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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HMVV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245418**
2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BELGRADE NURSING HOME**
(L4) **103 SCHOOL STREET, PO BOX 340**
(L5) **BELGRADE, MN** (L6) **56312**

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 05/16/2012 (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 IMR	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 **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jacqueline Stradtman, HFE NEII 6/11/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 07/17/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 7/20/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/16/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

A standard survey was completed at this facility on March 1, 2012. The most serious deficiency was cited at a scope and severity (S/S) level of F.

Compliance with the health deficiencies had not yet been verified and since day 70 for the current enforcement cycle at this facility was May 10, 2012, we recommended the following enforcement remedy to the CMS RO:

- Mandatory DOPNA, effective June 1, 2012

The facility was subject to loss of NATCEP.

A post certification revisit was completed on May 16, 2012 and one deficiency was reissued at a S/S level of C. The facility has reached substantial compliance effective March 30, 2012.

As a result of the revisit findings, Mandatory DOPNA, effective June 1, 2012 was rescinded. The facility is no longer subject to a loss of NATCEP.

Please refer to the CMS 2567B for both health and life safety code as well as the CMS 2567 along with the facility's plan of correction.

Effective March 30, 2012, the facility is certified for 49 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5418 July 17, 2012

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, PO Box 340
Belgrade, Minnesota 56312

Dear Mr. Lord:

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 March 30, 2012, the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900 , St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 0112

May 30, 2012

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, PO 340
Belgrade, Minnesota 56312

RE: Project Number S5418022

Dear Mr. Lord:

On May 8, 2012, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 1, 2012. (42 CFR 488.417 (b))

This Department also notified you in our letter of May 8, 2012, 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 June 1, 2012.

This was based on the deficiencies cited by this Department for a standard survey completed on March 1, 2012, and lack of verification of substantial compliance with the health deficiencies at the time of the May 8, 2012 notice. The most serious health deficiencies in your facility at the time of the standard survey were found 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 May 16, 2012, 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 May 16, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 16, 2012. Based on our visit, we have determined that your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our PCR, completed on May 16, 2012, effective March 30, 2012. The deficiency not corrected is as follows:

F0226 -- S/S: C -- 483.13(c) -- Develop/implement Abuse/neglect, Etc Policies

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of May 8, 2012:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 1, 2012 be rescinded. (42 CFR 488.417 (b))

In our letter of May 8, 2012, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 1, 2012, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 30, 2012, 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.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility may be conducted to verify that substantial

compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 6872

May 8, 2012

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, PO Box 340
Belgrade, Minnesota 56312

RE: Project Number S5418022

Dear Mr. Lord:

On March 19, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2012. 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 April 20, 2012, 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 March 1, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 19, 2012. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on March 1, 2012.

However, compliance with the health deficiencies issued pursuant to the March 1, 2012 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found 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.

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 June 1, 2012. (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 June 1, 2012. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 1, 2012. 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, Belgrade Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 1, 2012. 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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the April 20, 2012 revisit is enclosed.

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: Oliver Potts, Chief
330 Independence Avenue, SE
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.

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 September 1, 2012 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

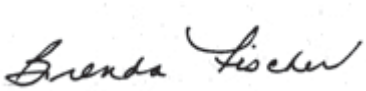
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	R 05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(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	{F 000}		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to develop an abuse prohibition policy which required a thorough investigation of any alleged abuse, neglect, injuries of unknown origin and immediate notification to the administrator and state agency, which had the potential to affect 49 who currently reside in the facility. Findings include: The facility's "Abuse Policy and Procedures" document dated as revised on 6/11, was reviewed on 5/16/12, and lacked investigation and identification components in the policy. The policy also contained inaccurate reporting information as well. Page 1 of the policy noted "Any suspected abuse of any resident, including injuries of unknown origin, must be reported to a Facility Contact [which included the administrator] as soon as it is practical once the suspected abuse or incident has been observed or identified." The language should have read it must be reported immediately	F 226	F226 – Plan of prevention and policies and procedures related to abuse, mistreatment, neglect, of residents, and the misappropriation of resident property. The former policy regarding the and Abuse and Neglect Prevention Plan was reviewed by the, Administrator, DON, MDS RN, and Social Services. The Administrator, with input from the DON, MDS RN, and Social Services, revised the plan creating the updated: BELGRADE NURSING HOME POLICIES AND PROCEDURES FOR THE IDENTIFICATION, INVESTIGATION, AND PREVENTION OF OCCURRENCE OF ABUSE, NEGLECT, INJURIES, AND THEFT OF PROPERTY OF RESIDENTS OF THE BELGRADE NURSING HOME Included in the update was inclusion and/or enhancement of the sections related to the definitions of Abuse, Neglect, Misappropriation of property / theft, Verbal Abuse, Sexual abuse, Physical abuse, Mental abuse, Corporal punishment, Involuntary seclusion, Short term separation or seclusion, and Injury of an unknown source.	

6/11/12 JK

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Philip Lord — TITLE: Administrator — (X6) DATE: 6.5.12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	R 05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(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 226	Continued From page 1 to the administrator and state agency. Page 3 of the policy noted that screening of applicants and employees was completed through reference checks, and lacked the identification of who would be contacted for that reference, such as a current or previous employer. The policy indicated the Nurse Aid Registry and Board of Nursing were consulted, but lacked the directive they would be contacted for verification purposes. The policy then noted "After hiring, a background study is done", rather than before hiring. Page 4 noted, " In the event of alleged improper care reported by a resident or on their behalf..." The language of "improper care" was obscure and could be misinterpreted to the reader of the policy instead of using the terminology of abuse. Page 5 of the policy noted " If there is a concern of family abuse, staff will make every effort to visually monitor the visitation or may ask the family not to visit", rather than staff "will" visually monitor the visitation. Page 5 indicated if an employee was involved in the incident, he/she would be informed of the allegation and suspended if the situation warrants, to prevent further potential abuse, while the investigation is in progress. The policy lacked directives to ensure the employee who allegedly was abusive, would not have any contact with the involved resident or others until the investigation was completed. Page 6 of the policy noted that training would be accomplished at orientation and the existing policy would be reviewed annually thereafter. The	F 226	Investigation and identification components were updated and the language of reporting immediately was added. The new employee applicant reference check procedure was updated and clarified as to who would be contacted for reference checks, and that those being contacted for reference checks were being contacted for employment verification purposes. The reference and background checks will be completed before an individual is hired. The policy was updated to direct that staff will visually monitor visitations between suspected abusive family members and residents. An employee who is alleged to have been abusive will be reassigned away from the involved resident, or from others, during the investigation of the alleged abuse, neglect, or theft of resident's property. Orientation, training, and annual review sections of the policy were updated as to content. The new updated policy will be reviewed at staff meetings and individual copies will be made available to employees. A master copy will be made available for all staff members in the first (A) red three-ring binder at the facility nurse's station.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	R 05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(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 226	Continued From page 2 policy lacked which training component would be included. The policy lacked any directives on how an investigation would be completed. It also lacked how to identify what needed to be reported and investigated. The policy lacked any directives on how an investigation would be completed. It also lacked how to identify what needed to be reported and investigated. When interviewed on 5/16/12 at 2:55 p.m., the facility social worker and administrator verified the language in the policy contained inaccurate information, was conflicting at times. They stated the policy was still being revised and they had not completed the revisions to date. When interviewed at 3:05 p.m., on 5/16/12 the director of nursing stated they follow proper procedure as identified in the federal regulation with proper reporting and investigation. She was not aware of any written procedure or directives to refer to for the investigative process for everyone. She stated it was something she knew how to do, and got it done. At 3:25 p.m., the director of nursing stated she contacted the staff person who was revising the policy, and learned the new policy information was on that person's flash drive (computer). The director of nursing and the administrator both verified the new policy information was not accessible to anyone at the time, and therefore would not be useful to serve as the facility's policy. Although review of the facilities investigations	F 226	Information related to the BELGRADE NURSING HOME POLICIES AND PROCEDURES FOR THE IDENTIFICATION, INVESTIGATION, AND PREVENTION OF OCCURRENCE OF ABUSE, NEGLECT, INJURIES, AND THEFT OF PROPERTY OF RESIDENTS OF THE BELGRADE NURSING HOME will be presented at the quarterly QA meeting by the DON to discuss findings and to report on the Audit findings. The Administrator and DON will monitor for compliance.	06/04/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	R 05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(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 226	Continued From page 3 identified they were reporting and investigating incidents in accordance with federal regulations, the written policy was not updated to contain accurate and complete information in order to provide correct directives for all staff.	F 226		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245418	A. Building B. Wing	5/16/2012

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/13/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/01/2012**	ID Prefix **F0373** Reg. # **483.35(h)** LSC	Correction Completed **03/05/2012**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/30/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/cbl	06/11/2012	21797	07/17/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/1/2012			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245418	A. Building B. Wing **01 - MAIN BUILDING 01**	4/20/2012

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0018	Correction Completed **04/16/2012**	ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **03/06/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/cbl	05/08/2012	27200	04/20/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/28/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HMVV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245418**
2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BELGRADE NURSING HOME**
(L4) **103 SCHOOL STREET, BOX 340**
(L5) **BELGRADE, MN** (L6) **56312**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/01/2012** (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 IMR	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 **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	49			
(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):

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :

Jessica Sellner, HFE NEII 04/10/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:

Colleen B. Leach, Program Specialist 04/13/2012 (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
Posted 4/16/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 7015

March 19, 2012

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, Box 340
Belgrade, Minnesota 56312

RE: Project Number S5418022

Dear Mr. Lord:

On March 1, 2012, 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:

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

<u>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;

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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

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 April 10, 2012, 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 April 10, 2012 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2012 (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 September 1, 2012 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

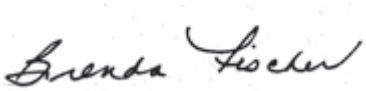
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

cc: Licensing and Certification File

APR 0 6 2012

Belgrade Nursing Home
P.O. Box 340
Belgrade MN 56312-0340

(320) 254-8215 Fax: (320) 254-8238 Located at: 103 School Street

ADDENDUM TO SURVEY OF 2012

F225 ar

F-226 – ADDED "IMMEDIATELY" TO REPORTING OF "ALLEGED" NEGLECT, ABUSE, MISTREATMENT OR MISAPPROPRIATION OF RESIDENT'S PROPERTY TO STATE AGENCY.

THE DON/AND OR DESIGNEE COMPLETING THE FOLLOW-UP AUDIT WILL PREVENT REOCCURRENCE THROUGH WEEKLY RANDOM INTERVIEWS OF STAFF, AND EDUCATION AT NURSE AND CNA MEETINGS.

THE DON AND/OR DESIGNEE WILL MONITOR FOR COMPLIANCE AT WEEKLY DEPARTMENT HEAD MEETINGS.

F-329- ADDED RN WILL DO A COMPREHENSIVE ASSESSMENT OF RESIDENTS MEDICATED WITH AN ANTIPSYCHOTIC THERAPY TO IDENTIFY, ASSESS, AND MONITOR CLINICAL INDICATIONS FOR THE USE OF ANTIPSYCHOTIC MEDICATION QUARTERLY AND WITH SIGNIFICANT CHANGE IN CONDITION.

DON AND/OR DESIGNEE WILL AUDIT QUARTER ASSESSMENTS OF RESIDENT'S RECEIVING ANTIPSYCHOTIC MEDICATIONS MONTHLY TO ENSURE THEY ARE IN COMPLIANCE.

F-373-ALL RESIDENTS FED BY A PAID FEEDING ASSISTANT WILL HAVE A COMPREHENSIVE FEEDING ASSESSMENT DONE QUARTERLY AND WITH SIGNIFICANT CHANGE TO ENSURE THEY ARE APPROPRIATE TO BE FED BY PAID FEEDING ASSISTANT.

THE DON AND/ OR DESIGNEE WILL MONITOR FOR COMPLIANCE THROUGH REVIEW AT EACH MONDAY MORNING MEETING.

A REVIEW OF RESIDENTS FED BY PAID FEEDING ASSISTANTS WILL PRESENTED AT QUARTERLY QA MEETINGS TO DISCUSS COMPLIANCE.

Marlene Groetsch RN DON 4/5/12

MARLENE GROETSCH RN/DON

4/10/12
AA

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, BOX 340 BELGRADE, MN 56312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	On March 13, 2012, a mandatory nurse meeting was held to review lack of immediately reporting of incident reports of allegations of abuse and/or neglect. Staff was instructed to report all alleged violations of mistreatment, neglect, or abuse of an unknown source, or misappropriation of resident's property, to the State Agency in a timely manner. All RNs/LPNs were instructed on the online reporting process to the State Agency. They were walked through the reporting process with a reporting instruction manual. Reoccurrence of not reporting all reportable incidents will be prevented by reviewing all new incident reports at the beginning of each shift. Records of all reviews will be presented at monthly staff meetings as well as at quarterly QA meetings. The DON will monitor for compliance.	03/13/12

4/10/12 Del addendum POC accepted BT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Philip Lord — TITLE: Administrator — (X6) DATE: 4·2·2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, BOX 340 BELGRADE, MN 56312

(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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure vulnerable adult investigations were reported to the State agency immediately for 5 of 20 residents (R24, R 26, R22, R7 and R 42) in the sample of vulnerable adult reports reviewed. Findings include: R24 had a diagnoses of Alzheimer's disease. The most recent significant change minimum data set (MDS), dated 01/24/2012, which indicated that R 24 was cognitively impaired. The MDS indicated R24 was independent with ambulation, but required extensive assistance with dressing, toileting and grooming and made poor choices in judgment. In review of an incident report sent to the State agency on 09/01/2011, R24 was found outside the facility on 08/23/2011 at 4:45 a.m., "waiting for the bus". The report indicated that the	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, BOX 340 BELGRADE, MN 56312

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F 225	Continued From page 2 administrator had been contacted, however, the report was submitted to the State Agency 10 days after the incident occurred. During interview at 1:00 p.m. on 03/01/2012, the Director of Nursing (DON) indicated that this report was missed and sent in to the State agency when it was noticed to have been forgotten. R26 had a abuse allegation that was not reported immediately to the state agency. R26 had diagnoses of osteoporosis and cerebral vascular accident (CVA). The annual MDS, dated 11/28/11, indicated she was alert and orientated. At 3:34 p.m. on 2/27/12 during interview with R26 she stated that about a month ago a staff member was rough with her and that she reported this to the director of nursing (DON). Review of R26's incident report submission to the state agency indicated that on 11/16 to11/17/11 sometime during the night a staff person came in to toilet her and jerked her when transferring. The report was submitted the following day on 11/18/11. The administrator was notified of the incident. Although the facility was aware of the incident that occurred during the night on 11/16/11 to 11/17/11 the facility did not notify the state agency until the following day. R22 had an abuse allegation that was not reported immediately to the state agency.	F 225		

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F 225	Continued From page 3 R22 had diagnosis of hypertension and anxiety. The admission MDS, dated 11/10/11, indicated she was alert and orientated. Review of R22's incident report submission to the state agency indicated that R22 stated " the people on nights are mean people. They are not nice people." the report indicated the incident occurred on 1/4/12. The report was not submitted until 1/6/12. The administrator was notified of the incident on 1/4/12. R7 had neglect of health care that was not reported immediately to the state agency. R7 had diagnoses of dementia and depression. The annual MDS, dated 1/5/12, indicated he had severely impaired cognitive deficits, and needs extensive assistance with transfers and toileting. Review of incident report submission to the state agency indicated that on 10/12/11 R7 "was placed on commode in his room for toileting at 8:20 p.m. He was discovered still sitting on the commode at 9:30 p.m. by nursing assistant. The incident was not reported to the state agency until the following day on 10/13/12. The investigative report submitted on 10/13/11 indicated "resident was placed on the commode for a bowel movement at 8:20pm. When checked on some time later, he told the aid he wanted to sit longer. The two aids on the north end became busy with a new admission and getting others ready for bed and admit they had forgotten resident on the commode until 9:30pm...." The administrator was informed of the incident on 10/12/11.	F 225		

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F 225	Continued From page 4 Although the facility was aware of the incident on 10/12/11 the facility did not notify the state agency until the following day. R42 had neglect of health care that was not reported immediately to the state agency. R42 had diagnoses of dementia and Schizophrenia. The quarterly MDS, dated 11/30/11, indicated that R42 was alert and orientated and independent with mobility and transfers. Review of incident report submission to the state agency indicated that on 11/9/11 "resident was on outing with activity department and other resident's to see a musical at the Melrose School. When it was time to leave following the program, staff observed this resident and another heading towards the exit. They were told to go to the buses and staff saw them going that way. Staff went to get two other residents and got them on the bus. ... The bus left in about 10-12 minutes the driver received a phone call from Belgrade nursing home that R42 was still at the school..." The incident was not reported to the state agency until 11/11/11. The administrator was notified on 11/9/11. Although the facility was aware of the incident on 11/9/11 the facility failed to report to the state agency immediately. At 12:28 p.m. on 3/1/11 interview with the DON stated the incidents were not reported to the state agency immediately and thought she had 24 hours to submit to the state agency.	F 225		

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F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a policy for the prevention of abuse and neglect, that indicated the State agency was to be contacted "immediately." This affected 5 of 20 residents (R 24, R26, R22, R7 and R 42) incident reports reviewed. Findings include: R24 had an neglect allegation that was not reported immediately to the state agency. R24 had a diagnoses of Alzheimer's disease. The most recent significant change minimum data set (MDS) dated 01/24/2012, which indicated that R 24 was cognitively impaired. The MDS indicated R24 was independent with ambulation, but required extensive assistance with dressing, toileting, and grooming and made poor choices in judgment. In review of an incident report sent to the State agency on 09/01/2011, R24 was found outside the facility on 08/23/2011 at 4:45 a.m., "waiting for the bus". The report indicated that the administrator had been immediately contacted, however, the report was submitted to the State Agency 10 days after the incident occurred.	F 226	The policy regarding the Abuse Prevention Plan was reviewed and updated by the DON and Social Services. All staff will be educated on policy by April 19, 2012. The Policy will include contacting the State Agency of neglect, abuse, mistreatment, and misappropriation of resident property. The DON and/or designee completing the followup audit will prevent reoccurrence through random interviews of staff to ensure that they understand the Vulnerable Adults policy. All information will be presented at the quarterly QA meeting by the DON to discuss findings and to report on the Audit findings. The DON will monitor for compliance.	04/19/12

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F 226	Continued From page 6 During interview at 1:00 p.m. on 03/01/2012, the Director of Nursing (DON) stated this report was missed and they sent in to the State agency when they noticed this had been forgotten. R26 had an abuse allegation that was not reported immediately to the state agency. At 3:34 p.m. on 2/27/12 during interview, R26 stated that about a month ago a staff member was rough with her and she reported this to the director of nursing (DON). Review of R26's incident report submission to the state agency indicated that on 11/16 to11/17/11 sometime during the night a staff person came in to toilet her and jerked her when transferring. The administrator was immediately notified of the incident but the report was not submitted to the state agency until the following day on 11/18/11. Although the facility was aware of the incident that occurred during the night on 11/16/11 to 11/17/11 the facility did not immediately notify the state agency until the following day. R22 had an abuse allegation that was not reported immediately to the state agency. Review of R22's incident report submission to the state agency indicated that R22 stated " the people on nights are mean people. They are not nice people." The administrator was immediately notified of the incident. The report indicated the incident occurred on 1/4/12 but was not submitted to the state agency until 1/6/12, 2 days after the incident.	F 226		

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F 226	Continued From page 7 R7 had neglect of health care that was not reported immediately to the state agency. Review of incident report submission to the state agency indicated that on 10/12/11 R7 "was placed on commode in his room for toileting at 8:20p.m. He was discovered still sitting on the commode at 9:30pm by nursing assistant. The incident was not reported to the state agency until the following day on 10/13/12. The investigative report submitted on 10/13/11 indicated "resident was placed on the commode for a bowel movement at 8:20pm. When checked on some time later, he told the aid he wanted to sit longer. The two aids on the north end became busy with a new admission and getting others ready for bed and admit they had forgotten resident on the commode until 9:30pm...:" The administrator was notified of the incident 10/12/11. Although the facility was aware of the incident on 10/12/11 the facility failed to notify the state agency until the following day. R42 had neglect of health care that was not reported immediately to the state agency. R42 had diagnoses of dementia and schizophrenia. The quarterly MDS dated 11/30/11 indicated that R42 was alert and orientated and independent with mobility and transfers. Review of incident report submission to the state agency indicated that on 11/9/11 "resident was on outing with activity department and other resident's to see a musical at the Melrose School.	F 226		

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F 226	Continued From page 8 When it was time to leave following the program, staff observed this resident and another heading towards the exit. They were told to go to the buss and staff saw them going that way. Staff went to get two other residents and got them on the bus. ... The bus left in about 10-12 minutes the driver received a phone call from Belgrade nursing home that R42 was still at the school..." The administrator was immediately notified of the incident on 11/9/11 but the incident was not reported to the state agency until 11-11-11, 2 days after the incident. Although the facility was aware of the incident on 11/9/11 the facility failed to report the incident to the state agency immediately. During an interview at 1:00 p.m. on 03/01/2012, the director of nursing (DON) stated she had found out from other facilities, back in December 2011, about the changes, and had an services in December 2011 and January 2012 with all facility staff. The DON provided a copy of the information (undated), entitled: "Employee Reporting for Reasonable Suspicion of a Crime," which was reviewed with the facility employees. The facility's abuse and neglect policy (not titled), dated "SR 6/11", the policy indicated under "Reporting" the following: "All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriations of resident property must be reported to Licensed Nurse/Administrator/Director of Nursing/Social Services and others in 24 hours in accordance with the state law." During an interview at 1:20 p.m. on 03/01/2012,	F 226		

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F 226	Continued From page 9 the Social Work Designee (SWD) stated that prior to last week, she was unaware that Federal language had changed, requiring the state agency be notified immediately of any allegations of abuse, neglect, injuries of unknown origin, and misappropriate of property. The SWD went on to state, she had just received a copy of another facility's abuse/neglect policy late last week, but had not made any changes to their current policy to reflect these changes and would be doing this.	F 226		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	On March 1, 2012 (R52) the Care plan and MAR was updated to identify behaviors and moods to monitor for use of antipsychotics. The Care Plan was updated to include non-pharmacological interventions for use of antipsychotic drugs. The DON and/or designee will monitor medication sheets at the end of the month to ensure that all residents administered antipsychotics medications will have identified mood and behaviors. All residents administered antipsychotics will be monitored by Social Services at Care Conference to ensure that non-pharmcacological interventions are in place in the Care Plan. The DON will monitor for compliance.	03/01/12

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F 329	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 1 of 10 residents (R52) in the sample who were reviewed for medication monitoring. Findings include: R52 received both Olanzapine and Risperidone (antipsychotics) since 1/2/12 , however the record lacked ongoing monitoring of his identified behaviors and did not identify non-pharmacological interventions. R52 had diagnoses which included antisocial personality and a brain injury. The admission Minimum Data Set Assessment (MDS) dated 1/12/12, noted the resident was severely impaired in cognition and did not exhibit hallucinations, delusions, or physical behavioral symptoms toward others. The MDS indicated the resident did demonstrate verbal behavioral symptoms. The Care Area Assessment Summary Statement dated 1/11/12 noted the resident had mostly inappropriate verbal behaviors, but lacked a specific description of what the specific verbal behavior consisted of. According to the physician's orders dated 3/12, the resident received Olanzapine 2.5 milligrams (mg) in the morning and 7.5 mg at bedtime every day and Risperidone 2 mg twice a day. The resident's plan of care plan printed 03/1/12, noted the resident had a mood/behavioral problem. The	F 329		

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F 329	Continued From page 11 care plan lacked specific mood and behaviors descriptions, nor was there any non-pharmacological approaches identified. The facility progress notes contained the following information regarding the resident's behaviors: 1/8/12 -refusing to wash up or change clothes, swearing at caregiver 1/12/12- refused hygiene cares 2/14/12- refused evening cares and skin inspection 2/16/12-demanding that staff do things he is capable of 2/16/12-swearing at another resident 2/21/12-refusing cares 2/23/12-refusing cares and changing clothes The facility's data collection sheets dated 1/31/12 through 3/1/12 indicated the nursing assistants monitored behaviors each shift of wandering, verbal and physical behavioral symptoms, and rejecting care. These sheets did not identify what specific verbal and physical symptoms were to be monitored for R52. The behaviors identified on the collection sheets were the same behaviors the facility monitored for all residents residing at the facility. During interview at 1:40 p.m. on 3/1/12 registered nurse (RN)-A stated R52 was admitted to the facility with these antipsychotics medications for encephalopathy and psychosis. RN-A stated they did not have specific monitoring for R52 behavior, and used the same sheets for all residents in the facility. RN-A verified R52 care plan also did not identify what behaviors he was exhibiting, or what	F 329		

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F 329	Continued From page 12 non pharmacological interventions were to be implemented to decrease these behaviors, "we missed him."	F 329		
F 373 SS=E	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as	F 373	On March 5, 2012 ,residents (R1, R19, R31, R4, R6, R24, and R2) had a comprehensive assessment to ensure that they could be fed by a paid feeding assistant. All residents fed by a paid feeding assistant will have a comprehensive feeding assessment done to ensure that they have no complex feeding problems. All residents identified with feeding difficulties, such as swallowing difficulties, will be not be fed by paid feeding assistants. The Production Dietary Manager/designee will monitor the list of residents that have a comprehensive feeding assessment and can not be fed paid feeding assistants. The DON and/or the Dietary Consultant will monitor for compliance.	03/05/12

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F 373	Continued From page 13 specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 7 of 7 residents, (R1, R19, R31, R4, R6, R24, and R27) who were identified by the facility as being appropriate to be fed by a paid feeding assistant (PFA)had a comprehensive assessment to ensure they could be safely fed by a PFA. Findings include: R1 was identified by the facility as a resident to be fed by a PFA even though she had not been	F 373		

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F 373	Continued From page 14 assessed to be fed by a PFA. R1 had diagnosis of dementia. The annual Minimum Data Set (MDS) dated 12/2/11, indicated R1 was totally dependent on staff with eating, the MDS also indicated R1 had no swallowing problems and needed a mechanically altered diet. At 5:37p.m. on 2/27/12 R1 was observed to be fed by nursing assistant (NA)-A and R1 exhibited no swallowing or eating difficulties. Review of the medical record, did not identify an assessment had been completed to determine if R1 could be fed by a PFA. The current plan of care dated 12/08/11, indicated R1 needed total assist of one staff for meals, snacks, and fluids. An unlicensed staff who passed the feeding program could assist with feeding. Although R1 was identified as needing assistance to eat by a PFA, there was no comprehensive assessment completed to ensure R1 could be fed safely by a PFA. R19 was identified by the facility as a resident to be fed by a PFA even though she had not been assessed to be fed by a PFA. R19 had diagnoses of Alzheimer disease and dementia. The quarterly MDS dated 1/31/12, indicated she needed extensive assistance of one with feeding and received a mechanically altered diet. At 5:30 p.m. on 2/27/12 R19 was observed to be fed by licensed practical nurse (LPN)-A and	F 373		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, BOX 340 BELGRADE, MN 56312

(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 373	Continued From page 15 exhibited no difficulties with eating or swallowing. Review of the medical record, did not identify an assessment had been completed to determine if R19 could be fed by a PFA. The current plan of care dated 5/4/11, indicated to feed R19 alternating food and fluids and alternating food groups, allow time to chew and swallow and that R19 received a diabetic diet with ground meat. The care plan also indicated unlicensed nursing staff who passed the feeding program may feed R19. Although R19 was identified as needing assistance to eat by a PFA, there was no comprehensive assessment completed to ensure R19 could be fed safely by a PFA. R31 was identified by the facility as a resident to be fed by a PFA even though she had not been assessed to be fed by a paid feeding assistant. R31 had diagnosis of dementia. The annual MDS dated 12/9/11, indicated she needed set up assistance with feeding and received a therapeutic diet. At 5:37p.m. on 2/27/12 R31 was observed to be fed by nursing assistant (NA)-A and R31 exhibited no swallowing or eating difficulties. Review of the medical record, did not identify an assessment had been completed to determine if R31could be fed by a PFA. The current plan of care dated 2/22/12, indicated she received a mechanically altered diet and needed total assistance with feeding. Although R31 was identified as needing	F 373		

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	245418	A. BUILDING _____ B. WING _____	03/01/2012

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BELGRADE NURSING HOME	103 SCHOOL STREET, BOX 340 BELGRADE, MN 56312

(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 373	Continued From page 16 assistance to eat by a PFA, there was no comprehensive assessment completed to ensure R31 could be fed safely by a PFA. R4 did not have a comprehensive assessment completed to ensure she could be safely fed by a PFA. R4 had diagnoses including Parkinson and dementia. The annual Minimum Data Set (MDS) dated 12/16/11, identified R4 with severe cognitive impairment, needed total assist with eating, and had no swallowing problems in the prior 7 days prior to competing the MDS. The current plan of care dated 2/20/12 identified R4 was on a pureed diet with regular liquids and could be fed by unlicensed staff who had completed the feeding program. There was no assessment in the record that indicated R4 could be safely fed by a PFA. At 7:30 a.m. on 2/29/12 PFA-N was observed feeding R4 breakfast. R4 was sleeping in her wheelchair and PFA-N tried several times to wake her up by putting spoonfuls of pureed toast and a cup of juice up to her mouth. At 8:15 a.m. PFA-N stopped trying to assist R4 as she was unable to get her to wake up. Although R4 was assisted with eating by a PFA, there was no comprehensive assessment completed to ensure R4 could be fed safely by a PFA. R6 did not have a comprehensive assessment completed to ensure he could be safely fed by a PFA.	F 373		

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F 373	Continued From page 17 R6 had diagnoses including dementia and mild retardation. The quarterly MDS dated 1/19/12, identified R6 with severe cognitive impairment, needed extensive assist with eating, and had no swallowing problems in the prior 7 days to completing the MDS. At 8:05 a.m. on 2/19/12 PFA-O was observed feeding R6 breakfast without any problems eating. R6's current plan of care dated 10/21/11, identified R6 was on a pureed diet as tolerated and could be fed by unlicensed staff who had completed the feeding program. There was no assessment in the record that indicated R6 could be safely fed by a PFA. Although R6 was assisted with eating by a PFA, there was no comprehensive assessment completed to ensure R6 could be fed safely by a PFA. R27 did not have a comprehensive assessment completed to ensure she could be safely fed by a PFA. R27 had diagnoses including dementia and Alzheimer's disease. The annual MDS dated 1/18/12, identified R27 with severe cognitive impairment , needed extensive assist with eating, and had no swallowing problems in the prior 7 days to completing the MDS. R27's current plan of care dated 1/25/12 identified R27 was on a pureed diet and could be fed by unlicensed staff who had completed the	F 373		

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F 373	Continued From page 18 feeding program. There was no assessment in the record that indicated R27 could be safely fed by a PFA. At 8:05 a.m. on 2/19/12 PFA-O was observed feeding R27 breakfast. During the observation R27 had no problems eating. Although R27 was assisted with eating by a PFA, there was no comprehensive assessment completed to ensure she could be fed safely by a PFA. R24 did not have a comprehensive assessment completed to ensure that she could be safely fed by a PFA. R24 had diagnoses including Alzheimer disease and failure to thrive. The significant change MDS dated 1/24/12, identified the resident with severe cognitive impairment, needed extensive assist with eating, and had no swallowing problems in the prior 7 days to completing the MDS. R24's current plan of care dated 2/1/12 identified R24 was on a pureed diet PRN (as needed) and could be fed by unlicensed staff who had completed the feeding program. There was no assessment in the record that indicated R24 could be safely fed by a PFA. At 8:15 a.m. on 2/29/12 PFA-N was observed feeding R24 breakfast. During observation R24 had no problems eating. Although R24 was assisted with eating by a PFA, there was no comprehensive assessment completed to ensure R24 could be fed safely by a	F 373		

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F 373	Continued From page 19 PFA. During interview at 7:05 a.m. on 2/29/12 with PFA-O she stated that she assisted with feeding the residents almost every morning and noon meal that she worked. She stated that she usually feeds R6 and R27 and neither of them have ever had any swallowing problems. She stated that she was able to feed anyone in the facility but if she couldn't the nurses would let her know. During interview at 7:50 a.m. on 2/29/12 with PFA-N she stated that she assisted only with feeding and worked full time (72 hours every 2 weeks). She stated that she could feed anyone in the facility but usually feeds R4, R31, R19, R1, and R24. She stated that none of them have had any swallowing problems when she had been assisting them. During an interview at 5:15 p.m. on 2/29/12, the Director of Nursing (DON) identified the facility had several trained PFA's which could feed anyone in the facility. She stated no residents in the facility had any current complicated feeding or swallowing problems. The DON stated the facility does not have a written assessment of who was safe to be fed, but rather completes an assessment by "exception" if a resident is having actual swallowing problems. The facility policy "Feeding assistants" dated 8/2010 indicated, "The facility must ensure that a feeding assistant feeds only those residents who have no complicated eating problems...The center must base resident selection on the residents latest assessment and plan of care and	F 373		

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F 373	Continued From page 20 the registered nurses assessment of the residents current condition." No further information was provided.	F 373		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	To correct surveillance and investigation of infections, a monthly record of infections will be maintained. A monthly tracking form has been put into place to identify the type of organism that was found, the antibiotics used, and any trends that may be noticed. The Infection Control nurse will report all trends to the DON. An action plan was implemented by the DON. The DON will present Infection Reports at the quarterly QA meeting. The DON will monitor for compliance.	03/30/12

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F 441	Continued From page 21 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program to include surveillance and investigation of infections that occur in the facility, track employee infections, maintain accurate and comprehensive records of infections, or perform antibiotic review to monitor the appropriate use of antibiotics. This had the potential to affect all 46 residents in the facility. Findings include: During review of the facilities infection control program at 12:40 p.m. on 3/1/12 with registered nurse (RN)-A, who was identified as the infection preventionist nurse, components of a comprehensive infection control program were noted to be missing. RN-A stated she had just taken over this duty about 5 months ago. She had attempted to track employee infections to contrast with resident infections when the facility had an outbreak of respiratory illness in January 2012, but there was no program for ongoing tracking of employee infections. RN-A stated this is difficult to do as staff are reluctant to state the reason for their illness. The facility did not analyze antibiotic use to determine appropriate use and did not calculate illness rates for contrast and identifying trends. Further, RN-A indicated there was no tracking of infections that had not	F 441		

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F 441	Continued From page 22 been treated with an antibiotic. During review of the facilities resident infection control logs the following was not addressed: February 2012: The "infection control-reporting form" did identify 12 resident infections including 9 respiratory infections, 1 urinary tract infection (UTI), and 2 wound/skin infections. However, the facility did not identify where the resident was located in the facility, symptom tracking was missing for 8 of the infections, location for one skin infection was not identified, the UTI did not identify a causative organism, and there was no way to determine if the treatment provided was effective for these infections. The facility had not identified if the infections were acquired in house or from the community. Further, the facility did not have any documentation that they had analyzed this data or identified any trends even though there were 9 respiratory illnesses identified in February and 18 in January. January 2012: The "infection control-reporting form" identified 17 infections including 11 respiratory, and 4 UTI's. No causative organism was identified for any of the UTI's. No symptoms were identified for the UTI's or respiratory infections. In addition, the facility had a separate log to track 7 additional respiratory infections and 1 gastrointestinal illness. This separate log identified 2 of the residents identified on the "infection control-reporting form" having a total of 18 respiratory illnesses. The separate log did identify symptoms of infection and which hallway the resident resided on. There was no way to determine on either form/log what room the ill resident resided in, if their treatment was	F 441		

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F 441	Continued From page 23 effective. RN-A stated she had analyzed the data and had some cultures done for some of the residents affected by the respiratory illness with one returning as influenza. She was unable to provide documentation of analysis or if residents had been isolated or related to any employee infections. The facility had not identified if the infections were acquired in house or from the community. Further, the respiratory illness had carried over into February with 9 ill residents, but no further trending was completed. December 2011: The "infection control-reporting form" identified 4 respiratory infection, 1 ear infection, 2 wound/skin and 2 UTI's. The logs did not identify location of the resident in the facility, any causative organism for the UTI's, if the treatment was effective, symptoms of infection for 6 of the infections and there was no documentation the data had been analyzed for trends. The facility had not identified if the infections were acquired in house or from the community. November 2011: The "infection control-reporting form" identified 2 respiratory, 2 skin/wound, and 2 UTI's. The residents location in the facility was not identified, causative organism was not identified for the UTI's, symptoms of infection were not identified for 5 of the 6 infections and there was no way to determine if the treatment provided was effective for these residents. The facility had not identified if the infections were acquired in house or from the community. Further, there was no documentation the facility had analyzed this data for trends. October 2011: The "infection control-reporting	F 441		

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F 441	Continued From page 24 form" identified 3 UTI's, 4 respiratory and 1 wound/skin infection. The logs did not identify where the residents were located in the facility, any symptoms for 2 of the UTI's, the causative organisms had not been identified and there was no indication if the treatment was effective for these residents. The facility had not identified if the infections were acquired in house or from the community. Further, there was no documentation the infections had been analyzed for trends. September 2011: The "infection control-reporting form" identified 3 UTI's, 2 respiratory and 4 skin infections. Another resident was listed as having an infection and on an antibiotic, but there was no way to determine what type of infection he had. The facility did not identify where each resident was located in the facility, did not identify symptoms for 4 of the infections, did not list causative organism for any of the infections and failed to identify if the treatment was effective for these residents. The facility had not identified if the infections were acquired in house or from the community. Further, there was no documentation the facility was analyzing the data to determine trends. The facility provided infection control meeting minutes dated 10/5/11 and 12/6/11. The meeting minutes failed to include any information the facility had analyzed the data it had collected to determine trends, effective practices or performance issues. During interview with the facilities director of nursing (DON) at 2:45 p.m. on 3/1/12, she stated the facility does bring information to their quality	F 441		

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F 441	Continued From page 25 assurance meetings to include trending and facilities action to this analysis but she was unable to provide documentation. An undated facility policy entitled Infection control policy and procedure included under "An effective infection control program..." included "Prepare lists of persons who are ill and try to identify recent human and environmental contacts of each resident to facilitate an infection management plans." Under "elements of the program" included "surveillance based on systematic data collection to identify infections in residents. A system for detection, investigation and control of outbreaks of infections diseases...A system for antibiotic review and control."	F 441		

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

F5418020

PRINTED: 03/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, BOX 340 BELGRADE, MN 56312

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Belgrade Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	RECEIVED APR 4 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok PB 4-9-12	

DC: 04.10.2012

EXIT: 03.01.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Philip Lord — TITLE: Administrator — (X6) DATE: 4.2.2012

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 Pat.Sheehan@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. Belgrade Nursing Home is a 1-story building with no basement. The building was constructed at 5 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1968, an addition was added to the north that was determined to be of Type II(111)construction. In 1981 an addition was added to the north of the East Wing that was determined to be of Type II(111) construction. In 1987 an addition was added to the south and east of the original building that was determined to be of Type V(111). In 1988 the Dining Room and Kitchen were added on to that was determined to be of Type V(111) construction. Because of the lack of 2 - hour fire resistive construction between the Type II(111) original building and the 1987 & 1988 additions the building construction type is downgraded to Type V(111) and the facility was surveyed as one building. The building is protected by a complete fire	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, BOX 340 BELGRADE, MN 56312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 018	The door impediments were removed. The Plant Operations Manager will monitor for continued compliance.	02/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

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K 018	Continued From page 3 had a corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.6. This deficient practice could affect the safety of all residents, staff and visitors, if smoke were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 12:00 PM and 3:00 PM on 02/28/12, it was observed that the facility was using polyester bath/shower curtains in place of the required doors in the corridors. The curtains were located in the north and south wings of the facility at the soiled utility room/tub room alcoves leading into the corridor. The curtains were used for separating the tube room in the north wing from the alcove leading to the corridor. The curtains were also used in both the north and south wings to separate the alcoves from the corridors. The required corridor doors are to be 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. This was confirmed by the Plant Operations Manager (DW).	K 018	The privacy curtains are being replaced with flame retardant curtains. A replacement door will be installed with a 20 minute fire resistance door. The Plant Operations Manager will monitor for continued compliance.	04/04/12 04/16/12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	A door closer was attached to the Service Room door. The Plant Operations Manager will monitor for continued compliance.	03/06/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

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K 029	Continued From page 4 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 12:00 PM and 3:00 PM on 02/28/12, observation revealed, that the Housekeeping storage room labeled "Service Room 8" had a door the led to the corridor is not equipped with a door closer ensuring that the door will positively close and latch within the door frame. This was confirmed by the Plant Operations Manager (DW).	K 029		