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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M4BS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00313

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245410**

2.STATE VENDOR OR MEDICAID NO.
(L2) **585219600**

3. NAME AND ADDRESS OF FACILITY
(L3) **RICE CARE CENTER**
(L4) **1801 SOUTHWEST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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 **02/18/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NE II 02/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 04/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/03/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245410
April 7, 2015

Ms. Pam Adam, Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, Minnesota 56201

Dear Ms. Adam:

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 15, 2015 the above facility is certified for or recommended for:

78 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 26, 2015

Ms. Pam Adam, Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number

Dear Ms. Adam:

On December 31, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 5, 2015. (42 CFR 488.422)

On February 5, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil Money Penalty effective December 18, 2014

This was based on the deficiencies cited by this Department for a standard survey completed on December 18, 2014. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 18, 2014, as of January 15, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 15, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 5, 2015:

- Civil Money Penalty be discontinued as of January 15, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245410	A. Building B. Wing	2/18/2015

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0243** Reg. # **483.15(c)(1)-(5)** LSC	Correction Completed **01/01/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **01/15/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **01/07/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/15/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/08/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **01/15/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/08/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	3/2/2015	32613	2/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/18/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245410	01 - MAIN BUILDING 01	2/3/2015

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	01/09/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By JS/KJ	Date: 4/9/2015	Signature of Surveyor: 32613	Date: 2/3/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/16/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M4BS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00313

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(L1) **245410**

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(L4) **1801 SOUTHWEST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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 **02/18/2015** (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**
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

And/Or Approved Waivers Of The Following Requirements:
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* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NE II 02/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 04/07/2015 (L20)

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01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/03/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245410
April 7, 2015

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Rice Care Center
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Willmar, Minnesota 56201

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Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 26, 2015

Ms. Pam Adam, Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number

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In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 5, 2015:

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The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245410	A. Building B. Wing	2/18/2015

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0243** Reg. # **483.15(c)(1)-(5)** LSC	Correction Completed **01/01/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **01/15/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **01/07/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/15/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/08/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **01/15/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/08/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/08/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	3/2/2015	32613	2/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/18/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245410	01 - MAIN BUILDING 01	2/3/2015

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 01/09/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	4/9/2015	32613	2/3/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/16/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M4BS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00313

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245410**

2.STATE VENDOR OR MEDICAID NO.
(L2) **585219600**

3. NAME AND ADDRESS OF FACILITY
(L3) **RICE CARE CENTER**
(L4) **1801 SOUTHWEST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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 **12/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Lu Anne Heglie, HFE NE II 01/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 01/30/2015 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/03/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 31, 2014

Ms. Pam Adam, Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number S5410024

Dear Ms. Adam:

On December 18, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Brenda.fischer@state.mn.us

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

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy), whereby significant corrections were required was issued pursuant to a survey completed on April 3, 2014. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 5, 2015. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

by the same deficient practice;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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, 2015 (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 June 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this **eNotice.**

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5410s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 243 SS=E	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents, who resided on the short term unit were provided an opportunity to be involved in Resident Council activities. This would have the potential to affect 30 of 72 resident who reside in the building.	F 243	F243 Participation in Resident and Family Groups Corrective Action: All residents (patients)of Rice Care Center were given a monthly calendar of the date and time of	1/1/15

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

Electronically Signed | 01/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	12/18/2014

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F 243	Continued From page 1 Findings include: During interview on 12/17/14, at 9:31 a.m. registered nurse (RN)-C stated the general length of stay of the short term unit residents was generally 7-14 days. Because they did not stay very long, this unit does not have a Resident Council meetings nor is there an opportunity to go to other resident council meetings in the facility. RN-C reported all psychosocial needs are met by two social service staff who were specifically assigned to the unit. During an interview with social worker (SW)-A on 12/17/14 at 9:57 a.m. she reported she was in charge of coordinating resident council meetings at the facility. She stated the short term stay unit did not have a Resident Council. She indicated the residents on the long term units had active Resident Councils but the short term unit had no Resident Council meeting, and that this had been overlooked. The facility policy Resident Council, last reviewed 5/13, directed staff to ensure all resident had an opportunity to meet as a Resident Council. The facility failed to adhere to its policy.	F 243	Patient (Resident) Council. Patient council has been added to the calendar template. This was completed on 01/01/2015 Corrective Action-Identify other residents: All residents in long term households (Cushman Cottage and Sophia House) meet monthly. Therapy Suites has added Patient Council to meet the second Tuesday of every month. All residents and patients receive a monthly calendar posted in their room. Corrective action to prevent reoccurrence: Patient Council has been added to the calendar template to ensure compliance. Monitoring for compliance: Audits will be completed in each household by the Social Services Mentor to ensure Resident and Patient Council are on the monthly calendar and that every resident and patient have a calendar in their room. Results will be brought to QA for recommendation on the need to further audit. Social Services Mentor will ensure compliance.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		1/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R32) reviewed for activities, was provided with activities to meet their individual preferences based on a comprehensive assessment. Findings include: R32's annual Minimum Data Set (MDS), dated 11/18/2014, identified R32 had diagnoses that included anxiety and unspecified hearing loss. R32 was identified as severely cognitively impaired with feelings of depression, sleep disturbance and difficulty concentrating. The MDS also identified that the resident had moderate difficulty hearing and required the speaker to increase the volume and speak distinctly and needed extensive assistance of one staff with her activities of daily living. The MDS also identified that it was very important for R32 to have books, newspapers and magazines to read and to be able to be involved in her favorite activities, religious services and practices. The care area assessment (CAA) dated 11/24/14, identified R32 was alert but had cognitive impairment and was repetitive in her conversation. She was able to verbalize her needs and had episodes of anxiety. Her ability to understand others was impaired, was hard of hearing and had hearing aids. She was able to tell staff when she did not hear them. During observation on 12/18/14 at 9:15 a.m. an activity in the common area of the unit was occurring with 8 of 25 residents, who resided on	F 248	Corrective Action: Education to nursing staff working in Cushman Cottage that Res 32 must have completion of charting after programming of 1:1 services was given. Res 32 was given 1:1 activity. Daily check by Household Coordinator completed to ensure activity was actually done. Corrective Action: Identify other residents All residents receiving 1:1 have been identified and care plans have been reviewed for accuracy of personalized visits per resident's preference/needs. 1:1 activities now has a primary staff assigned on the day and evening shift. Activity documentation log is available to staff to document 1:1 charting. Corrective Action to prevent reoccurrence Education was provided to all care assistants on 01/05/2015. Education was provided to nursing staff on 01/7/2015 regarding the documentation of 1:1 visits per personalized preferences based on comprehensive assessment. Primary Certified Nursing Assistant on day shift provides the 1:1 activity. Household Coordinator will review documentation log to ensure the 1:1's are being provided.	

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F 248	Continued From page 3 the unit, were in attendance. R32 was in her room alone, sitting in her recliner, with her eyes closed. Review of the facility Activities-Recreation Services Assessment, dated 11/24/14, indicated R32 was active with her religion, but was uncooperative, withdrawn at times and needed encouragement related to activity involvement. She preferred activities on an individual basis and independent leisure activities. R32's plan of care, dated 3/5/2013, indicated R32 preferred to self-direct her own activities and choose to spend most of her time in her room. The plan of care indicated she found strength in her religious beliefs and staff were to arrange church clergy to visit in her room when she was unable to attend monthly communion services. The care plan directed staff to provide R32 with craft activities as requested, assist her with the television remote as needed, and to read scripture or religious readings. In addition, staff were directed to offer individual visits five times per week. Review of R32's 1:1 Activity Charting Records for October 2014 identified R32 received nine (9)1:1 activities out of 23 opportunities; November 2014 she received three (3) out of 20 opportunities; and December 1 thru 17, 2014, R32 received one (1) out of 12 opportunities for 1:1 activities. Review of R32's Rice Care Center Recreation Services document for October, 2014 to December 17, 2014 identified R32 had not seen the clergy during this time. The majority of the activities were rest and relaxation in the resident's room and staff completed a 1:1 activity of reading	F 248	Monitoring for Compliance: Household Coordinator or designee will monitor charting and activity on residents that receive 1:1 daily for 30 days. Following 30 days, audits will be done weekly for one month. Results will be brought to QA for recommendation on the need to further audit.	

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F 248	Continued From page 4 to R32, only twice. Even though the assessment and care plan identified that church, religious reading were important for F32. On 12/7/14 at 1:06 p.m. an interview with nursing assistant (NA)-A was completed. NA-A reported she was very concerned R32 was not being offered activities as scheduled. She indicated the resident preferred to stay in her room and the 1:1 session that were to occur five times a week were not being implemented. She stated any resident who had cognitive impairment, did not attend the traditional activities were not getting the activities they needed. On 12/17/14 at 1:55 p.m. an interview with Household Coordinator (HC)-D stated that activities are planned according to the resident interests/preferences. She acknowledged the only activity preference or interest assessment completed was the MDS screening process. She reported she was responsible for overseeing activities and ensuring they are occurring and that she reviews each resident's involvement in activities at least quarterly. She felt R32 was receiving individual sessions but the documentation may be lacking. On 12/18/2014 at 9:55 a.m. NA-E stated R32 was afraid of leaving her chair in her room. According to NA-E, when R32 is taken out of her room, she would ask to be returned to her room immediately. She was aware that 1:1 ' s were planned for the resident and would talk to the resident whenever she is responding to a request or when she provided care to the resident. She confirmed no individual activity sessions were	F 248		

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F 248	Continued From page 5 completed with R32 as identified in the care plan. On 12/18/2014 at 10:22 a.m., licensed practical nurse (LPN)-B was interviewed. LPN-B reported R32 did not like to come out of her room. She indicated she was aware staff were to have individual sessions and was unsure if they were occurring. LPN-B did report R32's favorite activity was going from her recliner to the bathroom and back. On 12/18/2014 at 10:28a.m., NA-F was interviewed. NA-F reported she was aware R32 was to have individual sessions but thought it was to be done on Tuesday and Thursday evening only but R32 sleeps about 80% of the day. The facility policy Activities, reviewed 3/09 directed staff to ensure the Activity Program was multi-faceted and reflected each individual residents ' needs. Supportive activities that provide stimulation or solace to residents who cannot generally benefit from group activities were to be provided. A variety of activities shall be offered and will be designed to meet each individual ' s interests, needs and wants. An interview on 12/18/14 at 9:15 a.m. the director of nurses (DON) stated the facility had made changes in the provision of all services related to the household concept of care. Household staffs are responsible for providing all activities, in addition to all other assessed needs of the resident. She acknowledged R32 was not getting the planned activities at the present time.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		1/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 6 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for 1 of 3 residents (R19) in the sample with pressure ulcers. Findings include: R19's quarterly Minimum Data Set (MDS) dated	F 278	F 278 Resident Assessment Corrective Action: Res #19 Quarterly MDS dated 10-28-14 has been modified and identified pressure ulcer Corrective Action-Identify other residents:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 7 10/28/2014 indicated R19 had a diagnoses of dementia, hypertension, Parkinson's disease and was moderately cognitively impaired. The MDS also identified R19 was at risk of developing pressure ulcers, and did not have any unhealed pressure ulcers. The Skin Risk Assessment (with Braden Scale) dated 10/26/14 identified R19 had a pressure ulcer on coccyx. The assessment interventions included a turning and repositioning program, nutrition to manage skin problems, ulcer care and application of ointments and medications. When interviewed on 12/18/14, the registered nurse (RN)-A stated that the last skin assessment, dated 10/26/14 identified that R19 had a pressure ulcer and confirmed the MDS should have identified the pressure ulcer. Even though a pressure ulcer was identified on the Skin Risk Assessment, dated 10/26/14, the quarterly MDS did not indicate R19 had a current pressure ulcer.	F 278	All residents with pressure ulcers have been audited for accuracy of MDS Corrective Action to Prevent Reoccurrence: Education completed on 1//7/2015 on the importance of accurate coding of MDS of pressure ulcers Monitoring for Compliance: DON or designee will audit accuracy of coding MDS section M weekly for one month, audits will be brought to QA for recommendation on the need to further audit.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		1/8/15

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F 279	Continued From page 8 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a comprehensive care plan to include skin goals and individual interventions to reduce the risk of skin impairment for 1 of 3 residents (R28) reviewed for pressure ulcers. Findings include: R28's significant change in condition Minimum Data Set (MDS), dated 9/12/14, indicated he had moderately impaired cognition, and required extensive assistance with bed mobility and transfers Further, the MDS indicated he had a pressure relieving device on his chair / bed, was on a turning a reposition program, and received a nutrition or hydration intervention to manage skin problems. The facility Tissue Tolerance Assessment, for R28 dated 10/16/14, indicated he had no history of pressure ulcers in the past 6 months, and required a two hour reposition schedule. R28's Skin Risk Assessment, dated 10/27/14, indicated he had no current pressure ulcers, was at risk of skin breakdown and had pressure relieving	F 279	F 279 Comprehensive Care Plan Corrective Action: R28 Comprehensive Care Plan has been updated with interventions to reduce the risk of skin breakdown Corrective Action Identify other residents: All residents with Braden Risk Score of 10 or below have been identified to ensure the care plans include appropriate goal & interventions Corrective Action to Prevent Recurrence: Education completed on 1/7/15 to all nurses/TMAs to review care plans monthly to ensure accuracy of resident Problems & interventions for High risk & Moderate risk residents Weekly IDT will review all residents at risk with skin breakdown Monitor for Compliance: DON or Designee will audit care plans for individualized interventions weekly for 2 months then 2xs a month. Results will	

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F 279	Continued From page 9 device for his chair and bed, application of ointments, and nutrition or hydration interventions. R28's Pressure Ulcers Care Area Assessment (CAA), dated 10/13/14, indicated he was confined to his bed or chair most of the time, required a special mattress to reduce or relieve pressure, and needed a regular schedule of turning. R28's declining health status increased his risk of skin problems and he required, "Ongoing monitoring and support to prevent open areas." Further, the CAA indicated a care plan decision to be addressed. R28's care plan, dated 10/17/14, indicated he experienced bowel and bladder incontinence, and interventions of applying a moisture barrier to his coccyx and reporting signs of skin breakdown to the nurse. The care plan lacked any problem, goals or specific interventions for R28's skin including, guidance on how often to assist R28 with repositioning, what type of pressure relieving devices were in use for him, nor what nutrition interventions were in place to address his skin breakdown concerns as identified on the significant change MDS, Skin Risk Assessment, and/or CAA. When interviewed on 12/17/14, at 12:29 p.m. nursing assistant (NA)-D stated R28 was able to reposition himself, but staff remind him to do so every 2 hours or so just like for all the residents in the facility. NA-D was unaware what R28's care plan indicated for how often to assist him with repositioning, nor any other interventions being used to reduce his risk of skin breakdown. On 12/17/14, at 12:41 p.m. NA-C and licensed	F 279	be brought to QA for recommendation on the need to further audit.	

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F 279	Continued From page 10 practical nurse (LPN)-C were interviewed regarding R28's skin care plan and interventions to reduce his risk of breakdown. NA-C stated R28 will develop redness on his coccyx at times after he had been in bed too long. Further, she stated R28 required no assistance or cues from staff for repositioning. LPN-C stated R28's care plan was not comprehensive because it lacked a plan of care regarding his risk of skin breakdown and corresponding interventions to reduce the risk, "We need to be looking at his skin." When interviewed on 12/17/14, at 1:04 p.m. registered nurse (RN)-B stated R28 lacked a skin plan of care as the CAA indicated to include interventions on the care plan and, "That didn't happen." Further, "He doesn't have a complete, comprehensive care plan." During interview on 12/18/14, at 1:52 p.m. the director of nursing (DON) stated a comprehensive care plan is created by following the assessment completed in the CAA, and R28's skin risk and interventions, "Should be on the care plan." A facility Care Planning System policy, dated 11/1997, indicated, "The MDS (minimum data set) provides the data base for resident care plan development." Further, the policy directed staff to identify the problem(s) or needs, determine appropriate goals, and select actions on how to meet the developed goal of the resident care plan.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		1/15/15

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F 282	Continued From page 11 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 1 of 3 resident (R32) in the sample with cognitive and physical impairment, with activities as indicated by the plan of care. The findings include: R32 annual minimum data set (MDS), dated 11/18/2014, identified R32 had severe cognitively impaired and needed extensive assistance of one staff with her activities of daily living. There was no indication R32 was uncooperative with any of her cares or had any behaviors. The MDS also identified that it was very important for R32 to have books, newspapers and magazines to read and to be able to be involved in her favorite activities, religious services and practices. During observation on 12/18/14 at 9:15 a.m. an activity in the common area of the unit was occurring with 8 of 25 residents, who resided on the unit, were in attendance. R32 was in her room alone, sitting in her recliner, with her eyes closed. R32's plan of care, dated 3/5/2013, indicated R32 preferred to self-direct her own activities and choose to spend most of her time in her room. The plan of care indicated she found strength in her religious beliefs and staff were to arrange church clergy to visit in her room when she was	F 282	Corrective Action: Education to nursing staff working in Cushman Cottage that Res 32 must have completion of charting after programming of 1:1 services was given. Res 32 was given 1:1 activity. Daily check by Household Coordinator completed to ensure activity was actually done. Corrective Action: Identify other residents All residents receiving 1:1 have been identified and care plans have been reviewed for accuracy of personalized visits per resident's preference/needs. 1:1 activities now has a primary staff assigned on the day and evening shift. Activity documentation log is available to staff to document 1:1 charting. Corrective Action to prevent reoccurrence Education was provided to all care assistants on 01/05/2015. Education was provided to nursing staff on 01/7/2015 regarding the documentation of 1:1 visits per personalized preferences based on comprehensive assessment. Primary Certified Nursing Assistant on day shift provides the 1:1 activity. Household	

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F 282	Continued From page 12 unable to attend monthly communion services. The care plan directed staff to provide R32 with craft activities as requested, assist her with the television remote as needed, and to read scripture or religious readings. In addition, staff were directed to offer individual visits five times per week. Review of R32's 1:1 Activity Charting Records for October 2014 identified R32 received nine (9)1:1 activities out of 23 opportunities; November 2014 she received three (3) out of 20 opportunities; and December 1 thru 17, 2014, R32 received one (1) out of 12 opportunities for 1:1 activities even though the care plan identified 1:1 five days a week. Review of R32's Rice Care Center Recreation Services document for October, 2014 to December 17, 2014 identified R32 had not seen the clergy during this time. The majority of the activities were rest and relaxation in the resident's room and staff completed a 1:1 activity of reading to R32, only twice. Even though the care plan identified 1:1 five days a week. On 12/7/14 at 1:06 p.m. an interview with nursing assistant (NA)-A stated she was very concerned R32 was not being offered activities were are to occur five times a week were not being completed. On 12/18/2014 at 9:55 a.m. NA-E stated she was aware that 1:1 ' s were planned for the resident and would talk to the resident whenever she is responding to a request or providing care to the resident, but no other individual 1:1 sessions were being completed.	F 282	Coordinator will review documentation log to ensure the 1:1's are being provided. Monitoring for Compliance: Household Coordinator or designee will monitor charting and activity on residents that receive 1:1 daily for 30 days. Following 30 days, audits will be done weekly for one month. Results will be brought to QA for recommendation on the need to further audit.	

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F 282	Continued From page 13 During an interview on 12/18/14 at 9:15 a.m. the director of nurses (DON) stated that household staffs are responsible for providing all activities, in addition to all other assessed needs of the resident. She acknowledged R32 was not getting the planned activities at the present time as identified by the care plan.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 document review, the facility failed to complete routine grooming for 1 of 1 residents (R25) whom was dependant on staff for care, and reviewed for activities of daily living. Findings Include: R25's quarterly Minimum Data Set (MDS), dated 9/9/14, indicated he had severe cognitive impairment, and was totally dependent on staff for personal hygiene care. R25's care plan, dated 12/13/11, indicated he required assistance with activities of daily living (ADL) related to cognitive decline and impaired mobility, and identified a goal that R25, "will be clean and well groomed daily." Further, the care plan indicated R25 required total assist of one for	F 312	Corrective Action: Resident 25 had nail care completed on December 17, 2014 and nails are clean and trimmed. Res 25 care plan was updated to include his preferences. Corrective Action-Identify other residents: All residents are assisted with their ADL needs including nail care. Nail care audits were completed on all residents on December 29, 2014. Corrective action to Prevent Reoccurrence: The Fingernails-cleaning & Trimming Policy & Procedure was reviewed to all nursing staff. Reviewed nail care to be completed weekly at bath time at the Mandatory Education on January 5th &	1/8/15

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F 312	Continued From page 14 grooming. During observation on 12/15/14 at 7:50 p.m., R25 was seated in the dining room watching television. R25 had long, un-kept looking fingernails with dark debris visible underneath the nails. During subsequent observations, on 12/16/14 at 8:30 a.m., and 12/17/14 at 7:02 a.m., R25 continued to have long fingernails with black debris visible underneath the nails. When interviewed on 12/17/14 at 8:46 a.m., nursing assistant (NA)-C stated nail care should be completed on a residents bath day. R25 had a bath yesterday (12/16/14), and nail care should of been completed, "They need to be clipped." Further, NA-C stated R25 had no preference for long fingernails. During interview on 12/17/14 at 8:55 a.m., licensed practical nurse (LPN)-C stated R25's fingernails should have been cleaned and trimmed. During a telephone interview on 12/17/14 at 9:09 a.m., family member (FM)-E stated R25 had always taken good care of his nails in his past and being seen with long, dirty fingernails would be embarrassing, "It would bother him." When interviewed on 12/17/14 at 9:18 a.m., registered nurse (RN)-B stated resident nail care should be completed on bath days, and R25's nails should have been cleaned and trimmed. During interview on 12/18/14 at 1:46 p.m., the director of nursing (DON) stated residents should have nail care completed with their bathing, and NA's should be looking to make sure resident nails are clean and trimmed.	F 312	7th of 2015. Monitoring for Compliance: The DON or designee will audit proper nail care of 10% of resident population weekly for one month. The results of these audits will be discussed and reviewed at QA who will determine when compliance is indicated.	

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F 312	Continued From page 15 A facility Bath - Shower or Tub policy, dated 3/2002, indicated a purpose of cleaning and refreshing the resident. Further, the policy indicated, "Trim nails if necessary or to resident wishes."	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R19) with pressure ulcers, was assessed weekly to determine whether the current treatment was effective, and to ensure staff provided care to ensure current pressure ulcers were healing, and failed to prevent the development of new pressure ulcers, which caused actual harm for R19. Findings include: R19's quarterly Minimum Data Set (MDS) dated 10/28/14 identified R19 had diagnoses of dementia, hypertension and Parkinson's disease with no pressure ulcers. The MDS also indicated	F 314	Corrective Action: Res 19 Comprehensive pressure ulcer risk assessment completed on December 18, 2014. Appropriate interventions to prevent further development of additional pressure ulcers have been added to care plan. Wound progress sheet completed on December 18, 2014. Corrective Action-Identify other residents: All residents with pressure ulcers have been reviewed for appropriate assessment. Wound monitoring progress sheet reviewed to ensure current pressure ulcers are healing and to prevent the development of new pressure ulcers.	1/8/15

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F 314	Continued From page 16 R19 had moderate cognitive impaired, was dependent on staff for bed mobility and was at risk for pressure ulcer development. Review of the pressure ulcer, Care Area Assessment (CAA), dated 7/29/14 identified that R19's risk factors included staff assistance to reposition, frequently incontinent of bowel and bladder, poor nutrition and non ambulatory. The CAA verified there were no current pressure ulcers identified for R19. Although R19 was identified at moderate risk for pressure ulcers, and had a pressure ulcer identified on 10/26/14. R19 developed two (2) additional stage 2 pressure ulcers on her coccyx on 12/18/14. The facility did not develop an individualized plan of care based on a comprehensive assessment to identify what interventions should be implemented or modified to help decrease the risk of R19 developing additional pressure ulcers and promote healing. There was no indication the pressure ulcers were re-assessed or consistently monitored on a weekly basis to determine staging, size, exudate, pain, wound bed and a description of the surrounding wound edges. This resulted in R19 having three stage 2 pressure ulcers, which resulted in actual harm. R19 was observed on 12/17/14 from 7:00 a.m. until 9:08 a.m. At 7:00 a.m. R19 was lying on her back, on an alternating pressure mattress in bed. R19 continued to lay in this position until 7:41 a.m. when registered nurse (RN)-A and licensed practical nurse (LPN)-B positioned R19 on her right side and provided R19 with cares for bowel incontinence. During the observation, there was an open area observed on R19's coccyx. LPN-B	F 314	Care plan interventions reviewed for appropriate interventions to prevent the development of new pressure ulcers. Corrective action to prevent reoccurrence: Education completed on January 7, 2015 on the Skin Care Policy with Suzanne Kueseman RN, WOC Nurse. All nursing staff educated on revised weekly wound documentation progress sheet & how to complete, skin integrity event□pressure sore/statis ulcer in Matrix & progress note in resident/patient chart. Education on updating or initiating care plan on new pressure ulcers with Problem/Goal/Approaches Weekly IDT will review all residents at risk with skin breakdown Monitoring for Compliance: Audits will be completed by DON or designee weekly at wound meetings in each neighborhood to assure wound monitoring sheets are completed and pressure ulcer is healing and measures in place to prevent the development of new pressure ulcers. Care Plans will be reviewed weekly at wound meetings for appropriate problem/goal/approaches.	

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F 314	Continued From page 17 applied Calazime (a skin barrier paste) to the open area and left the room. At 7:52 a.m. (11 minutes later) R19 was re- positioned onto her back by RN-A and LPN-B. R19 remained on her back until 8:33 a.m. when nursing assistant (NA)-B and NA-A came into the room, provided personal care and applied Calazime and stomahesive powder to the open area on the resident's coccyx. NA-B and NA-A, assisted R19 into a wheelchair with a cushion and took her to the neighborhood dining room for breakfast. R19 was observed on 12/18/14 from 7:59 a.m. to 8:53 a.m. At 7:59 a.m., R19 was lying on her back on an alternating pressure mattress in bed. R19 remained in this position until 8:53 a.m. when NA-B provided R19 with incontinence care. At that time two open areas were observed to R19's coccyx. The NA-B applied Calazime and Stomahesive to both open areas. At 10:03 a.m. NA-B left the room and reported to LPN-B that R19 had a possible second open area. At 10:10 a.m. RN-A and LPN-B came into the room to provide wound care and to measure R19's coccyx open areas. LPN-B stated the coccyx measurements were 1.1 centimeters (cm) by 0.8 cm. In addition, LPN-B stated there were now two additional open areas to the resident's coccyx were not present the previous day (12/17/14). These open areas measured 0.8 cm by 0.5 cm and 0.3 cm 0.5 cm., for a total of three open areas on R19's coccyx. Review of the facility's Skin Risk Assessment (with Braden Scale) dated 10/26/14, identified R19 had a pressure ulcer on her coccyx, and that the Braden Scale (tool used to assess risk for pressure ulcers) score was 13. The score indicated R19 was at moderate risk for	F 314		

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F 314	Continued From page 18 development of pressure ulcers. The assessment was a checklist and indicated R19 was completely immobile and had a problem with "Friction and shear, 1- Problem - Requires moderate to maximum assist in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assist. Spasticity, contractors or agitation leads to almost constant friction." The assessment interventions that were checked included a turning and repositioning program, nutrition to manage skin problems, ulcer care and application of ointments and medications. R19's care plan identified a problem dated 11/14/ 2007 indicated a problem of reoccurring open area on coccyx related to moisture and abrasion from cleaning incontinent stool. The care plan interventions included: "Treat open areas as directed on buttock/coccyx as per directions of the WOCN [Wound Ostomy Certified Nurse]. Chng [Change] per toileting schedule. Clean and dry skin after every toileting. Apply Remedy Skin Protectant BID [twice a day] to peri area. Apply calazime to coccyx area if skin breakdown present-PRN [as needed]." The care plan also directed staff to reposition R19 every hour when awake and during the night and to encourage to lay down on her bed to rest two to three times during the day to get off her buttocks. Additional interventions included air mattress on bed and a ROHO (a specialty cushion for pressure relief) cushion in her wheelchair. The care plan also identified R19 required "Bed mobility: Total assistance of two staff to assist with turning. Extensive assist of 2 to pull resident up to sitting position & balance on edge of bed."	F 314		

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F 314	Continued From page 19 Review of R19's Physician Order Report, dated 12/18/2014 - 02/18/2015, identified the following treatment orders for skin care: 7/31/2013 (1) Cleanse Coccyx/gluteal fold crack with peri spray (remove all old cream), apply stomahesive power and thick Calazime if coccyx area is open BID twice a day PRN (as needed); AM, and HS. 10/3/14 (2) apply Remedy skin protectant with dimethicome to peri area if redness is present every shift as needed. 10/30/14 (3) may use Mepilex Lite or Mepilex 4x4 to coccyx PRN as needed for protection to open areas on peri areas/buttocks and No Mepilex Border. Review of the facility Wound Progress Sheet, dated 8/7/14 - 9/23/14 identified the resident had an open area stage 2 (partial thickness loss of dermis presenting as a shallow open ulcers with a red-pink wound bed without slough) "abrasion" on her coccyx on 8/7/14 which measured 1.0 centimeter (cm) by 1.0 cm. Review of the documentation indictaed the facility had completed measurements on a weekly basis, until the area healed on 9/23/14. R19's Resident Progress Notes dated 10/20/14, included: "Resident has chronic shearing issues on coccyx area R/T [related to] moisture, thin skin over tailbone & poor nutrition." On 10/31/14, R19's progress notes included: "She is at risk for skin breakdown.... Currently has a sm [small] open area on her coccyx - a reoccurring open area from moisture/abrasion related to when she is cleaned from her incont [incontinence] sticky BM's [bowel movements]." There were no additional notations about the open area on R19's coccyx until 11/22/14 (22 days later). The 11/22/14 progress note documentation from CNA/TMA-H [certified nursing assistant/trained	F 314		

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medication aide], included: "Weekly Skin Assessment: General skin remains CDI [clean, dry and intact]." An 11/27/14 progress note from CNA/TMA-H identified, "Resident has a dime size open area on coccyx....writer placed a Mepilex boarder [sic] 3x3 on the open area." A progress note dated 12/7/14 identified that R19 had a Mepilex boarder applied to her coccyx. A progress note dated 12/12/14, included: "Resident has an open area to her coccyx that is getting larger in size." The next progress noted dated 12/17/14, documented by CNA/TMA-H identified, "Weekly Skin Assessment: General skin remains CDI. Has open sore on coccyx that has Mipilex boarder [sic] [absorbent foam dressing] in place." Even though the facility was using the Mepilex Border product, on 11/27/14, 12/7/14 and 12/17/14, there was a physician's order, dated 10/31/2014, for Mepilex Lite or Mepilex 4x4 to coccyx as needed for protection, and "(**NO MEPILEX BORDER)".

When interviewed on 12/18/14 at 11:23 a.m., RN-A stated the resident's last skin assessment had been completed on 10/26/14 when R19 had a pressure ulcer on her coccyx. RN-A confirmed the staff had not completed weekly assessment or monitoring of the coccyx pressure ulcer to determine if it was healing or not.

The facility's Skin Care Policy, reviewed/revised 3/10, included a protocol for "Documentation on the wound progress sheet weekly." The policy directed staff to complete weekly documentation include: Drainage-amount, type, and color; Color, edema, temperature, induration and pain; size; any tunneling or undermining; specific location; stage of pressure ulcer; pain; edema; periwound skin; residents' condition and response to

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F 314	Continued From page 21 treatment.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the need for, and have medical justification for use of an indwelling Foley catheter for 1 of 2 residents (R55) whom was observed to have a catheter. Findings include: R55's quarterly Minimum Data Set (MDS), dated 10/21/14, indicated he had an indwelling catheter (a flexible tube placed into the body to remove fluid, often urine), was totally continent (able to retain urine due to the catheter), and had never been trialed on a toileting program (e.g. scheduled toileting or bladder training). During observation on 12/16/14 at 8:42 a.m., R55 was seated in a recliner chair in his room with his Foley catheter drainage bag un-covered and	F 315	Corrective Action: Resident #55 expired 12/25/2014 Documentation was obtained 12-17-2014 from NP & Diagnosis from physician on 12/16/2014 Corrective Action-Identify other residents All residents with Foley Catheters have been identified. Urologist documentation of clinical condition that catheter is necessary is in resident electronic record Corrective Action to Prevent Reoccurrence: Weekly at Clinical Team Meeting nurses will review all residents with catheters. Any resident with continued use of Foley Catheter will have medical justification for use of Foley Catheter Monitoring for Compliance:	1/8/15

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F 315	Continued From page 22 sitting on the floor to his right side. Licensed practical nurse (LPN)-C entered his room to provide medication, and picked up R55's drainage bag and clipped it to his recliner chair so it was off the floor. The resident was comfortable and had not signs or symptoms of pain. During observation on 12/17/14 at 6:56 a.m., R55 was again seated in his recliner chair, and his covered catheter drainage bag was on the floor next to his recliner chair. The resident was comfortable, with no signs and symptoms of pain. Review of R55's care plan, dated 7/31/14, indicated R55 had a indwelling catheter but did not identify a medical diagnosis for the use of the catheter. Further, the care plan indicated R55 had a history of chronic kidney disease, benign prostate hypertrophy (BPH, swelling of the prostate gland), and prostate cancer. R55's admission Bladder Assessment, dated 7/30/14, indicated he was continent of bladder (due to the use of a catheter), and had the catheter for a "terminal illness or severe impairment and movement causes intractable pain." The admission MDS dated 7/25/14 identified R55 had occasional pain, but did not interfere with his daily life, and did not have a scheduled pain medication regime. R55's most recent Bladder Assessment, dated 11/7/14, indicated he was continent of bladder, but continued to have a catheter for, "terminal illness or severe impairment and movement causes intractable pain." The assessment did not identify a medical reason for the catheter, nor any evaluation if it was still necessary. The quarterly MDS dated 10/21/14 identified R55 had	F 315	Weekly at Clinical Team meetings nurses will review all residents with Foley Catheters and audit record for medical justification for use of Foley Catheter. Audits will be brought to QA for recommendation on the need to further audit	

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F 315	Continued From page 23	F 315		

occasional pain, but this did not limit his day to day activity and was not on a scheduled pain medication regime. The assessment did not identify a medical justification for the use of the indwelling catheter for R55.

During interview on 12/16/14 at 9:50 a.m., registered nurse (RN)-B stated R55 had a history of urinary tract infections (UTI), and no attempts had been made to remove the catheter and monitor for retention.

During review of the medical record, did not identify a diagnosis to justifiy the continued use of the catheter for R55's.

When interviewed on 12/16/14 at 9:50 a.m., registered nurse (RN)-B stated R55 had the catheter since admission (July 2014). Further, RN-B was unable to identify a medical diagnosis for the catheter in the medical record.

During interview on 12/16/14 at 2:05 p.m., RN-B stated she had reviewed R55's entire medical record and identified R55 had benign prostate hypertrophy (BPH, an enlarged prostate gland) but was unable to determine why he needed an indwelling catheter. RN-B called hospice (a care entity that provides care for the severely ill) who also was unable to provide a medical diagnosis for R55's catheter use. RN-B called the Affiliated Community Medical Center (ACMC) and requested a urology progress notes for R55. R55 was seen by urology in 10/1999 but at that time he did not have a catheter and RN-B was unable to locate any information for the justification for the use of the catheter.

When interviewed on 12/17/14 at 9:01 a.m.,

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F 315	Continued From page 24 RN-B stated hospice felt R55's goals were comfort driven, however an assessment of why he had a catheter was not completed. When interviewed on 12/17/14 at 9:44 a.m., RN-B stated she had spoken to the nurse practitioner (NP) who also unsure why R55's had an indwelling catheter. The NP had reviewed R55's hospital notes and was only able to determine that he had it when seen in the hospital in June 2014. The NP had also placed a call to R55's family member to try to determine why he was catheterized. RN-B stated they were unable to find a comprehensive assessment that identified the justification for the continued use of the catheter. "I suppose that is a system breakdown." During interview on 12/18/14 at 1:40 p.m., the director of nursing (DON) stated R55 was admitted with the catheter in place, and it was left because hospice felt it was necessary. Further, any catheter should have a medical reason for use, and nursing staff should have completed an assessments to determine if they are needed, "Try to get to the root cause." A facility policy on catheter use and assessment was requested, but none was provided.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325		1/15/15

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F 325	Continued From page 25 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess nutritional needs for significant weight loss for 1 of 2 residents (R28) reviewed for nutritional needs. Findings include: R28's admission Minimum Data Set (MDS), dated 10/7/14, indicated he was admitted to the facility in July 2014, had moderate cognitive impairment, reported having a poor appetite during half or more of the days in the review period, and required set up with eating. Further, R28 had sustained weight loss. A review of R28's Vital Results identified the following weekly weights: 7/15/14 - 145.6 lbs 7/28/14 - 137.7 lbs 8/02/14 - 136.6 lbs 8/21/14 - 133.2 lbs 9/06/14 - 128.4 lbs 9/26/14 - 124.4 lbs 10/10/14 - 125.0 lbs 11/18/14 - 122.2 lbs 12/05/14 - 120.0 lbs R28 had lost 25.6 lbs, or 17.6% of his body weight, since admission to the facility.	F 325	Corrective Action: RD completed R28 Nurtitional assessment reviewing care plan and goals on 1/5/15. Res. 28 has been added to the dietary risk list for weekly review by IDT committee. Corrective action-identify other residents: RD currently reviews all residents at risk for significant weight loss as communicated by CDM at weekly IDT meeting. Weights will be reviewed twice a month at IDT meeting and RD will be consulted if significant weight loss. Corrective Action to Prevent Recurrence: Education will be provided 1/12/15 discussing expections of RD. CDM and RD will meet every 2 weeks and review risk list and nutrional approaches for further nutrional needs for residents. Weekly IDT wound documentation sheet now includes notification of RD. Monitoring for Compliance: A wound Audits tool will be completed by	

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F 325	Continued From page 26 During observation on 12/18/14, at 8:16 a.m. a breakfast meal tray consisting of a blue pitcher with water, cup of coffee, small glass of orange juice, two poached eggs and a single piece of toast was prepared in the Sophia House kitchen for R28. Nursing Assistant (NA)-D delivered the tray to R28 in his room at 8:20 a.m., and helped R28 cut up his toast and apply jelly to it. R28 stated he enjoyed breakfast, and was able to eat without staff assistance. NA-G removed R28's tray from his room at 8:48 a.m., R28 had consumed all the eggs, and 50% of toast. NA-G stated this was a typical intake for R28. Review of R28's Initial Diet Visit note, dated 7/18/14, indicated he had a fair appetite, was started on 2 Cal (an oral supplement), weighed 143 pounds (lbs), but had weighed 180 pounds five months before admission. An Initial Nutrition Summary note, dated 7/27/14, indicated R28 was to be, "Consuming 25-75% of some meals with noted poor appetite." Further, his admission weight had been 143 pounds (lbs), however, "Resident states significant weight loss over the past 4-5 months from 180# [pounds]." A Significant Change Nutrition Summary note, dated 10/8/14, indicated, "Current weight 124# - significant weight loss noted since admit with 7.5% over the past 1 month and approx. [approximately] 13% since admit..." R28's Initial Nutrition Assessment, dated 7/22/14, indicated he received a regular diet and 3 oz. (ounces) of 2 Cal three times daily, was at moderate nutritional risk, and had no chewing or swallowing problems. There were no concerns with any laboratory values, or mental functioning identified on the assessment and a plan of care would be developed. However, there were no	F 325	CDM weekly at IDT Meeting that includes notification of RD and weight loss/gain. Results will be brought to QA for recommendation on the need to further audit.	

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specific interventions identified besides the 2 Cal supplement, also there was not tracking to ensure if R28 was consuming the 2 Cal or not.

An additional Nutrition Assessment, dated 10/7/14, indicated R28 had a significant change in status and had a steady decline in weight since admission. There were no chewing or swallowing problems and he continued to leave 25% or more of food uneaten at meals. The assessment identified he was at high nutritional risk, due to his weight loss, there was no monitoring of the 2 Cal or Ensure to determine if R28 was consuming the supplements or not.

Review of the dietary notes from 7/18/14 to 12/16/14, did not identify the RD had assessed R28, to assist in developing interventions to stabilize or help reduce his weight loss even though R28 was considered at nutritional risk.

R28's care plan, dated 7/22/14, indicated he sustained a significant weight change since admission, but kept a fridge in his room to have snacks readily available. A supplement of Ensure was provided as needed (PRN), and staff would offer meal choices at every meal. R28's hospice care plan, dated 9/18/14, indicated he admitted to hospice care on 9/18/14 for a primary diagnosis of chronic obstructive pulmonary disease (COPD).

When interviewed on 12/17/14, at 12:04 p.m. R28 stated he just quit eating prior to his admission, and only eats two meals a day, breakfast and dinner but thought his appetite had been improving the past few weeks. He stated the facility registered dietician (RD) had never visited with him about his weight loss, or his dining

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F 325	Continued From page 28	F 325		

preference of only two meals a day.

During interview on 12/17/14, at 1:11 p.m. registered nurse (RN)-B stated when he (R28)first came in he wanted to die and was not eating. She was unsure what interventions were implemented for R28.

When interviewed on 12/17/14, at 1:58 p.m. the certified dietary manager (CDM) stated R28 had lost weight since admission, "Its definitely significant." R28 was provided food as he allowed or desired because he was on hospice. Further, the CDM was unsure if R28 nutritional concern had been reviewed by the RD.

When interviewed on 12/18/14, at 9:46 a.m., RN-B stated there was no record R28 had ever been seen by the facility RD, however would not comment further on his weight loss or the facility action regarding it.

During interview on 12/18/14, at 10:16 a.m., the CDM stated the RD maintains a nutritional risk list and determines who should be reviewed each month. R28 admitted to the facility in mid- July 2014 and should have been reviewed by the RD for his weight loss before being placed on hospice care in September 2014, but this was not completed.

When interviewed on 12/18/14, at 1:52 p.m. the director of nursing (DON) stated R28 had sustained, and continued to lose weight since admission, "Everybody is aware of it." R28 was admitted in July 2014 for rehabilitation, but hospice care was discussed at admission as well. His nutritional concerns should have been reviewed by the RD due to his significant weight

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F 325	Continued From page 29 loss, to see it other interventions could be implemented to stabilize his weight. During interview on 12/18/14, at 2:02 p.m. the RD stated she was not familiar with R28 or his weight loss, however verified his weight loss was substantial after reviewing his weights. RD stated she typically does not assess or visit residents on hospice care unless asked by the facility. The RD reviewed R28's weights since admission, prior to hospice care being started in September 2014, and stated she should have been consulted for his significant weight loss. Although R28 had reported weight loss prior to admission, and continued to sustain weight loss after admission, preferred to eat two meals a day, was on supplements but there was no indication of how much or if he consumed any of them. The facility had not completed a comprehensive nutritional assessment to determine what interventions could be implemented to eliminate or prevent additional weight loss. A facility Nutritional Assessment policy, dated 3/2005, indicated a purpose of assessing individual nutritional status and identifying strengths and concerns for each resident. Further, "The consulting dietician will review all nutritional assessments competed on new residents and review all reassessments on residents at potential nutritional risk. Time period is one month of the assessment or reassessment, with documentation in the medical record."	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		1/8/15

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F 371	Continued From page 30 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired frozen foods, that had potential to cause food borne illness, were properly dated when opened for resident use in 1 of 3 neighborhoods (Cushman Cottage) and 1 of 1 main production kitchens. This had potential to affect all 72 residents in the facility. Findings include: During tour of the facility kitchen with the certified dietary manager (CDM), on 12/15/14 at 12:57 p.m., a TrueFreezer brand freezer contained the following opened, undated items: 2 - One gallon containers of chocolate chip ice cream, 1 - One gallon container of chocolate marshmallow ice cream, 2 - 1/2 gallon containers of vanilla ice cream and, 1 - 1/2 gallon container of Bunny Tracks (contains chocolate fudge and peanut butter caramel) ice cream. When interviewed on 12/15/14 at 12:57 p.m., the CDM stated all food items should be dated when	F 371	Corrective Action: All unlabeled foods were dated in both neighborhoods and main production kitchen. Food storage informaiton booklet has been put in each household kitchen for homemaker reference guide. Corrective Action-identify other residents: All food that is not labeled & dated could have the potential to cause food borne illness. Corrective action to prevent recurrence: Education at all staff inservice completed on December 23, 2014 with all Homemakers regarding dating all frozen foods and properly dating food when opened. Monitor for compliance: CDM or designee will audit the kitchens throughout facility to ensure all foods have been dated. Audits will be completed 3X's week for 2 weeks then once a week for	

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(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 371	Continued From page 31 opened. During observation of the Cushman Cottage wing, on 12/15/14 at 1:32 p.m., homemaker (HM)-R had a large plastic bag in her hand, and was emptying several food items from the resident refrigerator/freezer. The plastic bag contained the following opened food items: Several white colored, Styrofoam containers which contained various food items, 1 - "JD Delights - Honey Wheat Flatbread Sandwiches", which had expired on 7/30/14, 1 - One gallon container of vanilla ice cream; and 1 - 1/2 gallon container of Bunny Tracks ice cream. When interviewed on 12/15/14 at 1:32 p.m., HM-R stated all of the food being removed from the refrigerator was un-dated, and verified the flatbread sandwiches were available for resident consumption, and had expired. Further, she stated all staff, including the nursing assistants (NA), were responsible to date foods when they are opened, and to check the resident refrigerators for expired foods. However, it had not been consistently occurring. During interview on 12/17/14 at 9:36 a.m., HM-S stated food items should be dated when opened, and the refrigerators should be checked every 3 days for un-dated and/or expired items. HM-S was not aware of a facility policy on long food items are kept for when opened, and further stated residents were at risk of becoming ill if they were to consume expired and/or old foods. When interviewed on 12/17/14 at 12:07 p.m., HM-T stated food should be dated when opened, but no formal process was in place to audit the	F 371	one month. Results will be brought to QA for recommendation on the need to further audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	12/18/2014

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F 371	Continued From page 32 refrigerators and freezers to ensure expired and un-dated foods were removed, "Its all of our responsibilities." During interview on 12/17/14 at 2:02 p.m., the CDM stated homemakers are responsible to ensure all food items in the refrigerators and freezers is labeled and dated when opened, "It's been inserviced." Further, the facility completed no auditing of the refrigerators or freezers to monitor for expired or undated foods. The residents of the facility are served ice cream typically every evening, but she was unaware how long the un-dated or expired foods had been in the freezers. A facility supplied Storage of Leftovers policy, dated 10/2013, indicated all leftover containers should be labeled and dated, and identified hazardous foods to consist of meat, fish, poultry, eggs, milk and cheese. Further, the policy indicated a reference of F377 (a federal regulation that was repealed in 2009) for a basis of procedure. When interviewed regarding the policy on 12/17/14 at 2:47 p.m., the CDM stated, "It's all I have", regarding use of a policy based from repealed regulation.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		1/8/15

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F 441	Continued From page 33 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a urinary drainage bag was kept off the floor for 1 of 1 residents (R55) reviewed for urinary catheter use. In addition, the facility failed to maintain clean technique for medication administration for 1 of 7	F 441	Corrective Action Resident # 55 expired on 12/25/2015 Communication to all nursing staff/TMA□s regarding medication preparation and administration; tablets & capsules are not	

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F 441	Continued From page 34 residents (R59) reviewed for medication administration. Findings include: URINARY CATHETER: During observation on 12/16/14 at 8:42 a.m., R55 was seated in a recliner chair in his room with his Foley catheter drainage bag un-covered and sitting on the floor to his right side. Licensed practical nurse (LPN)-C entered his room to provide medication, and stepped on the catheter drainage bag. LPN-C picked up R55's drainage bag and clipped it to his recliner chair so it was off the floor. LPN-C left R55's room and did not change or clean the drainage bag after seeing it laying on the floor. When interviewed on 12/16/14 at 8:42 a.m., LPN-C stated R55's catheter drainage bag should not be kept on the floor. During interview on 12/16/14 at 9:50 a.m., registered nurse (RN)-B stated R55 has a history of urinary tract infections (UTI), but it was not uncommon for R55's catheter drainage bag to be lying on the floor. R55 will move it around himself at times, however it should be secured and off the floor. When interviewed on 12/18/14 at 1:38 p.m., the director of nursing (DON) stated R55's catheter drainage bag, "shouldn't be on the floor." A policy on catheter care was requested, but none was provided. MEDICATION ADMINISTRATION:	F 441	to be touched directly with hands e.g., tissue/tweezers are to be used or gloves worn Corrective Action-Identify Other Residents Residents with Foley catheters are to use leg bag or cover large bag with cover and keep off floor by securing to w/c or side of bed at night. Improper medication administration can be a potential infection control risk for all resident Corrective Action To Prevent Reoccurrence Education completed on 1/7/2015 on Infection Control Policy regarding Catheter Bag Care and Medication Administration Policy Monitoring For Compliance: Random audits will be completed by DON or designee observing nurse/TMA administering medication according to medication pass guidelines & monitoring catheter bag placement to ensure they are off the floor. Audits will be completed 3X/week on random shifts for one month then 1 time a week for one month. Results will be brought to QA for recommendation on the need to further audit.	

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F 441	Continued From page 35 During observation of the meal service on 12/16/14 at 8:20 a.m., licensed practical nurse (LPN)-C was standing at a mobile computer cart preparing medication for R59. LPN-C picked up a potassium pill with her bare hands, broke the pill in half and placed it back into the med cup. LPN-C proceed to walk over to R59 to administer the medication, and was stopped by the surveyor. When interviewed on 12/16/14 at 8:20 a.m., after being stopped by the surveyor, LPN-C stated she was going to give the medication to R59 as prepared, but she should have worn gloves if she was going to touch a residents medication and did not. During interview on 12/16/14 at 9:50 a.m., registered nurse (RN)-B stated nurses should not touch medication with their bare hands before administering it. A facility Medication - Preparation and Administration policy, dated 5/1/14, indicated a purpose of ensuring correct and knowledgeable administration of medications as ordered by the physician, however did not include any direction regarding infection control and handling of medications during administration.	F 441		

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	245410	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/16/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. At the time of this survey, Rice Care Center - Building 01, was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR 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		01/09/2015

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/16/2014**

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@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. The facility was inspected as two separate buildings: Rice Care Center - Building 01, is a 1-story building with no basement that was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1995, an addition was constructed on the south side of the original building and was determined to be of Type II(111) construction. Since the original building and the 1995 addition are both Type II (111) construction they were both inspected as Building 01 under Existing Healthcare requirements. The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors, and that is monitored for automatic fire department notification. The facility is fully protected by an	K 000		

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	245410	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/16/2014**

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K 000	Continued From page 2 automatic fire sprinkler system. At the time of the inspection the facility has a capacity of 78 beds and had a census of 75. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 39 out of 78 residents. Findings include: On facility tour between 10:30 AM and 12:30 PM on 12/16/2014, observation revealed that the following was found:	K 029	Corrective Action: Open penetrations around conduite in the wall in Electrical Room 504 have been repaired. Corrective Action - Identify other residents There are no longer any open penetrations that could affect 39 out of 78 residents. Rice Care Center is now compliant with smoke-resisting partitions. Corrective Action to Prevent Recurrence: Rice Memorial Hospital conducts	1/9/15

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K 029	Continued From page 3 1. Open penetrations around several conduits and in the wall in Electrical Room 504. These deficient practices were confirmed by the facility Maintenance Director (RW) at the time of discovery.	K 029	environmental rounds to ensure building meets life safety codes. Monitor for Compliance The facility administrator will conduct building audits monthly and bring results to QA for recommendation on the need to further audit.	

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	245410	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**12/16/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Rice Care Center - Building 03, additions were found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was inspected as two separate buildings: The Rice Care Center - Building 03 consists of five separate additions that were constructed at four different times. The first addition was built in 2011, and is a 1-story addition without a basement that is located on the south side of Building - 01 and was determined to be of Type V(111) construction. The second addition was built in 2012, and is a 1-story addition without a basement that is located on the south side of the northeast wing of Building - 01 and was determined to be of Type V(111) construction. The third addition was built in 2013, and is a 1-story addition without a basement that is located on the south side of the northwest wing of Building - 01 and was determined to be of Type V(111) construction. The fourth addition to the facility consisted of two building that were both built in 2014, both additions are 1-story additions without basements that are located on the west side of Building - 01 and on the west side of the 2011 addition. It was	K 000	EPOC	

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

Electronically Signed | 01/09/2015

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	245410	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**12/16/2014**

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K 000	Continued From page 1 determined that both 2014 additions are of Type V(111) construction. Since the five additions are all constructed of Type V(111) construction, they were inspected as one building labeled as Building - 03 and to New Health Care facility standards. The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors. The facility's fire alarm system is also monitored for automatic fire department notification. The facility is fully protected by an automatic fire sprinkler system. At the time of the inspection the facility has a capacity of 78 beds and had a census of 75. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		