionally incontinent bladder, continent bowel, toileting program: 0500, upon rising, every three hours, at hs (bedtime) and PRN, nocs to check on rounds	F 282	This plan and response to CMS-2567 regarding Tag F282, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. The policies and procedures for implementation of care plans and care planning have been reviewed and found appropriate. After it was known that the resident□s R61□s toileting plan was not followed, the nursing assistants were educated on Resident 61□s toileting plan interventions. They were re-educated on the locations of the care plans and where to find the toileting plan on the care plan for all residents. All residents who reside at Chosen Valley Care Center have the potential to be	6/24/17

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	245423	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 toilet as needed and change if wet, staff to perform peri-care. During continuous observations on 5/17/17, from 12:28 p.m., through 3:57 p.m. (total of 3 hours and 29 minutes) the following was observed: -12:28 p.m. R61 was seated in her wheelchair in her room and had visitor. -12:58 p.m. room call light activated by roommate. -1:02 p.m. NA-C and NA-D entered room and assisted R61's roommate with toileting. R61 remained in her wheelchair and no offer of toileting or toileting was provided to R61. -1:22 p.m. NA-C entered room and asked R61 if she was going to church and left room. R61 remained in wheelchair in room and no offer to use toilet occurred. -1:42 p.m., R61 remains seated in wheelchair in room watching T.V. -2:04 p.m. NA-C entered the room and informed R61 they want R61 to come down for coffee and then NA-C wheeled R61 out of her room into the dining room, no offer of the toilet was provided. -2:25 p.m. an activity staff person assisted R61 back to her room from the dining room. While in the dining room no offer to toilet was offered. -2:45 p.m. a visitor was talking to R61 and reassuring her meals were paid for and assisted R61 back into her room. -2:51 p.m. NA-A entered R61's room and was passed linens. NA-A stated to R61 "Hi." When finished NA-A stated to R61 I will see you later, no offer of toileting occurred. -3:05 p.m. NA-E walked by R61's room, looked in room and said "Hi" to R61. No offer or assistance to toilet was done. -3:10 p.m. an activity staff entered R61's room and assisted R61 to the activity located by the	F 282	affected by this deficient practice. Nursing Assistants, Nurses, and TMAs have initially been notified in shift report of the expectations of following each resident□s toileting plan according to their plan of care, what the outcomes could be of not following care plans, where to identify residents□ toileting plan and who to see if there are questions regarding care plans. All licensed and unlicensed staff will be re-educated on resident care plans with emphasis on toileting plans at all staff in-services on June 19th, 20th, 21st, and 23rd, 2017. A Care Plan Intervention Audit was developed and will be completed to ensure that toileting interventions are followed according to the resident□s plan of care. The Director of Nursing or her designee will complete these monitors once weekly for four weeks and then quarterly audits will be completed and presented at the Quality Improvement Meeting for one full year.	

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F 282	Continued From page 4	F 282		

dining room area.
-3:48 p.m. an activity person assisted R61 back to her room. During the activity no staff offered to toilet R61.
-3:55 p.m. NA-A entered R61's room and assisted R61's roommate into the bathroom. At 3:57 p.m. NA-A stated to R61 are you ready for supper? R61 replied soon I guess. NA-A stated, "Should we go out there" and proceeded to wheel R61 out of her room. NA-A asked R61 if she wanted to watch the birds and then assisted R61 to the living room sitting area. NA-A had not offered R61 the opportunity to toilet.

On 5/17/17 at 4:04 p.m., NA-A when queried how staff know when was the last time a resident was toileted stated the NA's receive report form nurses and NA's when coming on duty. When queried what time was reported R61 had been toileted from the day shift towards the end of the day shift. Day shift ended at 2:00 p.m. and no staff offered to assisted to toilet the resident. When asked how often R61 was care planned to be toileted, NA-A stated the staff know when to toilet the resident from the resident care plan. On asking if NA-A had toileted R61 since the start of her shift at 2:00 p.m. NA-A said she had not.

On 5/17/17, at 4:17 p.m., registered nurse (RN)-A stated R61 had a change from occasionally incontinent to frequently incontinent. RN-A states she would expect the staff to follow the care plan for toileting. RN-A verified R61's care plan regarding times to be toileted.

On 5/17/17, at 4:23 p.m. the DON stated she would expect staff to follow the toileting schedule for R61 on the care plan and if any concerns notify the supervisor.

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F 282	Continued From page 5 The facility policy Urinary Continence and Incontinence, dated revised 9/10, indicated Policy Interpretation and Implementation 18. a. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. The facility policy Using the Care Plan, dated revised 8/06, indicated the care plan shall be used in developing the resident's daily routines and will be available to staff who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation 6. Documentation must be consistent with the resident's care plan.	F 282		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		6/24/17

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F 431	Continued From page 6 (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a medication label reflected the current physician order for 1 of 6 residents (R17) observed during medication administration.	F 431	This plan and response to CMS-2567 regarding Tag F431, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these	

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F 431	Continued From page 7 Findings include: R17's physician order dated 3/3/16, directed staff to give Tramadol (analgesic) 50 mg (milligrams) by mouth three times a day. During medication administration observation on 5/17/17, at 7:46 a.m., with trained medication assistant (TMA)-A revealed R17's medication label read Tramadol 50 mg , take two tablets by mouth three times a day, and one tablet every six hours as needed. The Tramadol was in a bubble pack and each dose had two tablets in individual bubbles. TMA-A placed one 50 mg tablet into a medication cup and the other 50 mg tablet was taped back into the bubble pack by TMA-A. TMA-A stated she tapes the other tablet back in for the evening staff to use and has been doing this for a long time. TMA-A further stated she had faxed the pharmacy several times, so the facility would have the correct label and correct amount of Tramadol in each bubble pack, but stated the pharmacy keeps sending the packs with two tablets in each bubble. On 5/17/17, at 7:57 a.m., registered nurse (RN)-B stated the physician order should match the medication label and the facility policy was not to tape any medication back into a bubble pack, but should be destroyed. On 5/17/17, at 8:16 a.m., RN-C verifies the medication label had been incorrect since 3/3/16 when R17's physician order was changed to decrease the Tramadol to 50 mg by mouth three times a day. 05/17/17, at 8:32 a.m., director of nursing (DON) verified that the physician order should match the medication label and the facility policy was not to tape any medication back into a bubble pack, but should be destroyed. The DON reported they do not have a policy and procedure for labeling of medications.	F 431	findings in their entirely should any remedies be imposed. The policies and procedures for medication administration/disposal has been reviewed and found appropriate. Resident R17□s medication label did not reflect the current physician order observed during medication administration. The physician order dated 3/3/16 directed staff to give Tramadol 50mg by mouth three times a day. On 5/17/17 the pharmacy label read Tramadol 50mg, take two tablets by mouth three times a day and one tablet every six hours as needed. TMA-A administered one 50mg tablet per physician order dated 3/3/16 and taped the second pill back in the bubble pack. The MD was notified immediately upon discovery on 5/17/17 of the dose reduction ordered on 3/3/16 which R17□s script did not reflect, and a new script reflecting the accurate order was received on 5/17/17. All residents who residents who reside at Chosen Valley Care Center have the potential to be affected by this deficient practice. Nurses and TMAs have initially been notified in shift report of the expectations of completing proper checks to ensure pharmacy label reflects the physician order. All licensed and unlicensed staff will be re-educated on medication administration/disposal on June 19th, 20th, 21st, and 23rd, 2017. A Medication Reconciliation Audit was developed and will be completed to ensure that physician orders correctly	

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F 431	Continued From page 8	F 431	match the pharmacy label. This monitor includes observing staff administering medications and ensuring the pharmacy label matches the physician□s order and notifying the physician immediately of any discrepancies. The Director of Nursing or designee will complete these audits once weekly for four weeks then quarterly audits will be completed and presented to the Quality Improvement Meeting for one full year.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		6/24/17

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F 441	Continued From page 9 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 441		

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F 441	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility to ensure proper infection control practices were implemented to prevent the spread of infection for 1 of 1 resident (R35) following a bowel and bladder incontinence. Findings include: R35 was observed on 5/16/17, at 6:35 p.m., when nursing assistant (NA)-B donned gloves and cleansed bowel movement from R35's rectal area. With the same soiled gloves on NA-B continued to apply a clean incontinent product, placed pillows around R35 for positioning in bed, adjusted blankets to cover R35, placed call light within reach for R35, moved R35's bed and then removed the soiled gloves. NA-B then proceeded to remove garbage from R35's room and bathroom, carried the garbage bags out of R35's room and disposed of the garbage in a soiled utility room. NA-B walked out of the soiled utility room and proceeded to chart on the computer screen located on the hallway wall. NA-B failed to remove gloves and wash hands after providing peri-cares. At the time NA-B verified gloves had remained on after providing peri-cares and hands had not been washed. On 5/17/17, at 11:03 a.m., the director of nursing (DON) stated she would expect staff to remove gloves after cleansing the peri-area and hands should be washed before leaving the residents room. The facility policy Perineal Care dated revised 10/10, indicated Steps in the Procedure 10. h. Wash and rinse the rectal area thoroughly,	F 441	This plan and response to CMS-2567 regarding Tag F441, is written solely to maintain certification in the Medicare and Medical Assistance programs. We wish to preserve our right to dispute these findings in their entirely should any remedies be imposed. Chosen Valley Care has developed and ensures that the facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. Resident #35 is currently receiving care with appropriate hand hygiene. All Nursing Assistants were observed with hand washing and audit was completed on 6/3/2017. All residents residing at Chosen Valley Care Center have the potential to be affected by this deficient practice. All licensed and unlicensed staff were educated on the importance of infection control and the importance of minimizing cross contamination at our mandatory in-services on June 19th, 20th, 21st, and 23rd, 2017. Hand washing audits during personal cares will be completed once weekly for	

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F 441	Continued From page 11 including the area under the scrotum, the anus, and the buttocks. i. Dry area thoroughly. 11. Discard disposable items onto designated containers. 12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly.	F 441	one month to ensure compliance is achieved and then quarterly audits will be completed and presented at the Quality Improvement meeting. Random shifts and staff will be observed to ensure proper infection control practices are in place and staff is in compliance with policies and procedures. The Director of Nursing of her designee will be responsible to monitor for compliance.	

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	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2017**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Chosen Valley Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/07/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Chosen Valley Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1975 and was determined to be of Type V(111) construction. In 1998, an addition was constructed and was determined to be of Type V(111) construction. In 2001, an addition was constructed and was determined to be of Type II(000) construction. In 2002, a canopy was constructed and was determined to be of Type V(111) construction. The construction type was changed after review of the architectural drawings that are on hand for the facility. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOSEN VALLEY CARE CENTER	**1102 LIBERTY STREET SOUTHEAST CHATFIELD, MN 55923**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Findings Include: On facility tour between 09:30 AM and 01:30 PM on 5/19/2017, based on observation and interview revealed that the following include: Found six or more wheelchairs being stored in corridors. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211	On May 19th, 2017, the Director of Environmental Services informed staff of the K211 tag and then all corridors were cleared of obstruction. A Safe Environment Audit has been developed and will be completed weekly for one month to ensure compliance is achieved. Quarterly audits then will be completed for one full year and reported to the Quality Improvement meetings. The Safety Committee will also monitor for compliance on their monthly rounds.	6/24/17
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.	K 291		6/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2017**

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K 291	Continued From page 3 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Findings Include: On facility tour between 09:30 AM and 01:30 PM on 5/19/2017, based on observation and interview revealed that the following include: Found emergency back up light in generator room does not operate when tested. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	On May 19th, 2017, a new battery was installed in the emergency backup light for the generator. A monthly test will be conducted and documented as part of our monthly generator inspector.	
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		6/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2017**

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K 321	Continued From page 4 hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321	On May 19th, 2017, the Director of Environmental Services installed a door closure on utility room 213 and the B-Wing utility room. Safety Committee will monitor utility room doors to ensure closures are in place and in working order as part of our monthly rounds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245423	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/19/2017**

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K 321	Continued From page 5 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Findings Include: On facility tour between 09:30 AM and 01:30 PM on 5/19/17, based on observation and interview revealed that the following include: Found two utility rooms, 213 and b wing needs closer's installed. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 321		