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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: J56F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**
2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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 **07/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **99** (L18)
13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(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):
A Health Comparative Federal Monitoring Survey was conduction by the Centers for Medicare and Medicaid Services (CMS) on 8/24/18 following a Minnesota Department of Health Survey on 7/12/18.

17. SURVEYOR SIGNATURE Date :
Lisa Ciesinski, HFE NE II 08/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 10/05/2018 (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
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 25, 2018

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, MN 55336

RE: Project Number S5263027

Dear Mr. Braband:

On July 12, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
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 August 21, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 21, 2018 the following remedy will be imposed:

- Civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 12, 2018 (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 January 12, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(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
E 000	Initial Comments A post certification survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 7/9/18 to 7/12/18 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		8/21/18

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

Electronically Signed | 08/02/2018

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E 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and	E 037		

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E 037	Continued From page 2 volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement,	E 037		

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E 037	Continued From page 3 and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide required training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This had the potential to affect 90 residents residing in the facility. Findings include: During document review of the Facility Emergency Action Plan Manual on 7/12/18, at 3:05 p.m., the manual contained a Hazard and Vulnerability Assessment Tool. This tool contained a listing of events that may occur,	E 037	GRHS Long Term Care has developed an Emergency Preparedness online learning module. This module contains information regarding an overview of the Incident Command System, staff responsibilities, communications, and emergency power systems. The training will be implemented immediately with an expected completion date of August 21st. Information regarding Emergency Preparedness will also be reviewed at the Mandatory Survey Plan of Correction Staff Meetings on 8/15/18 and 8/16/18. Going forward the training will be completed within the first 2 weeks of the first working day as well as annually. All staff working in Long Term Care will be expected to	

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E 037	Continued From page 4 probability of occurring, severity of impact and risk/relative threat. The manual also contained a Summary of Medical Center Hazards Analysis, a table of contents that included emergency call lists, a section on emergency management and a listing of various emergencies followed by specific emergency procedures the facility may encounter. However, the emergency plan lacked documentation of education and instruction provided to staff, contractors and facility volunteers to ensure all individuals are aware of the emergency preparedness program and failed to include the following required training documentation: -Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. -Emergency preparedness training at least annually. -Maintained documentation of emergency preparedness training. -Documentation that demonstrated staff knowledge of emergency procedures. During interview on 7/12/18, at 3:05 p.m. the administrator stated that they did a community wide drill in spring 2018, receiving trauma victims on the hospital side. In addition, the administrator stated they conducted an active shooter drill last fall of 2017 and a table top for active violence 8/1/17. The administrator went on to say they do drills for fire, flood. The administrator stated she felt staff know about the emergency preparedness and how the the command center works, but was not able to provide any documentation of staff's knowledge.	E 037	complete this education - Nursing, Administration, Maintenance, Nutrition Services, Housekeeping, Activities, Social Services, and Laundry. An information sheet regarding GRHS Long Term Care Emergency Preparedness plans will also be shared with volunteers as well as Long Term Care contracted services. The Education Coordinator or designee will monitor training completion through our LMS (Learning Management System) by running weekly reports every Monday and notifying supervisors of staff who still have this education to complete. We will assess if training has been sustained through annual online education review with a post-test requirement as well as annual drills involving our emergency preparedness plan. Results of these reports will be brought to the QAPI steering committee for 3 months for review. Continued monitoring of these reports will be determined by the QAPI steering committee.	

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F 000	Continued From page 5	F 000		
F 000	INITIAL COMMENTS On 7/9/18 to 7/12/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Glencoe Regional Health Services was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site visit 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure grooming needs for facial hair removal was provided for 1 of 3 residents (R288) who was dependent upon staff assistance with activities of daily living.	F 677	A Quality of Care LTC Policy & Procedure was found and updated. The purpose of this policy & procedure is to allow each resident to receive nursing care or personal and custodial care and supervision based on their individual	8/21/18

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F 677	Continued From page 6 Findings include: R288's diagnosis list, dated 7/12/18, indicated R288's diagnoses included fracture of second cervical vertebra, dysphasia, hypertension, major depressive disorder, ventricular tachycardia and stenosis for bilateral coratid arteries. R288's 48 hour care plan, dated 6/29/18, indicated R288 required assist with all activities of daily living, including grooming. R288's care area assessment work sheet (CAA) dated 7/12/18, indicated physical limitations with weakness, limited range of motion, poor coordination, poor balance, visual impairment and pain, and indicated R288 required extensive assist with personal hygiene. During interview on 7/10/18, at 8:30 a.m. R288 stated that staff do not know how to shave him so he does not ask them to shave him any more. R288 said he used to shave daily, and did not previously have facial hair. R288 had a halo brace that is screwed into his skull and a chest brace on 24 hours daily related to his diagnosis of fracture of second cervical vertebra. During observation on 7/11/18, at 7:23 a.m. nursing assistant (NA-C) assisted R288 to get off of the toilet, back into wheel chair, and made R288's bed. When NA-C was questioned about other cares to provide for R288, specifically long whiskers/beard, NA-C stated R288 did not ask for cares with his face. NA-C also stated she would check with him later and said staff do have the means to shave him and pointed to razor on his night stand.	F 677	needs. Grooming which includes facial hair removal, is included in this policy. This updated policy was shared with all staff on 8/2/18. The DON will conduct mandatory in-services on this Quality of Care Policy & Procedure with all clinical staff on 8/15/18 and 8/16/18. In-services will include but are not limited to: review of this policy & procedure and resident grooming to include facial hair removal. The affected resident'□s shaving needs were met by obtaining from the family an electric shaver and beard trimmer to not only assist the accessible area of his face for shaving but also to assist in reaching the difficult areas of the side of his face and neck which were limited because of his halo and brace. The shaving devices were obtained on 7/13/18 and have been being utilized daily per the resident'□s requests. Also, an appointment was set up for the resident to see a barber on 7/19/18 in the beauty shop. Resident will continue to be offered an appointment with the barber every time the barber is at the beauty shop. The DON or designee will monitor the implementation of this training by performing random grooming-facial hair removal audits that will include the affected resident weekly x4 weeks, then monthly for 2 months to ensure residents are having their facial hair removal needs met by assuring staff are offering this area of grooming to the resident. Results of this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(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 677	Continued From page 7 During interview on 7/11/18, at 9:12 a.m. NA-D was in R288's room, she stated he washed his own face and she helped wash his back folds, gave him perineal cares, and combed his hair. NA-D stated R288 tried to shave his face, and another nursing aide tried to assist him yesterday, but R288 did not want whiskers falling into chest area because it would itch with the wool from the brace. During observation on 7/11/18, at 1:30 p.m. R288 was in wheelchair in his room and said that he shaved a little around his mouth but batteries are weak, shaver pulls his whiskers and it hurts him. R288 stated his grand children are coming in evening and they can help him. During interview on 7/12/18, at 9:58 a.m. occupational therapy assistant (OTA)-A stated she helped R288 with his shaving on the sides of his face, but she could not get in there as R288 could not tip his head back. OTA-A stated she suggested having the barber shave him as he has a straight edge razor to get in there better. During interview on 7/12/18, at 11:14 a.m. bookkeeper (BKA)-A stated R288 is not on the schedule for the barber to visit him. BKA stated staff can put residents on the list or the residents can put themselves on the list. Barber comes on the first Monday of the month. During interview on 7/12/18, at 2:09 p.m. NA-E stated I have not tried anything to help R288 with shaving, he told me he was growing his beard. I would have to get the barber to shave him now because it is to long and would not want to pull on his hairs and hurt him. Stated the barber comes	F 677	audit will be brought to the QAPI steering committee for 3 months for review. Continued frequency of audits will be determined by the QAPI steering committee.	

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	245263	A. BUILDING _____ B. WING _____	07/12/2018

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GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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F 677	Continued From page 8 on first Monday of the month, in the mean time we will just have to keep the beard clean. Stated someone could talk to the bookkeeper to set appointment up for R288. During interview on 7/12/18 at 2:34 p.m. Registered nurse (RN)-A indicated she was not informed the staff were unable to give R288 a good shave. Stated she would expect a family member to bring in a razor with in 7 days of admission. After that she would expect trouble shooting from the staff including nursing aides, LPN's and RN's in order to get the resident shaved. RN-A stated I would not expect a resident to have a long beard if that is not what they wanted, and stated the resident should be shaved. Some suggestions RN-A had was to let nurse practitioner know of the situation and they could contact physician and see what can be done to get resident shaved or check with therapy department and see what suggestions they would have. RN-A stated the resident should be shaved in a reasonable amount of time and a plan should be in place with in a few days even if the physician was apprised of the situation. A facility policy on personal hygiene/grooming was requested and not provided	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		8/21/18

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	245263	A. BUILDING _____ B. WING _____	07/12/2018

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F 688	Continued From page 9 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to follow through on a therapy recommended walking program for 1 of 3 residents (R72) reviewed for activities of daily living. Findings include: R72's quarterly Minimum Data Set (MDS) dated 6/5/18, indicated cognition status to be good. Diagnosis of chronic pain unspecified, muscle weakness, abnormalities of gait and mobility, and wheelchair dependence. R72's facility Rehabilitation Orders, dated 10/9/17, indicate resident should walk 65 feet with a forward wheeled walker, five times week, for restorative nursing program. R72's Physician Orders, dated 6/26/18, indicated R72 had a pressure ulcer to left lateral foot that was now healed. During interview on 7/9/18, at 2:24 p.m. R72 stated she used to walk one time a day prior to her bunion on left foot. R72 went on to state she	F 688	The facility Rehabilitation/Restorative Nursing Services Policy & Procedure was reviewed and no changes are indicated at this time. A new form titled Maintenance Program will be implemented for all clinical nursing staff to use and track the restorative/maintenance programs, including walking, recommended by Therapy for our residents. The new form will be implemented on 8/6/18. This form will allow clinical staff to see all residents who are on a maintenance/restorative program for their wing while noting who still needs to complete their maintenance/restorative program for the day and/or week or who has refused. When a resident has 3 or more documented refusals in one week, a referral to therapy will be implemented. In PCC, a separate progress note heading will be created titled "Restorative Program" to allow nursing staff to document the reason for a resident refusal. This will allow for easier tracking of refusals and the reasons why.	

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F 688	Continued From page 10 is not walking much anymore and would like to walk, just does not want bunion to come back. During interview on 7/12/18, at 8:55 a.m. licensed practical nurse (LPN)-B stated she was not sure if R72 was walking with her restorative nursing program and asked nursing assistant (NA)-D if R72 has been walking. NA-D stated that R72 has not been walking lately and has been refusing and coming up with many excuses not to walk, including wanting to wait until later to ambulate. During interview on 7/12/18, 9:09 a.m. trained medication administrator (TMA)-A stated R72 just got her walking program of 65 feet and five times a week granted back to her as she had an ulcer on her foot earlier in month. TMA-A stated R72 is making excuses not to walk, saying her feet are not working. R72's current plan of care, last dated 6/11/18, had a goal to maintain R72's current level of mobility by ambulating 65 feet, five times a week, using forward wheeled walker and assistance of one staff as restorative nursing program indicates. During interview on 7/12/18, at 10:54 a.m. rehabilitation coordinator (RC) stated it has been awhile since she has seen R72 however, said R72 should be walking 65 feet five times a week. RC stated R72 should be walking to meals, as she has particular routines and goes to a lot of activities. RC stated her participation in nursing rehabilitation often varies due to pain issues like shingles, and a bunion that affect R72's movements. RC stated she should receive a referral screen to evaluate R72 if she is not following her walking program for a week or repetitive amount of time. RC went on to state	F 688	The DON will conduct mandatory in-services on restorative/maintenance nursing for all clinical staff on 8/15/18 and 8/16/18. In-services will include but are not limited to: review of the Rehabilitation/Restorative Nursing Services Policy &Procedure as well as review of the new Maintenance Program form. The DON or designee will monitor the implementation of training by performing random restorative/maintenance walking program audits weekly x4 weeks, then monthly for 2 months to ensure residents on restorative/maintenance walking programs are being walked according to their Therapy recommended walking programs. The DON or designee will also conduct random audits to ensure that residents who have refused 3 or more times within a week have documentation in PCC stating why they have refused and to ensure that a referral to Therapy has been completed. Results of these audits will be brought to the QAPI steering committee for 3 months for review. Continued frequency of audits will be determined by the QAPI steering committee.	

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	245263	A. BUILDING _____ B. WING _____	07/12/2018

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F 688	Continued From page 11	F 688		

that the team looks at restorative nursing programs quarterly and there should be a progress note if program is not being followed. RC stated she is noting a referral screen was made out however, on a wrong referral form. RC stated the occupational therapy assistant (OTA)-A may be hanging onto the referral because R72 was already on their case load. RC stated she was unaware that R72 was not walking and it should have been communicated to her. RC further stated, it looks like R72 has only walked 6 times in the last thirty days.

Documentation dated 4/12/18 through 5/11/18, regarding R72's nursing restorative walking program indicated staff walked her 5 times, refused to walk 12 times and was not asked to walk 49 times during this period of time. These dates include the day and evening shift.

Documentation dated 5/12/18 through 6/11/18, regarding R72's nursing restorative walking program indicated staff walked her 10 times, refused to walk 0 times and was not asked to walk 48 times during this period of time. These dates include the day and evening shift.

Documentation dated 6/12/18 through 7/11/18, regarding R72's nursing restorative walking program indicates staff walked her 1 times, refused to walk 10 times and was not asked to walk 49 times during this period of time. These dates include the day and evening shift.

A facility policy titled, Rehabilitation/Restorative Nursing Services identified it was the facilities policy to provide rehabilitative/restorative supportive care as needed for residents.

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	245263	A. BUILDING _____ B. WING _____	07/12/2018

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F 880	Continued From page 12	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		8/21/18

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	245263	A. BUILDING _____ B. WING _____	07/12/2018

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F 880	Continued From page 13 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to develop a system of surveillance to include day to day tracking of signs and symptoms of infections not requiring antibiotics. This had the potential to affect all 90 residents at the facility, staff and visitors in the facility. In addition, the facility failed to ensure proper hand hygiene and glove usage was implemented for 1 of 2 residents (R16) reviewed	F 880	The facility Infection Prevention and Control Policy & Procedure was reviewed, and no changes are indicated at this time. The charge nurse report sheet has been revised and is now called 24-Hour Report/Change in Condition Report. The new form was implemented on 8/1/18 and is being used to better identify signs/symptoms and/or illness that do not	

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	245263	A. BUILDING _____ B. WING _____	07/12/2018

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F 880	Continued From page 14 for urinary catheters. Findings include: The facility infection control data from January 2018 through July 2018, identified the following information: The facility infection control antimicrobial data forms dated January 2018 through July 11 2018, indicated an area to document the resident name, room number, onset date, symptoms, diagnosis, catheter, Loeb criteria,(minimum criteria for initiating antibiotic therapy) community acquired, hospital acquired, x-ray, culture, lab results, prescribing clinician, antibiotic name, dose, duration, antibiotic review date, transmission (isolation) based precautions, comments/notes. However, the data form did not include an area to track illness or symptoms of infection that did not require antibiotic treatment. Review of January 2018 antimicrobial tracking log, summarized all antibiotics prescribed during the month of January. A total number of 20 antibiotic courses in 13 residents were reviewed that month which included a variety of illnesses including respiratory, soft tissue, gastrointestinal and urinary track infections. Review of February 2018 antimicrobial tracking log, summarized all antibiotics prescribed during the month of February. A total number of 21 antibiotic courses in 16 residents were reviewed for that month. The illnesses identified were mainly respiratory infections, urinary track infections, skin and sensory illnesses. Review of March 2018 antimicrobial tracking log,	F 880	require antibiotics. Also, the antibiotic tracking form has been modified to include all illness or signs/symptoms of infection that do not necessarily require antibiotic therapy. Infection Control Lead and/or DON will conduct mandatory in-services on infection prevention and control for all clinical staff on 8/15/18 and 8/16/18. In-services will include but are not limited to: review of Infection Prevention & Control Policy &Procedure, glove use and the need for hand hygiene, and review of the new 24-Hour Report/Change in Condition Report. The Infection Control Lead or designee will monitor the implementation of training by performing random care audits weekly x4 weeks, then monthly for 2 months to ensure proper glove use and hand hygiene is being performed. The Infection Control Lead or designee will also conduct random audits by reviewing the new 24-Hour Report/Change in Condition Report to ensure clinical staff are documenting the required fields appropriately weekly x4 weeks, then monthly for 2 months. Results of these audits will be brought to the QAPI steering committee for 3 months for review. Continued frequency of audits will be determined by the QAPI steering committee.	

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F 880	Continued From page 15	F 880		

summarized all antibiotics prescribed during the month of March. A total number of 27 antibiotic courses in 18 residents were reviewed for that month. The illnesses identified were respiratory, sensory, urinary track infections, gastrointestinal, and soft tissue illnesses.

Review of April 2018 antimicrobial tracking log, summarized all antibiotics prescribed during the month of April. A total number of 32 antibiotic courses in 18 residents were reviewed for that month of April. The illnesses identified were respiratory, gastrointestinal, soft tissue and urinary track infections.

Review of May 2018 antimicrobial tracking log, summarized all antibiotics prescribed during the month of April. A total number of 20 antibiotic courses in 14 residents were reviewed for that month. The illnesses included respiratory, ,gastrointestinal, soft tissue and urinary track infections.

Review of June 2018 antimicrobial tracking log, summarized all antibiotics prescribed during the month of June. A total number of 6 antibiotic courses in 6 residents were reviewed that month.

Review of July 1st. 2018, through July 11th. 2018, antimicrobial tracking log, summarized 3 antibiotics courses in 3 residents were prescribed for skin and respiratory illnesses.

Although the facility had line by line antimicrobial infection control logs identified all required areas for infections with antibiotics, the facility failed to identify infections that did not require antibiotics.

During an interview on 7/11/18, at 10:31 a.m. the

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F 880	Continued From page 16	F 880		

director of nursing (DON), the safety manager (SM), and the infection control lead (ICL), all stated they have morning report for front line staff, and they discuss as a group any concerns with residents developing symptoms or illness that do not require antibiotics. DON, SM, and ICL stated the charge nurse passes off the information to their team and then information is passed off shift to shift. The DON stated they keep non-antibiotic illnesses on their radar and have a daily charge nurse report sheet. The DON, SM and ICL stated they do not have a comprehensive infection control program which includes data analysis of resident infections that do not require antibiotics, and/or trending to reduce the spread of infections to other residents.

An undated policy titled Infection Prevention and Control Program documents the facility will have an Infection Prevention Control Program that will determine its direction using the guidance of sound science., epidemiology data, regulatory requirements and external resources. We will be a leader in our community with regard to best infection prevention practices and procedures.

R16's medical diagnosis form, printed 7/12/18, included acute kidney failure, urinary tract infection, retention of urine, and chronic kidney disease, stage 4 (severe).

R16's quarterly Minimum Data Set (MDS), dated 4/5/18, identified R16 was cognitively intact, had an indwelling catheter, had a urinary tract infection within the past 30 days, and required extensive assistance with toileting and personal hygiene.

R16's care plan, dated 4/10/18, included R16 had

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F 880	Continued From page 17	F 880		

a suprapubic urinary catheter (surgically created connection between the bladder and the skin used to drain urine from the bladder) related to urinary retention.

R16's order summary report, printed 7/12/18, included a nursing order directing staff to cleanse around the catheter site and to apply a dressing every day and evening shift.

During an observation on 7/11/18, at 8:09 a.m. nursing assistant (NA)-A and NA-B entered R16's room and announced they would be assisting R16 with morning cares. R16 was lying in bed and was talkative and directing NA-A and NA-B with cares. NA-A and NA-B donned gloves, brought a wash basin and linens to the bedside, and proceeded to wash R16's face and upper body with a wash cloth, and dried with a towel. NA-A and NA-B then washed R16's groin area and buttocks, dried the areas, and covered R16 with a sheet. Both NA-A and NA-B removed their gloves. NA-A washed her hands, announced she would get the nurse, and left the room. Without performing hand hygiene, NA-B gathered R16's clothing, opened closet doors, and opened bedside table drawers. At 8:23 a.m. NA-B opened the bathroom door and donned gloves, obtained a graduate, and stated she was going to empty R16's catheter bag while waiting for the nurse. NA-B opened the clasp on the bag, used a wipe to clean around the tube, drained the urine into the graduate, clamped the clasp, again used a wipe to clean the tube, and secured the clasp onto the urine bag. NA-B carried the graduate into the bathroom, emptied the urine into the toilet, and rinsed the graduate. NA-B removed her gloves and tossed them into the garbage, but did not perform hand hygiene. NA-B opened R16's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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F 880	Continued From page 18	F 880		

closet, touched clothing in the closet, and straightened items on the bedside table. Licensed practical nurse (LPN)-A entered R16's room, talked with R16, gathered equipment, and donned gloves. NA-A reentered R16's room. Without performing hand hygiene, NA-B left R16's room. LPN-A used gauze to clean R16's abdominal fold of small white clumps, and applied an ointment to the area. LPN-A removed her gloves, and without performing hand hygiene, donned new gloves. LPN-A then used gauze to clean around R16's suprapubic catheter insertion site and the catheter tubing at the site, which had a moderate amount of dark red drainage. LPN-A removed the left glove, reached into her front pocket with the left hand, pulled a white folded piece of paper out of her pocket, looked at the writing on the paper, and placed it back into her pocket. LPN-A donned a new glove onto the left hand, and placed a gauze dressing around the catheter tubing at the insertion site, and removed her gloves. Without performing hand hygiene, LPN-A opened R16's supply cabinet, obtained gauze, and donned new gloves. NA-A donned gloves. LPN-A used gauze, dipped into clear liquid in a plastic medication cup, to clean R16's inner thighs and groin area, and then applied ointment to the areas with NA-A's assistance. LPN-A removed the gloves, and without performing hand hygiene, reached into her left pocket to pull out the white paper, looked at the paper, and then placed it back into her pocket. LPN-A opened the bathroom door and without performing hand hygiene, donned new gloves. LPN-A opened the top drawer of the bedside stand and retrieved a gauze bandage roll and placed the gauze into R16's inner thigh areas. Without removing the gloves, LPN-A again opened the drawer to the bedside stand, placing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	07/12/2018

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F 880	Continued From page 19	F 880		

the gauze bandage roll inside, closed the drawer, and removed the gloves. LPN-A donned new gloves. NA-A removed her gloves, and performed hand hygiene with hand sanitizer. LPN-A used a small gauze to remove more of the dried dark red substance from the catheter tubing near in the insertion site, removed her gloves, and without performing hand hygiene, went into the bathroom to don new gloves. LPN-A and NA-A assisted R16 to turn onto the left side, and LPN-A used gauze to clean the buttock area. LPN-A assessed the area and stated the area was red and irritated, but not open as it had been. LPN-A applied an ointment to the area, and removed her gloves. Without performing hand hygiene, LPN-A reached into her left pocket, pulled out the white folded paper, unfolded it, folded it back up, and placed it back into her pocket. LPN-A walked into the bathroom and washed her hands. LPN-A left R16's room. NA-A remained in the room and assisted R16 to get dressed.

When interviewed on 7/11/18, at 8:52 a.m. NA-B stated she always wears gloves when providing personal cares and was taught to wash her hands after removing the gloves, however, she didn't wash her hands today after emptying the catheter bag and removing her gloves, or before leaving R16's room, because she was nervous.

When interviewed on 7/11/18, at 8:57 a.m. LPN-A indicated hand hygiene should be performed each time gloves are removed, however, stated, "With [R16], I glove, glove, glove. He's got so much." LPN-A also stated, "I'm not a big believer in that stuff [hand sanitizer], so I just wash them when I'm done."

During an interview on 7/12/18, at 2:51 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	07/12/2018

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F 880	Continued From page 20 director of nursing (DON) indicated staff were trained and expected to perform hand hygiene after removing gloves, and stated, "We talk about it all the time." Review of the facility's undated policy, Hand Hygiene, identified indications for hand hygiene, including after any contact with blood or body fluids even if gloves are worn, after patient care, and after contact with the patient's environment.	F 880		

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	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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, State Fire Marshal Division, on July 10, 2018. At the time of this survey, Glencoe Regional Health Services C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/02/2018

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
	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2018**

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K 000	Continued From page 1	K 000		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Glencoe Regional Health Services C & NC was constructed in 1984, with one building addition constructed in 1995. Both buildings are one-story in height, have no basement, are fully fire sprinkler protected and were determined to be of Type I(332) construction.

The facility has an automatic fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility is separated from both a hospital and a senior apartment building, by complying two-hour fire wall assemblies. The facility has a capacity of 110 beds and had a census of 90 at time of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	**1805 HENNEPIN AVENUE NORTH** **GLENCOE, MN 55336**

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K 000	Continued From page 2 survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested and maintained in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect 110 of 110 residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 8:00 a.m. to 12:00 p.m. on 07/10/2018, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance Engineer revealed that the facility had not conducted the annual testing of the battery operated emergency lights found within the facility since January 2017. This deficient condition was verified by a Maintenance Engineer and Facility Administrator.	K 291	Emergency lighting 90 minute test was completed on 07/21/2018. The test was documented on the 2018 Emergency Light Test Log. Director of Maintenance will monitor compliance to ensure testing is completed annually within a 12 month period.	7/21/18
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		8/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2018**

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K 345	Continued From page 3 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code 2010 edition, section 7-3.2.1. This deficient practice could affect 110 of 110 residents,as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 8:00 a.m. to 12:00 p.m. on 07/10/2018, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Engineer and Facility Administrator revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by a Maintenance Engineer and Facility Administrator.	K 345	Annual sensitivity testing was completed on 11/06/2017. The report documented results as Pass or Fail. The Director of Maintenance contacted the contracted company ECSI and was informed that a report can be run for the 11/06/2017 test with numerical readings. ECSI was on site 08/01/2018 to run this report and Glencoe Regional Health Services received the completed document on 08/02/2018. The Director of Maintenance will monitor compliance.	

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	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2018**

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K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 110 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 07/10/2018 record review and staff interview revealed one fire drill was done prior to shift time on the night shift of the 4th quarter of 2017. This deficient condition was verified by a Maintenance Engineer and Facility Administrator.	K 712	Reviewed fire drill schedule at Safety Committee on 07/27/2018 and emphasized importance of conducting drills during scheduled time frame. The Risk Management Coordinator will monitor for compliance.	7/27/18
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories	K 901		7/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2018**

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K 901	Continued From page 5 Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems as designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents and an undetermined amount of visitors and staff. Findings include: During documentation review between 8:00 a.m. to 12:00 p.m. on 07/10/2018, documentation review and staff interview revealed the annual required risk assessment NFPA 99 was previously completed on 1/16/2017. This deficient condition was verified by a Maintenance Engineer and Facility Administrator.	K 901	The fire risk assessment was updated on 07/10/2018. The Risk Management Coordinator will monitor compliance to ensure the update is completed annually.	