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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MG6Y
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **24E117**

2. STATE VENDOR OR MEDICAID NO. (L2) **836420100**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE VILLA AT OSSEO**
(L4) **501 SECOND STREET SOUTHEAST**
(L5) **OSSEO, MN** (L6) **55369**

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 **06/16/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **115** (L18)

13. Total Certified Beds **115** (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
		115		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE: Robert Rexeisen, DSFM — Date: 06/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL: Kate JohnsTon, Enforcement Specialist — Date: 1/16/2015 (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 **01/01/1975** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/27/2014** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Page 2
Provider Number: 24-E117
Item 16 Continuation for CMS-1539

A standard survey was completed at The Villa of Osseo (24-E117) March 27, 2014 with a S/S = F. A post certification revisit (PCR) was completed May 19, 2014 and we reissued K025 with a S/S = F.

Second PCR to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 06/16/2014, the facility is certified for 115 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

June 27, 2014

Mr. Thomas Paul, Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, Minnesota 55369

RE: Project Number SE117023

Dear Mr. Paul:

On May 22, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 27, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on March 27, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on May 12, 2014. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 16, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on May 12, 2014, as of June 16, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 1, 2011. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 27, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 27, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 27, 2014, is to be rescinded.

In our letter of , we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 27, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 16, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of Minnesotans

Medicaid Provider # 24E117

January 16, 2015

Mr. Thomas Paul, Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, Minnesota 55369

Dear Mr. Paul:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective June 16, 2014 the above facility is certified for or recommended for:

115 Nursing Facility II Beds

Your facility's Medicaid approved area consists of all 115 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 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
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E117	A. Building B. Wing **01 - MAIN BUILDING 01**	6/16/2014

Name of Facility	Street Address, City, State, Zip Code
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

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 K0025	Correction Completed **06/16/2014**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	06/27/2014	28120	06/16/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/28/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MG6Y
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **24E117**

2. STATE VENDOR OR MEDICAID NO. (L2) **836420100**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE VILLA AT OSSEO**
(L4) **501 SECOND STREET SOUTHEAST**
(L5) **OSSEO, MN** (L6) **55369**

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 **5/12/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **115** (L18)

13. Total Certified Beds **115** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		115		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, Unit Supervisor 05/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 06/04//2014 (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 **01/01/1975** (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. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/27/2014** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Page 2
Provider Number: 24-E117
Item 16 Continuation for CMS-1539

A standard survey was completed at The Villa of Osseo (24-E117) March 27, 2014 with a S/S = F. The Department of Health completed a post certification revisit (PCR) May 12, 2014, findings indicate all tags corrected. The Department of Public Safety completed a (PCR) May 5, 2014, reissuing the following uncorrected deficiency with a S/S = F.

- 0025-Life Safety Code Standard-Nfpa 101 Bld: 01

As a result of this revisit, we recommend CMS impose Mandatory DOPNA effective June 27, 2014. If Mandatory DOPNA goes into effect, the facility would be subject to a loss of NATCEP for a two year period beginning June 27, 2014. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0358

Mr. Thomas Paul, Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, Minnesota 55369

RE: Project Number SE117023

Dear Mr. Paul:

On April 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 27, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 12, 2014, the Minnesota Department of Health and on May 19, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 27, 2014. The deficiency(ies) not corrected is/are as follows:

0025-Life Safety Code Standard-Nfpa 101 Bld: 01

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) , whereby corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 27, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 27, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 27, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Villa At Osseo is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 27, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Lyla Burkman , Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601

Telephone: (218)308-2104
Fax: (218)308-2122

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility 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 allegation of compliance and/or 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 27, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions about this letter.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E117	A. Building B. Wing	5/12/2014

Name of Facility	Street Address, City, State, Zip Code
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

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 F0151 Reg. # 483.10(a)(1)&(2) LSC	05/02/2014	ID Prefix F0167 Reg. # 483.10(g)(1) LSC	03/27/2014	ID Prefix F0226 Reg. # 483.13(c) LSC	04/01/2014
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	05/01/2014	ID Prefix F0309 Reg. # 483.25 LSC	05/01/2014	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	05/01/2014
ID Prefix F0327 Reg. # 483.25(j) LSC	05/01/2014	ID Prefix F0364 Reg. # 483.35(d)(1)-(2) LSC	05/01/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	05/01/2014
ID Prefix F0412 Reg. # 483.55(b) LSC	05/01/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	05/01/2014	ID Prefix F0492 Reg. # 483.75(b) LSC	05/01/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/KJ	5/30/2014	28035	5/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/27/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	R 05/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS FIRE SAFETY This Statement of Deficiencies Form is for UNCORRECTED deficiencies form the Survey of March 28, 2014. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, The Villa at Osseo was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division	{K 000}	POC ok 5-29-14 Comp DATE 6/13/14 RECEIVED MAY 29 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas [signature] | TITLE: Administrator | (X6) DATE: 5-29-14

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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
	24E117	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	R 05/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

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{K 000}	Continued From page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email 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. This 2-story building is downgraded from construction Type II (222) to Type V (111) due to wood joist and plywood floors in some of the linen closets. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 115 beds and had a census of 93 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	{K 000}		
{K 025} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are	{K 025}	Bids for construction have been recived and a contract has been awarded with construction	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E117	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	(X3) DATE SURVEY COMPLETED R 05/19/2014

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{K 025}	Continued From page 2 protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3. The deficient practice could affect the residents. Findings include: On facility tour between 9:15 AM and 10:45 PM on 03/28/2014, observation revealed that: 1. The second floor smoke barrier terminates at the monolithic ceiling at does not extend to the roof deck from exterior wall to exterior wall, 2. The first floor smoke barrier has penetrations above the ceiling that is not properly firestopped. These deficient practices were verified by the Maintenance Director at the time of the inspection. During the Post Certification Revisit on 05/19/2014 at 12:45 PM, a telephone interview with the facility administrator revealed that the second floor smoke barrier as identified in K25, Item 1 has not been corrected. K25, Item 2 is shown as corrected on 04/16/2014 per the facility Plan of Correction.	{K 025}	scheduled to be started on June 4th and completed by June 13th. (see attached)	

Thomas ... Paul 5-29-14

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

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Malkerson, Inc.

7951 Regent Avenue N
Brooklyn Park, MN 55443

Estimate

Date	Estimate #
5/26/2014	7

Name / Address
The Villa at Osseo

Terms	Project	Other

Description	Qty	Rate	Total
Provide dust barrier, mask and poly work area. Demo plaster ceiling to gain access to fire wall. Frame, sheetrock, fire tape, fire caulk area to roof deck. Supply, install, tape, coat, texture ceiling where demo was needed	1	3,200.00	3,200.00
		Total	$3,200.00

Malkerson, Inc. to provide Clean Up.

Waste Receptacle provided for Malkerson, Inc.

E-mail
abby@malkerson-inc.com

OK
5-28-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MG6Y
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **24E117**

2. STATE VENDOR OR MEDICAID NO. (L2) **354043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE VILLA AT OSSEO**
(L4) **501 SECOND STREET SOUTHEAST**
(L5) **OSSEO, MN** (L6) **55369**

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 **04/03/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **115** (L18)

13. Total Certified Beds **115** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		115		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, HFE NE II 5/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/22/2014 (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 **01/01/1975** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Page 2
Provider Number: 24-E117
Item 16 Continuation for CMS-1539

At the time of the standard survey completed 3/27/2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5106

April 16, 2014

Mr. Thomas Paul, Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, Minnesota 55369

RE: Project Number SE117023, Complaints Numbered HE117026 and HE117027

Dear Mr. Paul:

On March 27, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 27, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint numbers HE117026 and HE117027 which were found to be unsubstantiated.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

<u>Informal Dispute Resolution</u> - 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:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218)308-2104
Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 7, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 7, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 27, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 27, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

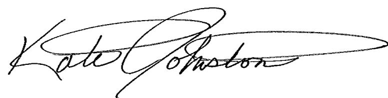
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



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

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

RECEIVED
APR 24 2014
Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ___ B. WING ___	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. " A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey. " An investigation of complaints HE117026 and HE117027 were completed. The complaints were not substantiated.	F 000	The Villa at Osseo objects to and disagrees with both the findings of non-compliance and the level of the deficiency citied. Submission of the Credible Allegations of Compliance is not a legal admission that the deficiency exists or that the Statements of Deficiency were correctly cited. It is also not to be construed as an admission against the interests of the Facility, its Administrator or any employees, agents or other individuals who may be discussed in the Credible Allegation of Compliance.	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to allow 1 of 3 residents (R16) reviewed for choices the right to make informed decisions about their care and safety by	F 151	Approved c Addendum 4/29/14 SB	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4-22-14

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

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F 151	Continued From page 1 restricting access to their personal bathroom. Findings include: R16's face sheet dated 3/27/14, indicated R16's diagnoses included diabetes, unspecified hemiplegia, paranoid schizophrenia and senile dementia. R16's quarterly Minimum Data Set (MDS), dated 02/06/14, indicated R16 had intact cognition with no delusions, hallucinations or rejection of care. R16's most current Falls Care Area Assessment (CAA), dated 11/20/13, revealed R16 required extensive assistance with toileting and had hemiparesis (weakness on one side of the body) on the left side due to infantile cerebral palsy. The CAA indicated R16 did not always wait for or ask for assistance from staff, desired to be more independent and sometimes did not understand the importance of the assistance. Additional risk factors for falls identified on the CAA included cerebral palsy, loss of arm or leg movement, incontinence, hemiplegia/hemiparesis, seizure disorder, impulsivity or poor safety awareness, cognitive impairment, other dementia and schizophrenia. Care planning considerations included was at risk for falls and observation/interventions needed to keep him safe, referral was indicated possibly to therapy. R16's most current fall assessment, dated 2/6/14 revealed R16 was at a moderate risk of falls due to the use of a diuretic and psychotropic medications, poor judgement, multiple falls due to not wanting to accept his limitations, when sitting holds head down.	F 151	The following measures have been taken to assure that this alleged deficient practice does not recur: Resident R16 has been assessed by nursing and screened by PT/OT on 3/31 /2014. He will continue to work with therapy and nursing to provide safe transfers and foster independence. The residents guardian was notified on 4-21-2014 in regards to having the door unlocked and she agreed to allow us to try this again. A wheel chair alarm will be placed on his wheel chair so when resident attempts to get up to go to the bathroom staff will be alerted to assist. The DON and PT/OT designated staff embers will monitor continued compliance by reviewing the clinical record for this resident. Noted problems will be immediately corrected and identified. Resident will be assessed quarterly, if a significant change occurs and annually	4/30/14

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F 151	Continued From page 2	F 151		

During interview on 3/24/14, at 2:03 p.m. R16 stated he was not treated in a dignified manner by the staff. R16 said their bathroom door was locked, and it was hard for him to wait to use the restroom. A sign, dated 7/09/13, was observed posted on R16's bathroom door and closet indicated the bathroom needed to be locked at all times. Observation of the bathroom door at this time revealed it was locked, not able to be opened without a key. R16 stated "It scares me." R16 was observed to have a sensor alarm in the wheelchair.

During further interview on 3/26/14, at 11:18 a.m., R16 stated locking the bathroom door made him feel the staff were playing "mind games with me and not using good psychology." R16 thought this had been going on for about "seven months or so, so that I don't fall." R16 said the locking of the bathroom door was hurtful to his pride.

During interview on 3/26/14, at approximately 2:00 p.m., nursing assistant (NA)-B stated staff have been locking R16's bathroom door for quite a while and she had worked at the facility about a year and a half. She confirmed R16 did not like this and stated it hurt his feelings "all the time, he (R16) complains about it to everyone." NA-B said all the aides and everyone working on R16's unit had a key to the bathroom.

On 3/26/14, at 4:35 p.m. R16 was assisted to the bathroom by NA-A. NA-A was observed to use a key to unlock R16's bathroom door prior to wheeling him in.

During interview on 3/26/14, at 4:44 p.m., NA-A stated R16 felt being locked out of the bathroom

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F 151	Continued From page 3	F 151		

was a "punishment, he states it all the time." NA-A stated she had worked on the facility for about a year. She further added, R16 was usually continent of bowel and bladder, and refused a scheduled toileting plan. NA-A stated R16 knew when he needed to use the restroom and did not like being told when to go. NA-A did not feel R16 could use a urinal independently for voiding as an alternative to the toilet.

Observation on 3/26/14, at 5:50 p.m. revealed R16 had his light on, which was answered by NA-A. R16 was very upset and was hollering at NA-A as he wanted to get into the bathroom right away.

During interview on 3/26/14, at 5:48 p.m. licensed practical nurse (LPN)-A confirmed R16's bathroom was locked so R16 would not attempt to bring himself to the bathroom and fall. LPN-A stated she had worked at the facility for many years, since prior to R16's admission and was very familiar with R16. LPN-A thought R16 was talked to about the reasons for the bathroom door being locked, however R16 wanted to be independent. LPN-A also thought the family had been informed of the door being locked.

Observation on 3/26/14, at 7:24 p.m. revealed NA-A assisted R16 to the bathroom. R16 was able to assist to cleanse himself, could partially pull up his pants, was able to walk with non-weight bearing assistance (hand on him to steady) from NA-A and was able to walk to the sink to wash his hands.

During interview on 3/27/14, at 10:03 a.m., the director of nursing (DON) stated R16 had several interventions attempted to reduce his fall risk

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F 151		F 151		

Continued From page 4

prior to their bathroom door being locked to prevent independent access. The DON also stated R16 had difficulty with toileting because he had weakness on one side of the body and based on therapy recommendations R16 was unsafe to go into the bathroom alone. The DON added, sometimes R16 had good days with relation to balance and was worse at other times. The DON confirmed the bathroom door was being locked to prevent R16 from trying to toilet himself. The DON stated she believed therapies (physical and occupational therapy) had talked to R16 and directed the surveyor to the falls care plan for further information. The DON confirmed R16 was usually continent of bladder and had not had any declines in continence as a result of locking the bathroom door. The DON stated she did not feel R16 had appropriate safety awareness and added R16's acceptance of the door being locked was "O.K. if you don't bring it up." The DON stated she did not feel the locked bathroom door was an issue. The surveyor staff asked for documentation of a discussion of the risk/benefits of self-transfers with R16 and their responsible party as one could not be located at this time. The DON thought something might have been documented by therapy and would check on this information.

Surveyor staff attempted to contact R16's family member (FM)-A who was R16's responsible party on 3/26/14, at 7:12 p.m. and on 3/27/14, at 9:10 a.m., with no return phone call during the survey.

During interview on 3/27/14, at 11:10 a.m. the social worker (SW)-A stated R16 had no recent declines in his mood or behavior and was usually a "mellow guy".

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F 151	Continued From page 5 During interview on 3/27/14, at 11:18 a.m. LPN-B stated R16 did not like his bathroom being locked, he complained about this "a lot." During interview on 3/27/14, at 11:45 a.m. R16 stated locking the bathroom door had "ruined my life." During interview on 3/27/14, at 1:39 p.m. physical therapy assistant (PTA)-C confirmed she had worked for the facility for eight years and was familiar with R16. PTA-C indicated locking a bathroom door would not be a decision therapy would make, they would never decide that. She stated R16 had been independent with toileting when he first came to the facility but now has difficulty with clothing management as well as gait and balance. PTA-C said R16 had difficulty with waiting sometimes, that was the hardest part of having the bathroom door locked for him. Review of R16's therapy documentation included: A physical therapy (PT) Therapist Progress & Discharge Summary, dated 9/4/13, revealed R16 was seen for difficulty in walking from 7/4/13, through 08/30/13. The discharge summary stated R16 required verbal cues and physical assistance for safe transfers, ambulation, and was a fall risk. An occupational therapy (OT) Therapist Progress & Discharge Summary, dated 09/13/13, revealed R16 had been seen for muscle weakness from 7/1/13, through 09/11/13. The physical therapy discharge information related to current toileting needs at the time revealed R16 was able to perform toileting tasks with stand-by assistance, however, at times needed help to cleanse himself	F 151		

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F 151	Continued From page 6 and was having increased difficulty using his left hand to help with tasks. Review of R16's most recent care conference notes included: A care conference note, dated 11/27/13, revealed a care conference was held with R16's sister. No mention of the locked bathroom door was referenced in the care conference notes. A care conference summary, date 2/13/14, revealed R16 had good cognition and reported no mood issues. R16's care plan for fall risk/accidents, dated 5/15/08, indicated due to (d/t) multiple falls with wheelchair (w/c), on 7/19/13, alarms put on w/c, and bathroom door kept locked at all times to reduce fall [sic], worked with PT and in agreement he is not safe to be up on his own going to the bathroom. Although the facility had implemented sensor alarms in the wheelchair on 7/19/13, the concurrent decision was made to lock R16 out of his bathroom. This eliminated the opportunity to evaluate whether the alarms in the wheelchair or increased supervision of the resident would have been effective to reduce the accident risk. No further fall incidents were recorded after 7/18/13. R16's bathroom door remained locked. R16's clinical record lacked written evidence of a discussion with R16 informing him of the risks of self transfers, or the planned intervention of locking the bathroom door prior to this being initiated. The clinical record lacked documentation of R16's feelings about this intervention, or that this intervention was agreed	F 151		

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F 151	Continued From page 7 to by R16's responsible party. On 3/27/14, at approximately 4:30 p.m., the DON was again asked to verify if documentation could be located in R16's clinical record related to education of R16 about risks of self-transfers, or family involvement in making the decision to lock his bathroom door. At approximately 5:30 p.m., a copy of the PT - Therapist Progress & Discharge Summary dated 09/14/13, was provided. This document did not include any recommendations to lock R16's bathroom, nor did it reflect a discussion with R16 regarding the risks of self-transfers to the bathroom. No documentation was given to survey staff demonstrating R16 or FM-A's involvement in deciding to lock his bathroom door.	F 151		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most	F 167		

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F 167	Continued From page 8 recent Federal and State survey results and plan of correction were posted and readily available. This had the potential to affect all 93 residents residing in the facility, family and visitors. During the initial tour of the facility on 3/24/14, at 7:10 a.m., a folder identified as having the state survey results was observed to be in a glass case near the front doors of the main entrance. Upon inspection of the papers inside the folder, it was discovered that the survey results were from the 2011, survey and not the most recent 2012, survey. During interview on 2/24/14, at 2:07 p.m., the director of nursing (DON) reviewed the paperwork within the folder and confirmed the documents were not from the most recent survey. DON indicated the administrator was responsible for ensuring the most recent survey results were posted. During interview on 2/24/14, at 2:10 p.m., administrator reviewed the documents and also confirmed they were from two surveys ago which was in 2011. Administrator stated he thought he had just reviewed the documents in the folder which were from the most recent survey and wasn't sure why the most recent survey results were now not available. Administrator also confirmed the facility did not keep multiple years' worth of survey results within that folder. A policy regarding the survey posting was requested, however the administrator indicated there was no such policy, rather, the facility just followed what the regulation required.	F 167	The following measures have been taken to assure that this alleged deficient practice does not recur: Copies of the last survey results were immediately replace on 3/24/2014. A copy of the most current MHD survey was placed in the file 4-21/2014 The Administrator or his assigned designee will monitor daily to ensure continued compliance.	3/24/14
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		

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F 226 SS=E	Continued From page 9 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to perform reference checks on 4 of 5 (LPN-C, NA-D, SW-B, NA-E) new employees. Findings include: Licensed practical nurse (LPN)-C was hired on 12/17/13. The employee file failed to include documentation of reference checks being performed prior to employment. Nursing assistant (NA)-D was hired on 1/28/14. The employee file failed to include documentation of reference checks being performed prior to employment. Social worker (SW)-B was hired on 12/17/13. The employee file failed to include documentation of reference checks being performed prior to employment. NA-E was hired on 11/5/13. The employee file failed to include documentation of reference checks being performed prior to employment. When interviewed on 3/27/14, at 3:01 p.m. the director of nursing (DON) indicated the process for hiring included calling references. She	F 226	The following measures have been taken to assure that this alleged deficient practice does not recur: All new Employees identified will have reference checks done by the appropriate dept. supervisors with the proper form filed in the personnel file. The Administrator and DON or their assigned designee will monitor continued compliance by reviewing employee records upon hire and annually for continued compliance. Noted problems will be immediately corrected and identified patterns or trends of non compliance will be brought to the QI committee for further corrective action	4/1/2014

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F 226	Continued From page 10 indicated she would put a note on the employment application while doing this. However, she was unable to provide documentation that references had been checked for LPN-C, NA-D, or NA-E. When interviewed on 3/27/14, at 3:15 p.m. the Administrator indicated he would call a current reference during the hiring process. He was unable to provide documentation a reference had been checked for SW-B. The facility's Policy and Procedure for Vulnerable Adult Report to the Minnesota Department of Health updated 1/2013, noted "Before new employees are permitted to work with residents, all references provided by the prospective employee must be checked and verbal responses received."	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility 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 interview and document review, the facility failed to implement the care plan for dialysis site access care for 1 of 1 resident (R6) reviewed for dialysis services, failed to encourage adequate fluid intake for 1 of 3 residents (R110) reviewed for hydration, and failed to assist 1 of 3 (R16) residents reviewed for activities of daily living with nail care as directed by the care plan.	F 282		

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
	24E117	A. BUILDING ____ B. WING ____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11 Findings include: R6 received dialysis three times a week at an outside facility. Review of R6's current signed physician orders dated 3/7/14, revealed an order for staff to monitor R6's dialysis fistula for bleeding. R6's care plan dated 11/15/13, identified R6 required hemodialysis related to renal failure. The interventions listed included to check and change dressing daily at the access site; document, and to monitor/document/report and signs and symptoms of infection to access site including swelling, warmth, or drainage. Review of R6's treatment administration record (TAR) for the months of 1/13, 2/13, and 3/13, revealed a treatment order to monitor dialysis fistula for bleeding. No documentation was on the TAR to indicate this task had been completed. Documentation was also not found to show staff were monitoring R6's dialysis access site for signs of infection or palpating the site for a thrill or listening for a bruit. During interview on 3/26/14, at 11:45 a.m., R6 stated staff at the facility never monitored R6's dialysis access site in any way after she returned. R6 described that she would leave the bandage on the site until the evening and then remove it herself and wash up prior to going to bed. During interview on 3/26/14, at 2:06 p.m., licensed practical nurse (LPN)-C stated she would look at R6's bandage when she returned from dialysis to see if it was bleeding or not, but that was all she did. LPN-C also confirmed she	F 282	The following measures have been taken to assure that this alleged deficient practice does not recur: 3/26/2014 TAR updated to include monitoring site for bleeding/infection and thrill/bruit monitoring. The care plan was updated to include site review. Corrective actions are evaluated for effectiveness through the QA program. The DON and or her designee will continue weekly contact with the dialysis to monitor the resident care and further updates or orders that enhance the residents overall health via referral.	5/1/2014

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did not document this observation at any time.

During interview on 3/26/14, at 4:26 p.m., the director of nursing (DON) stated the nurses were to be checking R6's site for bleeding, and also palpating the site for the thrill when R6 returned from dialysis. DON indicated these checks should be documented on the TAR. DON reviewed R6's 3/14, TAR and confirmed there was no documentation which indicated the nurses were completing any of the necessary clinical assessments of R6's dialysis access site. The DON stated no extra training was currently being offered to staff regarding dialysis residents and they should all be aware of the current standards of practice because they were taught that in school.

During interview on 3/27/14, at 9:10 a.m., LPN-D stated her biggest concern when R6 returned from dialysis was to check her blood sugar and offered no other information about any clinical monitoring needed.

During follow up interview on 3/27/14, at 9:36 a.m., R6 stated the nurse who had worked the evening shift on 3/26/14, had come in and fully assessed her dialysis access site. R6 stated the nurse helped to remove the bandages and listened to the site with a stethoscope. R6 confirmed this was the first time it had occurred since her admission to the facility.

R110 was not offered adequate fluid intake between meals to prevent potential dehydration as directed by the care plan.

On 3/24/14, at 11:45 a.m., R110 was observed to

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F 282	Continued From page 13 a have a dry, cracked lower lip and dry mucous membranes to the mouth. R110's admission Minimum Data Set (MDS) Cognitive Loss/Dementia Care Area Assessment (CAA) dated 3/16/14, identified R110 was severely cognitively impaired and had a diagnosis of dementia. The Nutritional Status CAA further identified R110 was independent to extensive assistance required with eating and accepted assistance with eating when needed. R110's hydration care plan dated 3/13/14, identified R110 had a potential for fluid deficit related to need for occasional extensive assist with eating. Interventions listed included observe for any signs and symptoms of dehydration such as cracked lips, furrowed tongue and directed staff to provide fluids between meals by encouraging adequate intake and assisting resident with consuming fluids as needed. The comprehensive nutritional assessment dated 3/13/14, identified R110 required independent-extensive assist with feeding, skin was intact with good turgor, had a vision impairment and had an estimated fluid need of 1430 milliliters (mL)'s per day. An observation was made of a pink water pitcher on the bedside stand next to R110's bed on 3/26/14 at 11:04 a.m. The pitcher was cool to the touch and full of ice water. At the top of the pitcher, a straw was sticking out through the opening and the straw had about 2 inches of the paper wrapper in place at the end. Follow up observations made throughout 3/26/14, showed the pitcher remained full and the wrapper on the straw was still in place.	F 282		

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On 3/27/14, at 9:57 a.m., observation was again made of the water pitcher on R110's bedside stand. It was cool to the touch and full of ice water. The tip of the straw again had a couple of inches of the paper wrapper still on the end. Follow up observations made throughout the day at 10:30 a.m. and 3:19 p.m. revealed the water pitcher remained full and the straw wrapper was still in place.

During observation on 3/26/14, at 1:12 p.m., R110 was seated in the dining room and was being totally fed both food and fluids.
During interview on 3/27/14, at 3:19 p.m., licensed practical nurse (LPN)-B indicated the water pitcher pass was completed after breakfast that morning.

During interview on 3/27/14, at 4:08 p.m., registered dietician (RD) indicated she had completed a nutritional assessment when R110 was admitted to the facility and estimated his fluid needs to be about 1410 mL's per day. RD estimated that after meal intake of 240 mL's per meal, an additional 690 mL's would be needed through medication passes and snacks. When asked how she was monitoring to be sure R110 was getting the required amount of fluids, RD stated she normally would visit with the staff and they would tell her how much the resident was drinking although she hadn't yet completed this task for R110 since admission. RD stated her initial assessment identified R110 needed encouragement to drink the fluids in his room.

During interview on 3/27/14, at 4:20 p.m., trained medication aide (TMA)-B confirmed giving R110 a glass of water with one medication pass on the

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evening shift which would amount to 120 mL's. TMA-B further stated the water pitchers were filled by the day shift and there was no monitoring of how much R110 drank from the water pitcher.

During interview on 3/27/14, at 4:31 p.m., the director of nursing (DON) stated her expectation was that staff were to be offering fluids to all residents and she would expect the nurses to follow up to make sure residents were drinking enough fluids.

During interview on 3/27/14, at 4:35 p.m., LPN-C stated she thought R110 drank well and was able to drink out of the water pitcher independently.

During interview on 3/27/14, at 4:37 p.m., nursing assistant (NAR)-G indicated the water pitchers were filled once a day during the day shift. NAR confirmed always working the evening shift and that the water pass was always done on the day shift and not again on the evening shift.

R16 was not assisted to trim his fingernails as directed by the care plan.

R16's most recent quarterly minimum data set (MDS) dated 2/6/14, indicated R16 had intact cognition and required extensive assistance of one staff person for grooming, and identified no rejection of cares from staff.

R16's current diagnoses, according to his face sheet dated 3/27/14, revealed hemiplegia unspecified (paralysis of one side of the body) and type II diabetes.

R16's care plan for bathing, dated 5/2/08, identified he required extensive assistance of one

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F 282	Continued From page 16 staff for bathing and that staff should assist R16 to trim fingernails and toenails with the bath, podiatry visit as needed. R16's nursing progress notes, dated 3/21/14, revealed R16 had a bath on 3/21/14. There were no comments regarding refusal of any bathing activities or information about whether nail care was completed in the progress note. During interview on 3/24/14, at 2:11 p.m., R16 was observed with long fingernails, approximately 3/4" long. A brownish debris was noted underneath the nails. R16 said "they should" help him with his nails. R16 began to profusely apologize for the condition of his fingernails, stating "Oh, I'm sorry, those look kind of bad." During interview on 3/26/14, at 11:15 a.m. R16's nails were observed trimmed and free of debris. R16 stated someone came to trim his nails, he asked them to do so because they were long. During interview on 3/27/14, at 9:49 a.m. nursing assistant (NA)-C and licensed practical nurse (LPN)-B stated nails should be trimmed on the resident's bath day. Nail trimming should be charted in the electronic progress notes, or if a resident refuses this should be charted in the notes. R16's bath was on Friday mornings and his nails should have been trimmed on his last bath day, 3/21/14. During interview on 3/27/14, at 9:59 a.m. the DON said the facility policy was to trim nails to a length that is acceptable for the resident, and make sure they are clean. Refusals should be care planned or charted. If a resident refused nail trimming, the expectation would be to reapproach	F 282		

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F 282	Continued From page 17 or get someone else to assist. Nail trimming was typically done on bath days. The facility policy, entitled Policy and Procedure for Cleaning and use of Resident Nail Care Equipment, dated 6/29/11, did not provide guidance as to how often nails should be trimmed or the procedure if a resident refused. Review of the facility policy, Using the Care Plan, revised 8/08, revealed documentation in the clinical records must be consistent with the resident's care plan and MDS.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor a dialysis access site for 1 of 1 resident (R6) who received dialysis at an outside facility. Findings include: R6's admission Minimum Data Set (MDS) dated 11/15/13, identified R6 was cognitively intact and had diagnoses of diabetes mellitus, congestive heart failure, hypertension, and end stage renal	F 309		

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F 309	Continued From page 18 disease. The MDS also identified R6 received dialysis treatment. R6 received dialysis three times a week at an outside facility. Review of R6's current signed physician orders dated 3/7/14, revealed an order for staff to monitor R6's dialysis fistula for bleeding. R6's care plan dated 11/15/13, identified R6 required hemodialysis related to renal failure. The interventions listed included to check and change dressing daily at the access site; document, and to monitor/document/report and signs and symptoms of infection to access site including swelling, warmth or drainage. Review of R6's treatment administration record (TAR) for the months of 1/13, 2/13, and 3/13, revealed a treatment order to monitor dialysis fistula for bleeding. No documentation was on the TAR to indicate this task had been completed. Documentation was also not found to show staff were monitoring R6's dialysis access site for signs of infection or listening for a bruit or palpating the site for a thrill. During interview on 3/26/14, at 11:45 a.m., R6 stated the staff at the facility never monitored her dialysis access site in any way after she returned. R6 described that she would leave the bandage on the site until the evening and then remove it herself and wash up prior to going to bed. During interview on 3/26/14, at 2:06 p.m., licensed practical nurse (LPN)-C stated she would look at R6's bandage when she returned from dialysis to see if it was bleeding or not, but that was all she did. LPN-C also confirmed she	F 309	The following measures have been taken to assure that this alleged deficient practice does not recur: 3/26/2014 TAR updated to include monitoring site for bleeding/infection and thrill/bruit monitoring. The care plan was updated to include site review. Corrective actions are evaluated for effectiveness through the QA program. The DON and or her designee will continue weekly contact with the dialysis to monitor the resident care and further updates or orders that enhance the residents overall health via referral.	5/1/2014

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F 309	Continued From page 19	F 309		

did not document this observation at any time.

During interview on 3/26/14, at 4:26 p.m., the director of nursing (DON) stated the nurses were to check R6's site for bleeding and also palpating the site for the thrill when R6 returned from dialysis. The DON indicated these checks should be documented on the TAR. The DON reviewed R6's 3/14, TAR and confirmed there was no documentation which indicated the nurses were completing any of the necessary clinical assessments of R6's dialysis access site. The DON stated no extra training was currently being offered to staff regarding dialysis residents and that they should all be aware of the current standards of practice because they were taught about that in school.

During interview on 3/27/14, at 9:10 a.m., LPN-D stated her biggest concern when R6 returned from dialysis was to check the blood sugar and offered no other information about any clinical monitoring needed.

During follow up interview on 3/27/14, at 9:36 a.m., R6 revealed the nurse who had worked the evening shift on 3/26/14, had come in and fully assessed her dialysis access site. R6 stated the nurse helped to remove the bandages and listened to the site with a stethoscope. R6 confirmed this was the first time it had occurred since her admission to the facility.

Review of the facility Dialysis (Program Guidelines) last updated 5/10, revealed nursing management included assessing internal accesses post dialysis therapy for:

a) Infection (assess daily)
b) Patency by feeling the site for a thrill,

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F 309	Continued From page 20 listening with a stethoscope for a bruit (daily) c) Dressing-remove gauze four hours after discharge from dialysis	F 309		
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 assist 2 of 3 residents (R16, R85) reviewed for activities of daily living who were dependent on staff for grooming with nail care. Findings include: R16's most recent quarterly Minimum Data Set (MDS) dated 2/6/14, indicated R16 had intact cognition and required extensive assistance of one staff person for grooming, and identified no rejection of cares from staff. R16's current diagnoses, according to his face sheet dated 3/27/14, revealed hemiplegia unspecified (paralysis of one side of the body) and type II diabetes. R16's care plan for bathing, dated 5/2/08, identified he required extensive assistance of one staff for bathing and that staff should assist R16 to trim fingernails and toenails with the bath,	F 312	The following measures have been taken to assure that this alleged deficient practice does not recur: The care plan for R16 and R85 have been updated to reflect nail care assistance as directed. NA/R's were in-serviced on 4/30/2014 on providing nail care as part of the resident plan of care. Staff NA/R's licensed nurses have been in-serviced by the DON on 4/30/2014 on importance of offering nail care and documenting resident compliance/noncompliance. Residents will have nail care during scheduled shower days. Noted problems will be immediately corrected and identified patterns/trends of non compliance will be brought to the QI committee for further corrective action.	5/1/2014

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F 312	Continued From page 21 podiatry visit as needed. R16's nursing progress notes, dated 3/21/14, revealed R16 had a bath on 3/21/14. There were no comments regarding refusal of any bathing activities or information about whether nail care was completed in the progress note. During interview on 3/24/14, at 2:11 p.m., R16 was observed with long fingernails, approximately 3/4 inch long. A brownish debris was observed underneath the nails. R16 said "they should" help him with his nails. R16 began to profusely apologize for the condition of his fingernails, stating "Oh, I'm sorry, those look kind of bad." During interview on 3/26/14, at 11:15 a.m. R16's nails were observed trimmed and free of debris. R16 stated someone came to trim his nails, he asked them to do so because they were long. During interview on 3/27/14, at 9:49 a.m. nursing assistant (NA)-C and licensed practical nurse (LPN)-B stated nails should be trimmed on the resident's bath day. Nail trimming should be charted in the electronic progress notes, or if a resident refuses this should be charted in the notes. R16's bath was on Friday mornings and his nails should have been trimmed on his last bath day, 3/21/14. During interview on 3/27/14, at 9:59 a.m. the DON said the facility policy was to trim nails to a length that is acceptable for the resident, and make sure they are clean. Refusals should be care planned or charted. If a resident refused nail trimming, the expectation would be to reapproach or get someone else to assist. Nail trimming was typically done on bath days.	F 312		

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F 312	Continued From page 22	F 312		
	R85's toe nails were approximately 1/4 inch in length. R85's diagnosis included Alzheimer's disease. R85's quarterly MDS dated 1/23/14, indicated R85 had severe cognitive impairment and required the assistance of one staff for personal hygiene. R85's care plan dated 1/31/2014, directed staff to trim finger nails and toe nails as needed. An observation on 3/27/14, at 3:10 p.m. of R85's toe nails revealed they were approximately ¼ inch in length on both feet. Progress notes dated 8/1/2013, through 3/13/2014, lacked documentation that nursing staff had attempted to trim R85's toe nails on any day. An interview on 3/27/14, at 4:03 p.m. licensed practical nurse (LPN)-C revealed she had never trimmed R85's toe nails. LPN-C verified R85's toe nails were approximately 1/4 inch in length on both feet. LPN-C stated toe nails and finger nails were trimmed every shower day if the resident was not a diabetic then the registered nurse (RN) would trim their nails. The facility policy, entitled Policy and Procedure for Cleaning and use of Resident Nail Care Equipment, dated 6/29/11, did not provide guidance as to how often nails should be trimmed or the procedure if a resident refused.			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		

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F 327	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R110) was offered adequate fluids between meals to meet the resident's assessed minimum daily needs and to prevent potential dehydration. Findings include: On 3/24/14, at 11:45 a.m., R110 was observed to have a dry, cracked lower lip and dry mucous membranes to the mouth. R110's admission Minimum Data Set (MDS) Cognitive Loss/Dementia Care Area Assessment (CAA) dated 3/16/14, identified R110 was severely cognitively impaired and had a diagnosis of dementia. The Nutritional Status CAA further identified R110 was independent to extensive assist with eating and accepted assistance with eating when needed. R110's hydration care plan dated 3/13/14, identified R110 had a potential for fluid deficit related to need for occasional extensive assist with eating. Interventions listed included observe for any signs and symptoms of dehydration such as cracked lips, furrowed tongue and directed staff to provide fluids between meals by encouraging adequate intake and assisting resident with consuming fluids as needed. The comprehensive nutritional assessment dated 3/13/14, identified R110 required independent-extensive assist with feeding, skin was intact with good turgor, had a vision	F 327	The following measures have been taken to assure that this alleged deficient practice does not recur:. This resident has the ability to request and seek fluids and has a fair/good appetite. NO s/s of dehydration was noted. No lab indication of dehydration. Fluids for Resident 110 were consumed per resident choice. All nursing staff will be in-serviced 4/30/2014. For offering fluids when doing cares on residents who are unable to do on their own. The DON or her designee will be responsible for monitoring continued compliance.	5/1/ 2014

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impairment and had an estimated fluid need of 1430 milliliters (mL)'s per day.

An observation was made of a pink water pitcher on the bedside stand next to R110's bed on 3/26/14, at 11:04 a.m. The pitcher was cool to the touch and full of ice water. At the top of the pitcher, a straw was sticking out through the opening and still had about 2 inches of the paper wrapper in place at the end. Follow up observations made throughout 3/26/14, showed the pitcher remained full and the wrapper was still in place.

On 3/27/14, at 9:57 a.m., observation was again made of the water pitcher on R110's bedside stand. It was cool to the touch and full of ice water. The tip of the straw again had a couple of inches of the paper wrapper still on the end. Follow up observations made throughout the day at 10:30 a.m. and 3:19 p.m. revealed the water pitcher remained full and the straw wrapper was still in place.

During observation on 3/26/14, at 1:12 p.m., R110 was observed seated in the dining room and was being totally fed both food and fluids. During interview on 3/27/14, at 3:19 p.m., licensed practical nurse (LPN)-B indicated the water pitcher pass was completed after breakfast that morning.

During interview on 3/27/14, at 4:08 p.m., registered dietician (RD) indicated she had completed a nutritional assessment when R110 had been admitted to the facility and estimated his fluid needs to be about 1410 mL's per day. RD estimated that after meal intake of 240 mL's per meal, an additional 690 mL's would be

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needed through medication passes and snacks. When asked how she was monitoring to be sure R110 was getting the required amount of fluids, RD stated she normally would visit with the staff and they would tell her how much the resident was drinking although she hadn't yet completed this task for R110 since admission. RD stated her initial assessment identified R110 needed encouragement to drink the fluids in his room.

During interview on 3/27/14, at 4:20 p.m., trained medication aide (TMA)-B confirmed giving R110 a glass of water with one medication pass on the evening shift which would amount to 120 mL's. TMA-B further stated the water pitchers were filled by the day shift and there was no monitoring of how much R110 drank from the water pitcher.

During interview on 3/27/14, at 4:31 p.m., director of nursing (DON) stated her expectation was that staff were to be offering fluids to all residents and she would expect the nurses to follow up to make sure residents were drinking enough fluids.

During interview on 3/27/14, at 4:35 p.m., LPN-C stated she thought R110 drank well and was able to drink out of the water pitcher independently.

During interview on 3/27/14, at 4:37 p.m., nursing assistant (NAR)-G indicated the water pitchers were filled once a day during the day shift. NAR confirmed always working the evening shift and stated the water pass was always done on the day shift and not again on the evening shift.

Policies related to monitoring intake and output and hydration were requested, however none existed prior to 3/27/14.

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F 364	Continued From page 26	F 364		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food that was palatable and at the right temperature for 7 of 92 residents (R39, R44, R30, R15, R17, R14, R58) who received meals at the facility. Findings include: During interview on 3/24/14, at 8:20 a.m., an unidentified resident stated "I am not sure the food is safe sometimes, the food is bad." The resident said she was here for short-term rehabilitation, however "felt sorry" for the residents that had to stay here permanently. She reported the food was not palatable, things that were supposed to be warm were cold, and cold things were served warm. The resident added the kitchen ran out of food on the second shift of meals, sometimes there was not enough bacon & residents might get oatmeal instead. The resident remarked there were not enough coffee cups or coffee, there were only coffee and cups now "Because you people are here." On 3/26/14, at 12:00 p.m., a test tray was requested by surveyor staff at the start of tray line. The test tray was prepared at 12:07 p.m.	F 364	The following measures have been taken to assure that this alleged deficient practice does not recur: All residents affected were re-assessed for like and dislikes. Adjustments have been made for resident satisfaction. Corrective actions are evaluated for effectiveness through the QA program. The dietary supervisor will continue weekly random audits of residents preferences.	

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F 364	Continued From page 27 The test tray consisted of the main entree and side choices for the noon meal of spinach, a pork cutlet with gravy and stuffing. This test tray was continuously observed and accompanied for the duration of the room tray service by surveyor staff from 12:07 p.m. when it was dished onto the plate until 12:35 p.m. when the last resident received tray service on the second floor. On 3/26/14, at 12:10 p.m. trays began to be served by dietary aide (DA)-A from a steel rack-style cart that had been covered with a clear plastic garbage bag. The individual plates on the trays were covered with a plastic plate cover. No other heat-retention equipment was utilized to keep the food warm during the room tray service. DA-A began serving room trays to residents on the first floor, carrying the trays into the room and lifting up the clear plastic bag on the tray cart to remove each tray. DA-A stated the second floor nursing staff had been kind of "loose" with ordering room trays on the second floor. DA-A added there used to be only four room trays, however the count now was up to twelve. DA-A said trays should be for people who really can't make it to the dining room. On 3/26/14, at 12:35 p.m. the last resident room tray was passed on the second floor. The temperature of the food was immediately taken by DA-A and was 85 degrees Fahrenheit (F) for the spinach, the stuffing measured 88 degrees F and the pork cutlet measured 88 degrees F. DA-A stated the increase in room trays had happened within the last 3 months. On 3/26/14, at 12:38 p.m., two surveyor staff tested the food for temperature and palatability. The food was cold. Follow up interviews with residents revealed the following:	F 364	The following measures have been taken to assure that the alleged deficient practices does not recur: The dietary dept will prepare resident meal trays in the dining room directly from the steam table immediately before transportation and service. The plate warmer ahs been repaired to heat the plates prior to serving. The plates will continue to be covered with a dome to retain heat as much as possible. The trays will be completed at a minimum of three times weekly by the Food Service Director. Food preparation temperatures and holding temperatures during meal will continue to be taken and recorded. Any foods outside of appropriate temperature range will be reheated, chilled or discarded.	

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F 364	Continued From page 28 During interview on 3/26/14, at 12:43 p.m., R39 said the food was very bad. R39 had resided at the facility since 1/11/11. R39's annual Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 (moderately impaired). During a follow up interview on 3/26/14, at 1:47 p.m. R44 confirmed her food was usually cold or room temperature when she got it. She added she received tuna salad a week ago for a meal that was room temperature when she received her room tray. R44 had resided at the facility since 3/6/11. R44's quarterly MDS, dated 1/16/14, identified a BIMS score of 15 (cognitively intact). During an interview on 3/26/14, at 5:36 p.m., R30 had just returned from the dining room, carrying two peanut butter and jelly sandwiches. R30 stated she preferred to eat in her room, "because it gets a little crazy in there," referring to the dining room. R30 stated by the time the room trays get to her room, "the hot food is cold, and cold food is room temperature," so she often chose to eat peanut butter and jelly sandwiches. R30 indicated the food was covered, "but the covers don't keep the temperature hot enough." R30 said she usually received a room tray and the trays were lukewarm at best, the covers being used didn't keep the food hot enough. R30 stated many residents have gotten the diarrhea from the food, "because they just aren't handling the food properly and heating the food properly." R30's quarterly Minimum Data Set (MDS), dated 1/10/14, indicated R30 was cognitively intact. During interview on 3/26/14, at 6:24 p.m., R15	F 364	The Dietary manger will be responsible along with the dietary cooks to maintain the meal service in compliance.	5/1/2014

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said when he received room trays, his meals were cold. R15 had resided in the facility since 1/10/01. R15's quarterly MDS, dated 2/6/14, revealed a BIMS score of 14 (cognitively intact).

During interview on 3/26/14, at 6:27 p.m. R17 said her food was usually cold. R17 ate meals in the main dining room and also ordered room trays part of the time. R17 had resided in the facility since 5/20/11. R17's annual MDS, dated 2/20/14, revealed a BIMS score of 15 (cognitively intact).

During an interview on 3/26/14, at 7:25 p.m., R14 was sitting in her room, visiting with her daughter. R14's daughter stated R14 has told her the food was never hot when served in the dining room, stating "If she doesn't like what's being served, they give her a peanut butter and jelly sandwich. That's what she had today at lunch because she didn't like what they were having." R14 indicated there were no alternatives offered except a cold sandwich. When asked how her supper was, R14 stated "It was cold...nothing is ever hot." R14's admission MDS, dated 3/11/14, indicated R14 was moderately cognitively impaired. A review of R14's care plan, dated 2/26/14, indicated R14 was able to eat independently with supervision, had nutritional problem due to poor appetite, and had a nutrition priority to ensure she consumed adequate nutrition through meals and snacks.

During a follow up interview on 3/27/14, at 3:20 p.m., R14 stated, "The food is usually cold. I like coffee and it is almost never hot."

During an interview on 3/27/14, at 1:45 p.m., R58 stated, "We don't get an alternative. All you get is

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F 364	Continued From page 30 a sandwich if you don't like what they're having. Portions are small." R58 indicated that when she gets her room tray, the hot food was always cold and the cold food was room temperature. R58 stated she always gets the diarrhea when she eats the egg salad, adding "lots of people get sick here from the food." R58's mother was present during the interview and voiced concern over the safety of the food being served. R58's mother stated she can't believe how many times she's heard that people are getting the diarrhea from the food, adding, "It scares me. She could get really sick." R58's annual MDS, dated 1/24/14, indicated R58 was cognitively intact. During interview on 3/26/14, at 2:03 p.m. the registered dietician (RD) and dietary manager (DM) said they were unaware of food complaints. A new process had been put into place within the last month to audit tray temperatures. The DM stated there had been one tray audit completed and he would provide surveyor staff this information. The RD said she had worked at the facility since last October and there had been no recently ill kitchen personnel. The last outbreak of kitchen staff illness she could recall was last November. The DM said he kept tight control of his food inventory and tried not to have any food waste. During interview on 3/27/14, at 9:27 a.m., the RD and DM denied they were aware of any recent complaints about cold food. The DM said food at 88 to 85 degrees F would be a concern for palatability. The DM said the time the elevator takes to get down to the dining area to begin passing the trays was an issue because of cross traffic of first and second seating at meals while residents were trying to return to their respective	F 364		

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F 364	Continued From page 31 units. The RD stated that an enclosed meal cart might help to retain the heat of the room trays, and added the facility would be responsible for this purchase. The DM said the facility would come up with a resolution to the concern and would be in touch with administration. During an interview on 3/27/14, at 6:07 p.m., registered dietician (RD) indicated there was always an alternative food option, including sandwiches, soup, mashed potatoes, or an alternate vegetable. The RD stated she was not aware of anyone getting sick from the food. Review of facility policies and documentation related to acceptable food temperatures and policies included: A Resident Tray Assessment, dated 2/28/14, and completed by the DM revealed an overall food quality score of unsatisfactory. The meal observed was lunch on first floor. The tray cart was noted to leave the kitchen at 11:52 a.m. and delivered to the test area at 11:55 a.m. The temperatures of the entree of breaded fish was 142 degrees F, the french fries were at 120 degrees F, the asian vegetables were 116 degrees F. The salad was 52 degrees, the lemon pudding at 60 degrees and the cranberry juice was at 54 degrees. The form identified hot entrees and vegetables should be served at over 130 degrees, cold foods and beverages at below 45 degrees. No other Resident Tray Assessment forms were on file. The Service Line Checklist, undated instructed hot entrees should be served at 150-160 degrees F, Cold entrees at 40 degrees F or below, vegetables at 150-160 degrees and cold beverages at 40 degrees F or below.	F 364		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 Mighty Shakes were stored at the proper temperature, and failed to ensure they were dated when removed from the freezer per manufacturer recommendations. This had the potential to effect 21 of 92 residents with ordered health shakes in the facility. Findings include: On 3/24/14, at 1:00 p.m. during review of the medication refrigerator on second floor with licensed practical nurse (LPN)-C, five chocolate Mighty Shakes and four strawberry Mighty Shakes (118 milliliter (ml) each) were observed unfrozen and without a date when removed from the freezer. LPN-C indicated it was not routine to date the shakes when they come up from the kitchen. On 3/24/14, at 1:35 p.m. during review of the medication refrigerator on first floor with assistant director of nursing (ADON), nine chocolate Mighty Shakes and five strawberry shakes were	F 371	The following measures have been taken to assure that this alleged deficient practices does not recur: the nursing staff were educated on importance of delivering supplements at the recommended temperatures and checking the date of delivery to the unit. Dietary staff will monitor delivery and that date as instructed. Weekly random audits will b performed by DON/ADON/dietary staff to monitor for continued compliance.	5/1/2014

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F 371	Continued From page 33 observed unfrozen and undated when removed from the freezer. ADON indicated the shakes were brought from the kitchen and it was not routine to date them. On 3/26/14, at 4:20 p.m. observed seven vanilla and one strawberry Mighty Shakes on top the first floor even hall med cart. On 3/26/14, at 6:40 p.m. observed five vanilla and two strawberry Mighty Shakes on the odd hall med cart. When interviewed on 3/26/14, at 4:28 p.m. trained medication aid (TMA)-C indicated she pulled the shakes needed for her shift and put them on the med cart, as she does not have time to run back and forth to the fridge. TMA-C verified the shakes would remain there until her bedtime med pass was complete, which was 8:00 p.m. or 9:00 p.m. When interviewed on 3/26/14, at 6:40 p.m. director of nursing (DON) verified Mighty Shakes should be dated when removed from the freezer. She also verified it would not be acceptable to have the shakes on the med cart from 4:00 p.m. until the bedtime medication pass was complete. The Mighty Shake's manufacturer recommendation noted a shelf life of 14 days thawed. Facility policy was not available related to this at the time of observation on 3/24/14.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412		

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F 412	Continued From page 34 The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to ensure resident dental services were followed up on as recommended for 1 of 1 resident (R85) reviewed for dental services. Findings include: R85's diagnosis included Alzheimer's disease. A quarterly Minimum Data Set dated 1/23/14, indicated R85 had severe cognitive impairment and required the assistance of one staff for personal hygiene. R85's care plan dated 1/30/2014, directed staff to provide R85 assistance with oral cares and provide verbal cues to R85 to have R85 brush his teeth. A Chart Progress Notes from Apple Tree Twin Cities dated 10/29/13, indicated R85 had three broken off teeth and several teeth that needed fillings. R85 also had extremely heavy plaque along the gum lines. It also indicated that R85 be provided assistance from staff with brushing and flossing two times a day. The dental service also requested a pre-operative physical by her	F 412	The following measures have been taken to assure that this alleged deficient practice does not recur: Resident 85 chart has been reviewed by nursing on 4/16/2014 and order clarified by MD and family that have agreed dental services are not needed at this time and the dental order has been discontinued. DON/ADON will work with staff HUC to ensure all appointments are made and follow up appoints tracked Weekly random audits will be performed for compliance.	5/1/2014

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F 412	Continued From page 35 physician for sedation at her next dental appointment. The facility needed to schedule the dental appointment after the physical. An interview on 3/26/14, at 6:31 p.m. with licensed practical nurse (LPN)-A indicated R85 does not have any dental concerns. LPN-A stated R85 went to the dentist yearly. An interview on 3/26/14, at 7:01 p.m. with director of nursing (DON) verified R85 went to a dental visit on 10/29/13, and that no follow up visit had occurred as ordered by the dentist. An interview on 3/27/14, at 11:01 a.m. with health information director (HID) revealed that the follow up visits for the residents at the facility were made by HID. The HID verified that no follow up visit was scheduled for R85.	F 412		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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
	24E117	A. BUILDING ______ B. WING ______	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

(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 431	Continued From page 36 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper labeling of medication for 1 of 1 resident (R83) utilizing insulin pens. The facility also failed to ensure medication reconciliation documentation was enforced for 4 of 4 medication carts. Findings include: R83 was admitted to the facility 6/3/13, with diagnosis including but not limited to diabetes mellitus. R83's current physician orders indicated R83 was to receive Lantus insulin 60 units subcutaneous twice per day, and Novolog insulin per sliding scale four times per day. On 3/24/14, at 1:00 p.m. with licensed practical nurse (LPN)-C during inspection of the second floor treatment cart, a Novolog flex pen and	F 431	The following measures have been taken to assure that this alleged deficient practice does not recur: Insulin pen was immediately discarded and a new insulin pen with residents name was ordered. Residents retuning from MD appointments with medications will be assessed for proper identification. Any medication without proper labeling will be discarded. Nursing TMA were immediately in-serviced on 4/30/2014 for importance of check and balance of medication reconciliation. Weekly audits will be completed by the DON/ADON of resident medications and or proper labeling. Nurses and TMA's were in-serviced on 4/30/2014 for ensuring proper labeling of resident medications and medication reconciliation.	

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F 431	Continued From page 37 Lantus pen were noted in the top drawer. No label was in place, and no date was on the pens indicating when they were opened. LPN-C indicated these were for R83. LPN-C was unable to indicate when these insulin pens were opened. LPN-C verified the insulin pens should have a label with the patient name and date on them, and that neither were present. When interviewed on 3/24/14, at 1:20 p.m. director of nursing (DON) verified both insulin pens were opened, and both would expire 28 days after opening. She also verified no label or date opened were present on either insulin pen. When interviewed on 3/27/14, at 4:42 p.m. pharmacy consultant verified insulin pens should have a label with the resident's name and date opened. Facility policy Storage and Expiration of Medications, Biological's, Syringes and Needles revision date 1/1/13, noted facility should ensure that medications and biological's have an expiration date on the label and have not been retained longer than recommended by manufacturer or supplier guidelines. On 3/24/14, at 12:40 p.m. during observation of the second floor odd and even medication carts with trained medication aid (TMA)-D the Shift to Shift Controlled Substance Count sheets were noted to have multiple blank spaces in the signature columns. On 3/24/14, at 1:35 p.m. with assistant director of nursing (ADON) during inspection of the first floor odd and even medication carts, the Shift to Shift Controlled Substance Count sheets were noted to	F 431	Weekly audits of the narcotic book s will be conducted by the DON and ADON to assure continued compliance with the appropriate signatures.	5/1/2014

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F 431	Continued From page 38 have multiple blank spaces in the signature columns. ADON verified each spot should have a signature. When interviewed on 3/26/14, at 6:40 p.m. the DON indicated the Shift to Shift Controlled Substance Count sheets should be counted with any change over on the medication carts, and all blanks on the sheet should be filled in. She also indicated when blanks were present, it made her wonder if staff were forgetting to do the count or forgetting to sign. Facility policy Daily Narcotic Count and Med Keys updated 4/14/18, noted "The narcotics in the bound book must be counted at the beginning and end or [SP] each shift by two persons (TMA's and/or nurses). The name of each person counting must be documented on the narcotic log sheet in the front of the MAR for each unit."	F 431		
F 492 SS=C	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and documentation the facility failed to ensure each supplemental nursing service agency was properly registered with the commissioner. This had the potential to affect all 93 of 93 residents who resided in the	F 492	The following measure have been taken to assure this deficient practice does not recur: Facility is developing program to be Supplemental Service agency free by May 15, 2014. Should Supplemental Service agency need to be utilized the Administrator will check the state supplemental service agency registry for current participants.	5/1/2014

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F 492	Continued From page 39 facility. Findings include: Upon request, a list of supplemental nursing agencies utilized by the facility was provided. On 3/27/14, at 2:22 p.m. the administrator indicated the facility only used one agency named Soul Care. Upon verification of registration it was found that the agency was not registered under the address provided by the facility. The administrator stated he had checked the website to see if the supplemental nursing agency was registered only. An interview on 3/27/14, at 2:27 with the director of nursing (DON) revealed that she had not checked to see if the supplemental nursing agency was registered properly with the state.	F 492		

Addendum to POC F 151

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:
    a. R 16 was assessed by IDT for continued use of locked bathroom door. The team has updated the careplan to reflect the discontinuation of the locked bathroom door intervention and the intervention of chair alarm use. R 16 was also assessed by OT/PT and nursing for therapy to work on safe transfers. Guardian has been informed of the intervention to leave the door unlocked with use of chair alarm and is satisfied with this intervention.

2. No other residents have been identified as having the having the potential to be affected by this alleged deficient practice for this intervention is not in place for other residents.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:
    a. The IDT has been in-service on the importance of ensuring that the resident and or guardian are informed and satisfied of new interventions set forth.
4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through her QA program.

   The DON or designee will complete random rounds to ensure no other bathroom doors are being locked as an intervention. This QA will be completed weekly x's 4 weeks. Noted problems will be immediately corrected and brought to the QA committee if further intervention are warranted

5. Completion Date: 5/2/14

Addendum recieved electronically 4/29/14
JB

Addendum POC F 282

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:
    a. R 6's site was checked on 3/26/14 upon return from dialysis the nurse fully assessed R 6's dialysis access site and removed the bandages. The thrill and bruit was checked and the nurse documented this on the TAR.
    b. R 110 was immediately offered fluids.
    c. R 16 was provided nail care immediately. Nails were trimmed and cleaned.
2. Resident who receive dialysis, residents who require assistance with fluid intake and residents who require assistance with nail care have been identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

    a. Nursing Staff have been in serviced on the importance of following the resident's plan of care. Specific discussion included
        - Assessing and monitoring the resident's access site post dialysis for bruit, thrill and bleeding to the site. Specific discussion included the importance of following the care plan intervention and to document on the TAR the services provided.
        - The importance of offering fluids residents who require assistance with fluid intake.
        - The importance of providing nail care to resident who require assistance

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through our QA program.
    a. The don/designee will complete weekly x's 4 audits of residents who go out to dialysis to ensure that the access site was assessed, monitored and documentation of competition was done.
    b. The don/designee will complete random rounds weekly x's 4 on residents who require assistance with fluid intake and nail care to ensure compliance.

5. Completion Date: 5/1/14

Addendum POC F 309

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:
   a. R 6's site was checked on 3/26/14 upon return from dialysis the nurse fully assessed R 6's dialysis access site and removed the bandages. The thrill and bruit was checked and the nurse documented this on the TAR.

2. Resident who receive dialysis, have been identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

   a. Nursing Staff have been in serviced on the importance of following the resident's plan of care. Specific discussion included
      - Assessing and monitoring the resident's access site post dialysis for bruit, thrill and bleeding to the site. Specific discussion included the importance of following the care plan intervention and to document on the TAR the services provided.

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through our QA program.
   a. The don/designee will complete weekly x's 4 audits of residents who go out to dialysis to ensure that the access site was assessed, monitored and documentation of competition was done.

Completion Date: 5/1/14

Addendum POC F 312

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:

    a. R 16 and R85 were provided nail care immediately. Nails were trimmed and cleaned.

2. Residents who require assistance with nail care have been identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

    a. Nursing Staff have been in serviced on the importance of following the resident's plan of care. Specific discussion included

        - The importance of providing nail care to resident who require assistance

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through our QA program.

    a. The don/designee will complete random rounds weekly x's 4 on residents who require assistance with nail care to ensure compliance.

5. Completion Date: 5/1/14

Addendum POC F 327

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:
    b. R 110 was immediately offered fluids.

2. Resident who require assistance with fluid intake and residents have been identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

    a. Nursing Staff have been in serviced on the importance of following the resident's plan of care. Specific discussion included
        - The importance of offering fluids residents who require assistance with fluid intake.

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through our QA program.

    a. The don/designee will complete random rounds weekly x's 4 on residents who require assistance with fluid intake to ensure compliance.

5. Completion Date: 5/1/14

Addendum POC F 371

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:

2. Twenty-one residents were identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

    a. Nurses were educated on importance of delivering Mighty Shakes at the recommended temperature and checking the date of delivery to the unit. Dietary staff will monitor delivery and thaw date as instructed.

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through her QA program.

    Weekly random audits x's 4 weeks will be performed by DON/ADON/Dietary staff to ensure that mighty shakes were stored at the proper temperature and have been dated on the removal of the supplement from the freezer, weekly for 4 weeks. Noted problems will be immediately corrected and identified patters/trends of noncompliance will be brought to the Quality Improvement Committee for further corrective action.

5. Completion Date: 5/1/14

Addendum POC F 412

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:
   a. Resident 85 chart has been reviewed by nursing on 3/27/2014 and family was contacted, and said that dental appointment is not needed unless resident is having pain. Order clarified by MD 4/16/14 dental services are not needed at this time and the dental order has been discontinued R 85

2. Resident who require follow-up up with dental service has been identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

   a. Health information manager has been in serviced on the importance of ensure that dental services appointments are followed up on timely.
   b. Staff will be alert to any statements of oral/dental pain

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through her QA program. DON/ADON will complete random weekly audits x's 4 weeks to ensure all appointments are made and follow up appoints tracked.

5. Completion Date: 5/1/14

Addendum POC F431

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:
    a. R 83's Insulin pen was immediately discarded and a new Insulin pen with the resident's label was ordered.
2. Residents who have orders for insulin pens have been identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

    a. Residents returning from MD appointments with medications will be assessed for proper identification. Any medication without proper labeling will be discarded.
    b. Nurse and TMA's were immediately in-serviced for the importance of check and balance of medication reconciliation.

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through the QA program.
    a. Weekly audits x's 4 weeks will be completed by the DON/ADON to ensure proper labeling and dating of insulin pens. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s).

5. Completion Date: 5/1/14

Addendum POC F492

Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:

1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice:
   a. Facility is developing program to be supplemental service agency free by May 15, 2014
   b. Should supplemental service agency need to be utilized the Administrator will check the state supplemental service agency registry for current participants

2. All residents have been identified as having the potential to be affected by this alleged deficient practice.

3. The following measures have been taken to assure that this alleged deficient practice does not recur:

   a. Should supplemental service agency need to be utilized the Administrator will check the state supplemental service agency registry for current participants

4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through her QA program. The Administrator will check annually to ensure that the commissioner site for agency compliance was checked when a supplemental service agency is used.

5. Completion Date: 5/1/14

FE117022

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	24E117	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, The Villa at Osseo was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok PR 5-1-14 RECEIVED APR 28 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 3-27-14 DC: 5-7-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas Paul	Administrator	4-22-14

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
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K 000	Continued From page 1 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. This 2-story building is downgraded from construction Type II (222) to Type V (111) due to wood joist and plywood floors in some of the linen closets. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 115 beds and had a census of 93 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025		

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K 025	Continued From page 2 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3. The deficient practice could affect the residents. Findings include: On facility tour between 9:15 AM and 10:45 PM on 03/28/2014, observation revealed that: 1. The second floor smoke barrier terminates at the monolithic ceiling at does not extend to the roof deck from exterior wall to exterior wall, 2. The first floor smoke barrier has penetrations above the ceiling that is not properly firestopped. These deficient practices were verified by the Maintenance Director at the time of the inspection.	K 025	The penetrations as noted by the Fire Marshall have been sealed as of 4-16-2014. Maintenance Dept. will be responsible for ongoing monitoring to assure any new penetrations that may be created will be sealed immediately. Facility has applied for a waiver for K-tag 025 smoke barrier construction.	5/1/2014