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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LTGK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245594**
2.STATE VENDOR OR MEDICAID NO.
(L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL-MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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 **02/07/2020** (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)
12/31

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Nicole Osterloh, Unit Supervisor 2/10/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 2/10/2020 (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
11/01/1991
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 10, 2020

CMS Certification Number (CCN): 245594

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

Dear Administrator:

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 January 28, 2020 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 10, 2020

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: CCN: 245594
Cycle Start Date: December 18, 2020

Dear Administrator:

On February 7, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LTGK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245594**
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3. NAME AND ADDRESS OF FACILITY
(L3) **GIL-MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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 **12/18/2019** (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)
12/31

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (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
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Angela Hatch, HFE NE II 01/13/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/17/2020 (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
11/01/1991
(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

January 3, 2020

Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: CCN: 245594
Cycle Start Date: December 18, 2019

Dear Administrator:

On December 18, 2019, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

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:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 March 18, 2020 (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).

In addition, if substantial compliance with the regulations is not verified by June 18, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/16/19 through 12/18/19, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based	E 039		1/28/20

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

Electronically Signed | 01/09/2020

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
	245594	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 039	Continued From page 1	E 039		

functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,
clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 039	Continued From page 2	E 039		

exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,
clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 039	Continued From page 3 questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 4 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039		

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E 039	Continued From page 5 emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop	E 039		

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E 039	Continued From page 6 exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a full-scale community and table top exercise to test their emergency preparedness program. This had the potential to affect all 29 residents who currently resided in the facility along with staff who work at the facility. Interview and document review on 12/11/19 at 12:02 p.m., with the maintenance director identified the facility had not completed a full scale exercise or a table top regarding emergency preparedness. The facility had only completed standard monthly fire drills and would review the emergency preparedness plan.	E 039	Our plan of correction is to properly test our facility emergency preparedness plan by holding a Table Top exercise and discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the effectiveness our facilities emergency plan. As noted in the 2567, this alleged deficient practice has the potential to affect all occupants of Gil-Mor Manor. We will conduct a Table Top Exercise and	

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E 039	Continued From page 7 Interview on 12/11/19 at 12:11 p.m., with the administrator confirmed there had not been a full-scale and/or table top exercise to test their emergency plan.	E 039	Discussion that is scheduled to be held on 01/15/2020 and 01/22/2020 which will be facilitated by the Maintenance Supervisor and Administrator. A narrated clinically-relevant emergency scenario in addition to prepared questions designed to challenge the emergency preparedness plan will be part of this testing to determine effectiveness of our emergency preparedness plan and make necessary changes. The corrective actions will be monitored as follows: Table Top Exercise scenario and results will be reviewed at following quarterly QAA Committee meeting which will be held on January 28, 2020. Emergency Preparedness Plan will be reviewed and updated as necessary and annually and the QAA Committee will track and schedule Emergency Plan testing to ensure that the plan is tested annually as per the regulation. Date of completion: January 28, 2020 SECTION 7: Life Safety SUBJECT: Evaluating, Testing and Revising Emergency Preparedness Plan Policy and Procedures EFFECTIVE DATE: 01/08/2020 Purpose: The purpose of the Emergency Preparedness Plan is to assess for facility risks and develop a plan in order to keep residents, tenants, staff, and other occupants safe. It is an effective way to set up a plan of action for a variety of emergencies or disasters that may occur and allows our staff to be trained on what is to be expected during these emergent	

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E 039	Continued From page 8	E 039	situations. Definition: Table-top Exercise (TTX): A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures. Testing An organization should review and test its disaster preparedness plan at least once a year to evaluate the effectiveness of its current disaster preparedness program. The testing process helps to clarify roles in the company, reinforces knowledge, reveals the need for additional training and helps improve employee performance. It also exposes aspects of the disaster plan don□t pan out in practice. Here are examples of the types of tests to conduct and include in your comprehensive evaluation: " System tests: Check the various systems within the organization, along with their respective processes or procedures, to ensure that they meet the requirements outlined in emergency preparedness plan. " Component-related tests: Make sure that all hardware and software	

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E 039	Continued From page 9	E 039	components that the organization will rely upon during an emergency, function according to plan. For example, a component is a backup generator or a data-saving program. " Recovery strategies: Check the IT infrastructure and the organization□s recovery strategies to ensure that they will resemble operational conditions after an emergency. " Inspections, tests and maintenance: Verify that protection systems, critical warning systems and communications systems are in good working condition. Exercises Don□t wait until after an emergency to identify areas of improvement. Simulate or discuss hypothetical incidents to enhance employee knowledge of the emergency preparedness plan, optimize plan performance and increase awareness of potential hazards. Exercises vary in scale and can consist of: " Full-scale drills of hypothetical events. " Discussion-based tabletop exercises to discuss roles and responsibilities. " Orientation meetings, workshops and walkthroughs to familiarize employees with the preparedness plan. " Functional exercises for specific employees, resources or procedures in a simulated environment that□s scenario-driven. " All exercises, regardless of their type, should have objectives, evaluations and post-exercise reports that list suggestions for improvement, evaluated by the emergency preparedness team.	

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E 039	Continued From page 10	E 039	Improving the Program Use exercises, tests and actual emergencies as learning experiences to assess the organization□s response to an incident. To improve the program, it□s important to measure the outcomes of the actions taken and the community□s and/or industry□s reactions to the response. Program Reviews Whenever there is a change in the organization that could compromise the effectiveness of an emergency preparedness plan, the emergency preparedness team should review the program and make any necessary adjustments. Such changes can include: " The launching or withdrawal of a new or existing product. " Changes in management, suppliers, funding, regulations, laws or processes. " The identification of new hazards. " Changes to the physical work site, infrastructure or workforce population. " The discovery of weaknesses during drills, tests or exercises. A review should ensure that plans and procedures are up to date. This includes verifying the accuracy of team rosters, resource availability and the contact information of emergency preparedness team members, relevant employees, suppliers and vendors, contractors and public agencies. Corrective Action	

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E 039	Continued From page 11	E 039	When the organization finds deficiencies and gaps after an exercise, drill or disaster, the emergency preparedness team will document the information and identify the following information: " Action or resource required. " Reason for the corrective action. " Action□s priority level. " Person or team responsible for completing the action, as well as the deadline and status.	
F 000	INITIAL COMMENTS On 12/16/19 through 12/18/19, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found NOT to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5594016C. However, no deficiency was cited. The following complaint was found to be UNSUBSTANTIATED. H5594017C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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F 000	Continued From page 12 regulations has been attained in accordance with your verification.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F 582		1/3/20

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F 582	Continued From page 13 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN-CMS 10055) for 1 of 3 residents (R19) who remained in the facility after their Medicare A coverage ended. Findings included: R19's last covered day of Medicare was 11/27/19. R19 had a known plan to remain in the facility after the last covered day of Medicare. No SNFABN was provided to R19. Interview on 12/18/19 at 10:32 a.m., with registered nurse (RN)-C identified she issued the beneficiary notices. RN-C would expect the correct forms be provided at the time skilled services were ending.	F 582	Our plan of correction is to protect and ensure that Medicare beneficiary□s rights, responsibilities and protections related to financial liability and appeals under the Fee-for-Service (FFS) Medicare and Medicare Advantage programs are communicated properly. These financial liability and appeal rights and protections are communicated to beneficiaries through the Medicare denial notices given by Gil-Mor. The Director of Nursing and Administrator provided education on 01/03/2020 to the RN MDS Coordinator, backup RN MDS Nurse, and Social Services on the correct SNFABN-Skilled Nursing Facility Advanced Beneficiary Notice and NOMNC-Notice of Medicare Non-Coverage Notice that is to be	

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F 582	Continued From page 14 Interview on 12/18/19 at 11:43 a.m., with director of nursing (DON) verified the correct forms had not been issued to R19. The DON would expect all appropriate notices are given per regulation. A policy for Medicare Advance Beneficiary Notices was requested but not provided.	F 582	provided to our residents. Also, a new policy and procedure was written, reviewed with staff and implemented on 01/03/2020. To date since implementation there have been no Medicare denials issued. In order to prevent this deficient practice in the future, all denial notices to be issued will be reviewed by The Director of Nursing (DON) or designee in order to ensure staff compliance with appropriate notices. A monthly audit will be conducted of the Medicare denial notices issued at the third weekly Medicare Team Meeting. The audit findings will be summarized and reported to the quarterly QAPI meetings so that it can be reviewed in order to identify the need for continued monitoring. Completion date is 01/03/2020.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		1/6/20

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F 755	Continued From page 15 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to properly dispose of Fentanyl (narcotic medication) patches for 3 of 3 residents (R17, R23, and R24) to prevent potential diversion. Findings include: Observation and interview on 12/17/19 at 12:12 p.m., with registered nurse (RN)-A identified when a Fentanyl patch was removed, it would be destroyed by folding it in half and putting it in the RX Destroyer (a chemical destruction system that make medication unusable). This was to be witnessed by another nurse and both nurses sign once it had been completed. RN-A easily unscrewed the cap on the RX Destroyer. Inside were 2 patches visibly floating in the black liquid in the jug. Interview on 12/18/19, at 10:35 a.m., with the	F 755	The Fentanyl Patch Removal, Administration and Disposal Policy and Procedure has been updated to include the proper disposal method by immediately flushing Fentanyl patch down the toilet after being removed. Also, the Fentanyl Medication Destruction Log has been updated to include a column for the disposal method. All licensed nurses and TMA□s reviewed the policy and was implemented on 01/06/2020. A monthly audit will be conducted by the Director of Nursing or designee of the Fentanyl Patch disposal compliance. The audit findings will be summarized and reported to the quarterly QAPI meetings so that it can be reviewed in order to identify the need for continued monitoring. Completion date is 01/06/2020. SECTION 10 Pharmaceuticals	

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F 755	Continued From page 16 director of nursing (DON), confirmed Fentanyl patches were destroyed after removal, by folding in half and placing in the RX Destroyer with 2 nurses present. The used RX Destroyer jug was disposed of in the regular garbage and not secured in any manner. She was unaware of any city ordinance that would prohibit the flushing Fentanyl patches into the sewer system, as indicated per manufacturer's guidelines. Review of the 9/21/19, Fentanyl Patch Removal, Administration, and Disposal Policy and Procedure identified after removal of a Fentanyl patch, it was to be disposed of by placing the patch in the RX Destroyer with 2 nurses present. There was no mention of following manufacture's suggested guidelines for destruction. Review of October 2018, Fentanyl Patch prescribing information from Mylan Pharmaceuticals identified failure to properly dispose of Fentanyl transdermal system has resulted in accidental exposures and deaths. Dispose of used patches immediately upon removal by folding the adhesive side of the patch to itself, then flushing down the toilet.	F 755	SUBJECT: Fentanyl Patch Removal, Administration and Disposal Policy and Procedure Effective Date: 01/06/2020 Purpose: The facility□s policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications. What are transdermal patches? They are medicated sticky, adhesive patches wore on the skin. The adhesive backing on the patch that sticks to the skin contains medication that is continuously delivered via the skin to the bloodstream. Many different types of medications can be ordered via the transdermal route. One of these medications are Fentanyl. What is Fentanyl? It is an opioid pain medication used to treat severe pain. Patients who use transdermal Fentanyl patches are opioid tolerant, meaning they experience chronic, severe pain that cannot be controlled with oral opioid medications. Therefore, the transdermal patch can deliver continuous amounts of Fentanyl to help manage the patient□s pain. These patches are not for patients who have never taken oral opioid medications (these patches usually contain high doses of Fentanyl and can be too strong for patients who have never taken Fentanyl, which can lead to severe side effects), acute pain such as post-op	

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F 755	Continued From page 17	F 755		

or surgical related etc.

Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies.

Nurse□s Role with a Transdermal Patch of Fentanyl:
1. When administering a new patch, ALWAYS remove the previous patch before applying the new one.
2. ALWAYS wear gloves when removing and applying a Fentanyl patch! Why? To prevent becoming contaminated with the drug.
3. ALWAYS have another nurse witness you disposing of the old Fentanyl patch according to facilities policy and procedures.
4. Never apply a new transdermal patch on the same site (always rotate sites), broken or irritated skin, or on hair (it will not stick).
5. Sites to place a transdermal patch include: upper arm, chest, or back. If the patient is confused, place the patch on a site where the patient cannot easily pull it off.
6. Always time, date, and initial the patch.
7. When applying a new patch, assess

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F 755	Continued From page 18	F 755	the patient for adverse side effects: Respiratory, depression, Hypotension, Decreased mental status (lethargic, confused etc.), or pain rating and its location 8. You may have to reinforce the patch with a tegaderm or tape to keep it from falling off, especially if the patient is sweaty, has oily skin, or it is located on an area that experiences a lot of friction. 9. Always chart where you place the patch so when the next dose is due the next nurse knows where to find the patch. Steps on How to Remove a Transdermal Patch 1. Note in the chart where the last nurse charted the location of the previous patch 2. Wash hands and put on gloves 3. Remove patch from skin and fold it sticky side to sticky side 4. Dispose by immediately flushing down toilet with another nurse as a witness 5. There is a clip board in the medication room to document that fentanyl patch was destroyed and both staff members that witnessed the removal and destruction of patch must sign clip board. 6. Clean site with warm soap and water to remove any residue or dead skin cells from the site, or use adhesive remover wipes to remove residue, then wash area with soap and water and apply lotion to area. 7. Remove gloves and wash hands Steps on How to Apply, Remove and Disposal of a Transdermal Patch 1. Perform the patient□s 5 Rights:	

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F 755	Continued From page 19	F 755	a)Right patient b)Right drug c)Right dose d)Right route e)Right time 2. Check the packaging (make sure it is not torn or expired) 3. Open new patch: don□t use scissors because you can mistakenly cut the patch 4. Write the time, date, and initials on the patch 5. Note in the chart where the last nurse charted the location of the previous patch 6. Wash hands and put on gloves 7. Remove patch from skin and fold it sticky side to sticky side 8. Dispose immediately by flushing down toilet with another nurse as a witness 9. There is a clip board in the medication room to document that fentanyl patch was destroyed and both staff members that witnessed the removal and destruction of patch must sign clip board. 10. Clean site with warm soap and water to remove any residue or dead skin cells from the site, or use adhesive remover wipes to remove residue, then wash area with soap and water and apply lotion to area. 11. Remove gloves and wash hands 12. Put on gloves, apply fentanyl patch to upper body and arms only and record in the MAR where the patch was placed. Medication nurse (TMA, LPN) to check placement of patch and ensure it still present on resident□s body daily and record in the MAR. (If order reads to apply tegaderm over the top of the patch, apply tegaderm to secure patch in place.) 13. Remove gloves and wash hands	

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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 FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 3, 2018 At the time of this survey, Gil-Mor Manor 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2020

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 By email to: FM.HC.Inspections@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. Gil-Mor Manor was constructed as follows: The original building was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1989 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a capacity of 35 beds and had a census of 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321		1/8/20

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K 321	Continued From page 2 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain 3 combustible storage rooms in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of residents, staff and visitors. Findings include: During the facility tour between 8:30 am to 12:30	K 321	This deficiency was corrected on 01/08/2020 when maintenance installed self-closing/automatic closers to the doors identified during the inspection to ensure doors automatically shut at all times. Completion date is 01/08/2020.	

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K 321	Continued From page 3 pm on 12/18/2019 observations revealed resident rooms 12, 14, and 20 were being used for combustible storage without having self closing doors. This deficient condition was confirmed by the Director of Maintenance.	K 321		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 14.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and	K 353	On 12/19/2019, Summit was contacted to conduct the 5-year internal pipe inspection. The internal pipe inspection agreement was received on 01/07/2020 and the signed agreement was returned to Summit on 01/09/2020. Inspection is scheduled to be completed on	1/21/20

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K 353	Continued From page 4 allow for the spread of fire. This could affect all of the 35 residents and an undetermined amount of staff and visitors. Findings include: During the facility tour between 8:30 am to 12:30 pm on 12/18/2019 documentation review revealed there was no record of a 5 year internal sprinkler pipe inspection and the date on the riser gauge exceed the five year limit for calibration or replacement. This deficient condition was confirmed by the Director of Maintenance.	K 353	01/21/2020. Completion date is 01/21/2020.	
K 754 SS=E	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by:	K 754		12/18/19

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K 754	Continued From page 5 Based on observation and staff interview the facility failed to properly store soiled linen containers in a protected hazardous room as stated in the Life Safety Code NFPA 101 2012 edition section 19.7.5.7. This deficient practice could affect the safety of 10 of 35 residents and an undetermined amount of staff and visitors if smoke or fire from one of these containers made the corridors non-useable. Findings include: During the facility tour between 8:30 am to 12:30 pm on 12/18/2019 observations revealed a mobile soiled linen cart stored in a room not designated as hazardous and the cart blocked the door in the open position. This deficient condition was confirmed by the Director of Maintenance.	K 754	On 12/18/2019, the soiled linen and trash container was moved to the soiled utility room. Staff was educated on the regulation forbidding that these containers be located in any other location than the soiled utility room. We have also included this information as a reminder to staff on the nursing 24-hour report. Stickers were placed on the containers that they must be kept in the soiled utility room. Maintenance supervisor will do quarterly audits to ensure compliance, findings will be reported to our quarterly QAPI meeting for review and determine if continued monitoring is needed. Completion date is 12/18/2019.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL	K 920		12/19/19

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K 920	Continued From page 6 standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to limit the use of extension cords as stated in NFPA 70 sections 400.8 & 590.3 item d. This deficient practice could affect an undetermined amount of residents. Findings include: During the facility tour between 8:30 am to 12:30 pm on 12/18/2019 observations revealed an extension cord in use in resident room 49. This deficient condition was confirmed by the Director of Maintenance.	K 920	Extension cord was removed from room 49 and replaced with a long corded relocatable power tap on 12/19/2019. Maintenance supervisor will do quarterly audits to ensure compliance, findings will be reported to our quarterly QAPI meeting for review and determine if continued monitoring is needed. Completion date is 12/19/2019.	