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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OXK7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00233

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245620**

2.STATE VENDOR OR MEDICAID NO.
(L2) **743749800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME MINNEAPOLIS**
(L4) **5101 MINNEHAHA AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55417**

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 **10/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **502** (L18)

13.Total Certified Beds **100** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 10/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/20/2014 (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
01/06/2014
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/02/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5620

Electronically Delivered: October 20, 2014

Mr. Cory Glad, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Dear Mr. Glad:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare program.

Effective October 15, 2014 the above facility is certified for:

100 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 20, 2014

Mr. Cory Glad, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

RE: Project Number S5620001

Dear Mr. Glad:

On September 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 28, 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 October 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 17, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 28, 2014, effective October 15, 2014 and therefore remedies outlined in our letter to you dated September 5, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245620	A. Building B. Wing	10/13/2014

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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 **F0244** Reg. # **483.15(c)(6)** LSC	**10/03/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**10/03/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**10/03/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	10/20/2014	18623	10/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/28/2014

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

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 A. Building B. Wing	(Y3) Date of Revisit
245620	01 - BLDG 19	10/17/2014

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0017	10/15/2014	ID Prefix Reg. # NFPA 101 LSC K0038	08/28/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 10/20/2014	Signature of Surveyor: 28120	Date: 10/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/28/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OXK7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00233

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245620**

2.STATE VENDOR OR MEDICAID NO.
(L2) **743749800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME MINNEAPOLIS**
(L4) **5101 MINNEHAHA AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55417**

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 **08/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **502 *** (L18)

13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 09/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/29/2014 (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
01/06/2014
(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.
00000
(L31)

30. REMARKS
* Licensed Beds
Bed type NH: 341 beds
Bed type BCH: 161 beds

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 5, 2014

Mr. Cory Glad, Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

RE: Project Number S5620001

Dear Mr. Glad:

On August 28, 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.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 October 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 October 7, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 28, 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 February 28, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly respond to resident grievances voiced in resident council meeting, potentially affecting 3 of 17 residents who attended the resident council meeting. Findings include: Residents reported that although staff was aware of ongoing issues with the mounting of a television for better viewing, cleaning of the dining room, and safety concerns with the dining room cupboards, they had not addressed those	F 244	F244 LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION a. Regarding R36 and R69, the unit television has been mounted at a higher level; above the fireplace. Cleanable corner protectors have been ordered for the overhead cabinets corner edges. Alternative cleaning product is being used on the dining room floor. Housekeeping staff were re-educated on the cleaning product. b. The facility□s Resident Concern/Grievance Procedure Policy is	10/3/14

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

Electronically Signed | 09/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 244	Continued From page 1 concerns timely to the satisfaction of the complainants. Resident council minutes were reviewed and revealed resident R36 expressed frustration in February 2014, regarding being able to see the common area television because it was mounted too low. R36 and R69 further expressed in February 2014, the cleaning of the dining room was a concern. The April 2014 resident council minutes discussed the dining room cabinet doors having a sharp corner where a resident has hit their head and the other concern was the glass doors on the cupboard for resident safety. The August 2014 resident council minutes read, "Cabinet doors have sharp corners, resident on Willow way bumped his head on the sharp corner. Still pending 8/18/14." When interviewed on 8/28/14, at 9:15 am R36 and R69, acknowledged it took a very long time for the television to be moved, and they were not informed why it would take so long. R36 stated, "It took quite a while to get it fixed and the staff did not get back to me about it." R36 says he has other concerns that were mentioned in the council minutes about the floors and walking on wet floors because he does not know the floor is wet and does not always see the wet floor signs set out. But the problem still continues with the floors being sticky and R36 stated, "sticky floors" in the dining room have been a problem that he has mentioned several times to the staff but no one ever gets back to him if the issue can be resolved. Review of the 8/18/14, resident council minutes read; "Reviewed Resident Right #26 regarding	F 244	being reviewed and revised as needed with an emphasis on improved response time. Re-education will be provided to staff regarding the Resident Concern/Grievance Procedure Policy. c. Random audits will be completed for Resident Council monthly meeting minutes over the next three months for compliance with promptness of response to resident council concerns/grievances. Audit results will be reported to the Quality Council quarterly as part of the facility□s internal Quality Improvement process.	

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F 244	Continued From page 2	F 244		

Grievances: Residents have the right to voice grievances and prompt efforts by the facility to resolve your grievances under the facility's written grievance procedure. New/updated grievance forms have been put in the wall pockets."

When interviewed on 8/28/14, at 9:00 a.m. the social worker (SW)-B acknowledged it took a very long time for the television to be moved. SW-B verified the facility did not initiate a concern/grievance form and there have been no forms completed since the last survey. SW-B verified she understood the follow up with the residents was important and validated the facility did not have a paper trail of resident concerns and they were not using the facility concern/grievance forms or procedures.

When Interviewed on 8/28/14, at 10:00 a.m. registered nurse (RN)-C acknowledged the dining room glass cupboards and the sharp edge have been an issue that was not resolved from the resident council meetings in April 2014.

A review of the facility policy titled "Resident Concern/ Grievance Procedure," under definition read: "Concern/Grievance- A disagreement/issue about the type of care you are receiving at the Veterans Home. You are free to voice concerns/grievances and recommend changes regarding matters including but not limited to care and treatment issues, rights violations and agency policies or services." The procedure directed, "The supervisor shall look into the matter if it is within her/his area of accountability or will refer the matter to the appropriate supervisor. *Within two working days of receipt of concern: " Furthermore the policy directed "Within seven working days of receipt of the grievance by

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F 244	Continued From page 3 the social worker or OD" A facility representative will discuss with grievant possible resolution and will establish a time frame for when the grievant will receive the proposed resolution in writing.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cleanliness of carpet floors in R54's room, R108's room, R82's room, R40's room, R9's room, R74's room, and carpet floor at the Day Room in Maple Drive 2nd floor. The facility also failed to keep R9's room in a repaired manner, and to ensure R91's room was free from strong urine odor. In addition, the facility failed to maintain a cleanable surface for R37's fall mat. On 8/28/14, at about 1:00 p.m. a team comprised of the physical plant director (PPD), the assistant administrator (AA), the executive housekeeper (EH), the morning building housekeeping supervisor (BS), and the surveyor conducted an environmental tour of the facility. The environmental tour team confirmed environmental concerns which have been continuously observed through out each day during the survey on 8/25/14, 8/26/14, 8/27/14 and 8/28/14. Concerns which remained during the environmental tour were as follows:	F 253	F253 HOUSEKEEPING & MAINTENANCE SERVICES a. Regarding cleanliness of carpet floors for R54, R108, R82, R40, R9, R74, and Day Room in Maple Drive 2nd floor; all carpeting has been cleaned and replaced if needed. Regarding R9 damaged wall; repair has been completed. Regarding R 91 room urine odor; the carpet has been deep cleaned, and replaced as needed. Regarding R37 non-cleanable surface for fall mat; the fall mat has been replaced. b. Cleanliness of carpet floors, damaged walls, room urine odor, and cleanable fall mats are being checked regularly via environmental rounds to determine if cleaning, repair, and/or replacement are needed. The facility□s Housekeeping Service and Responsibilities Policy was reviewed. Re-education will be provided to staff regarding reporting cleanliness of carpet floors, damaged walls, room urine odor, and cleanable fall mats. c. Random environmental round audits	10/3/14

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F 253	Continued From page 4 Dirty/Stained Carpet Floors: -R54's room, the environmental team found spots on the carpet floor. The EH identified the spots as "stains." -R108's room, dried red stain was observed on the carpet floor, which the team considered might be spilled "cranberry juice." -R82's room, two spots of red stain were observed in the carpet floor, EH identified one stain as "fresh" while the other stained spot was dried and "may have been there for a while." -R40's room, dark stains were observed on carpet floors in the stepping area to and off bed. The PPD stated the dark coloring of the carpet looked like shoe-stains. -R9's room, there were several stained spots throughout the tan carpet floor. The environmental team agreed the room needed to be cleaned or shampooed. -R74's room, R74 was asleep in bed and did not respond to knocks on door, but from the doorway, the environmental tour team spotted dark stains on the carpet floor just below bed, on R74's right side. The AA acknowledged the presence of the dark stains and AA stated stains would have to be cleaned. -Day Room in Maple Drive 2nd Floor, the environmental tour team observed the carpet floors dirty with what appeared to be food-like stains. Some spots were stained with what looked like dried white substances embedded in the carpet. Multiple stains of varied colors were observed throughout the carpet floors. There were four male residents observed in the Day Room watching a show on television. Licensed practical nurse (LPN)-A was working on medication cart that was parked in hallway behind the TV lounge/Dayroom. The carpet floor where the medication cart was parked was likewsie dirty	F 253	will be conducted for the next three months for cleanliness of carpet floors, damaged walls, room urine odor, and cleanable fall mats. Audit results will be reported to the Quality Council quarterly as part of the facility□s internal Quality Improvement process.	

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with whitish/milky colored stains. The AA and PPD both agreed the floor at the Dayroom in Maple Drive needed to be shampooed and cleaned.

Damaged Wall:
In R9's room (445) were gouges observed in the wall by the bed side that penetrated to the wall board and were no longer cleanable surface. AA and PPD stated the wall needed some repairs.

Urine Odor:
AA and surveyor entered R91's room (256) where AA verified strong urine odor. R91 was awake and was lying in bed during the tour. There was an empty and covered urinal hooked to a trash bin within R91's hand reach and the door to bathroom was open, both AA and surveyor could not identify where the urine odor was coming from inside the room. AA informed the other members of the environmental tour team, registered nurse (RN)-C and RN-E about the urine odor. RN-C stated urine odor was coming from the carpet and further stated R91 was at times non-compliant with use of urinal and would have the carpet wet with urine. R91's care area assessments (CAAs) dated 6/21/14, triggered for cognitive impairment, behavioral symptoms, visual and communication problems, and urinary incontinence.

Non-cleanable surface - fall mat:
The members of the environmental tour team agreed that R37's fall mat was worn on the edges and did not have a cleanable surface. R37's annual minimum data set (MDS) dated 2/12/14, indicated R37 was high risk for falls. AA stated the fall mat needed to be replaced.

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F 253	Continued From page 6 The facility's undated policy for carpet care and cleaning for all rooms and carpet areas in Building 19, directed staff to vacuum Monday to Friday and as needed, carpet spotting daily/weekly and as needed, extraction cleaning monthly to quarterly based on amounts of soil/traffic needs and as needed, "urine stain removal for residual urine orders" as needed. The policy further directed staff to "report any areas" that are stained to supervisor for the replacement of tile squares that were stained.	F 253		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		10/3/14

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F 441	Continued From page 7 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to observe acceptable infection control practices to prevent the spread of infection through handwashing during resident care for 2 of 3 residents (R9, R36) observed, and for 1 of 2 residents (R9) using the mechanical lift without sanitizing. Furthermore, the facility failed to clean and sanitize 6 of 6 trash and 6 of 6 linen chutes with appropriate chemicals to prevent the spread of infection. This had the potential to affect all 198 residents in the facility. Findings include: R9: During an observation on 8/26/14, at 9:30 a.m. nursing assistant (NA)-A washed hands for seven seconds and donned a pair of gloves. Wet a wash cloth in the bathroom, brought the wet washcloth to R9 and NA-A proceeded to wash R9's face. NA-A picked up the soiled floor fall matt, folded the soiled matt and moved it to the end of the bed. NA-A had on the same pair of gloves on and without changing or handwashing	F 441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS a. Regarding R9 and R36; involved nursing assistants were re-educated immediately on the facility□s Hand Hygiene Policy and the facility□s Equipment Cleaning and Disinfection Policy. Regarding cleaning and sanitizing trash and linen chutes; involved housekeepers were re-educated on cleaning the chute doors. b. Staff were provided re-education regarding the facility□s Hand Hygiene Policy and the facility□s Equipment Cleaning and Disinfection Policy. All residents have been issued mechanical lift slings for individual use only. Outer and inner trash and linen chute doors are cleaned daily using a chemical disinfectant. Housekeeping staff were re-educated regarding chute door cleaning. Internal chute cleaning of the laundry and trash chutes was completed on 9-10-14. Internal chute cleaning is on	

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F 441	Continued From page 8 performed the following steps. Removed R9 dirty socks, applied lotion to both feet, and donned a clean pair of socks. NA-A removed a plastic bag out from under the current soiled trash bag for dirty linen. NA-A assisted with R9's pants and shoes and assisted R9 to sit on the side of the bed. NA-A then washed underarms, put on deodorant, and put on a clean shirt. NA-A then moved the mechanical stand into position, put the mechanical stand sling against resident's skin, and R9 grabbed onto the stand. NA-A used the remote controls on the stand moved R9 into the bathroom where the urine soaked incontinent brief was removed and put into the trash container. NA-A obtained the electric shaver and proceeded to shave R9 while seated on the toilet. NA-A did not remove the soiled clothes or wash the hands. NA-A retrieved the deodorant from the night stand and stored it in the bathroom. NA-A the placed the dirty linen in the plastic bag on the floor next to the trash can. NA-A proceeded to rewash the resident's face after shaving, used the wash cloth to wash R9's hair and used the hair brush to brush hair. NA-A moved the wheelchair into position in the bedroom, then proceeded to use the controls on the mechanical stand to lift R9 off the toilet. Performed perineal care and applied a clean brief and pulled up R9's pants. NA-A put on the wheel chair foot pedals, returned to the mechanical lift to move R9 into the wheelchair, using the remote control to lower R9 into the wheel chair. NA-A picked up R9's glasses from the bedside stand, went to the bathroom, turned on the faucet to wash glasses. NA-A made the resident bed and placed the call light on the bed. NA-A took the trash out of the trash container, tied the bag, put in a clean trash bag, tied the dirty linen bag. Then, NA-A removed the gloves and washed hands for seven seconds by	F 441	a routine schedule. c. Random hand hygiene observational audits will be completed over the next three months for compliance with hand hygiene. Audit results will be reported to the Quality Council quarterly as part of the facility□s internal Quality Improvement process. Random equipment cleaning and disinfection audits will be completed over the next three months for compliance with equipment cleaning and disinfection. Environmental rounds will include auditing of the trash and linen chutes cleanliness. Audit results will be reported to the Quality Council quarterly as part of the facility□s internal Quality Improvement process	

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wringing the hands. NA-A picked up the contaminated linen and trash bag and took them to the locked area where NA-A used name badge to enter the room. The trash and linen chutes were opened by handle and revealed dried on black, brown, tan accumulation of some type of substance. NA-A left the room without washing the hands and proceeded to assist R9 with the breakfast meal prep.

NA-A proceeded to butter R9's toast pour the cereal into a bowl. R9 did not have his hands washed after the toilet use and prior to the breakfast meal. The mechanical stand and sling were not disinfected after being contaminated and was moved back to the storage area in the hallway. NA-A did not wash their hands at all during the observation nor was alcohol gel used to sanitize their hands.

R36:
On 8/26/14, at 1:20 p.m. NA-B assisted R36 using a walker to go to the bathroom. R36 used both hands to position penis while sitting on the toilet. After urinating, R36 positioned hands on the walker and NA-B was assisting R36 to walk out of the bedroom when surveyor intervened to have handwashing for the resident and to sanitize the walker hand grips.

During an interview on 8/27/14, at 9:45 a.m. NA-A verified the mechanical stand was not decontaminated after each resident use and that housekeeping was responsible to clean the machine weekly.

Interview with infection control registered nurse (RN)-A on 8/27/14, at 1:00 p.m. discussed the lack of handwashing and glove changing with R9

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F 441	Continued From page 10 and R36. RN-A confirmed the hand washing expectation was to follow the facility policy. RN-A verified residents are to wash hands after toileting and the mechanical stand remote control, and where the resident hands gripped should have been sanitized as well as the walker for R36 after toileting due to infection control contamination. RN-A validated each resident should have their own sling for the mechanical lift especially when the sling comes in contact with the resident skin and personal items in the bedroom. RN-A verified there was not an infection control audit of the housekeeping and laundry departments. Food cart: On 8/28/14, at 8:30 a.m. the clean food cart was stored in front of the trash and linen chute. Staff was observed brushing their clothing against the clean food cart, the tied trash and dirty linen bags against the food cart, and then throws the soiled trash and dirty linen down chute. When interviewed on 8/28/14, at 8:30 a.m. the housekeeper (H)-D verified the product used to clean the handles to open the linen and trash chutes was a product called "Power Force Premium Cleaner Degreaser." H-D verified the inside of the linen and trash chutes was heavily soiled with dried, dark brown, black, tan substances with heavier accumulation on the edges and corners of the chute doors. H-D verified housekeeping did not clean the inside of the chute doors. Further interview with H-C on 8/28/14, at 8:55 a.m. validated housekeepers do not clean the inside of the chute doors and verified the accumulation of grime was because, "They don't tie the plastic bags all the time and then throw it down the chute where it falls out."	F 441		

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F 441	Continued From page 11 The assistant director of nursing (ADON) was interviewed on 8/28/14, at 8:45 a.m. revealed the clean food cart was not to be stored in front of the dirty laundry/trash chute. During an interview with the H-A on 8/28/14, at 11:00 a.m. verified the main ingredient of Power Force Premium Cleaner Degreaser was phenoxyisopropanol and triethanolamine and was not a cleaner disinfectant. The product that was to be used on the dirty linen and trash chute handles was a "Clean on the Go" product because it contains the proper ratio of ammonium chloride. H-A stated "The inside of the chutes have not been cleaned probably since the pipes froze back in January [2014] and the automatic cleaning system broke down." Review of the facility infection control policy dated 8/20/09, and titled Hand Hygiene directed staff to decontaminate hands after contact with intact skin, body fluids or excretions, mucous membranes, moving from a contaminated body site to a clean body site during resident care and after contact with inanimate objects including medical equipment, and to decontaminate hands after removing gloves. The hand washing technique when washing hands with soap and water directed staff to rub hands together vigorously for at least 15 seconds. Furthermore, residents are to have hand hygiene after toileting.	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	**5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417**

(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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Minnesota Veterans Home Minneapolis, Building 19, 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 18 New Health Care. At this time, we are not recommending Medicare Certification. 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: 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.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/15/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING **01 - BLDG 19** B. WING _____	**08/28/2014**

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K 000	Continued From page 1 This 4 story, Type II (222) construction without a basement and was constructed in 2012. The facility is fully fire sprinkler protected with smoke detection in the corridors and areas open to the corridors which are monitored for automatic fire department notification. The facility is attached to non-Medicare receiving facilities and is separated by 2-hour fire walls with 90-minute doors. There is no parking within the facility, is a smoke-free facility and all cooking for the residents is conducted in a separated building. The facility has a capacity of 100 beds and had a census of 100 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the corridor walls which form a barrier to limit the transfer of smoke in accordance with NFPA 101, Section(s) 18.3.6.1, 18.3.6.2 and 18.3.6.5. This deficient practice could effect all residents.	K 017	K017 LIFE SAFETY CODE STANDARD 1. Building smoke penetration and fire barriers will be inspected and repaired. 2. Proposed completion date October 15, 2014. 3. The physical plant director will conduct random audits to verify	10/15/14

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K 017	Continued From page 2 Findings include: On facility tour between 9:30 AM and 12:30 PM on 08/28/2014, observation revealed that there are penetrations in the corridor above the suspended ceiling throughout the facility that are not fire stopped. The penetrations include Blue, Green, White and Yellow data cabling. This deficient practice was verified by the facility director at the time of the inspection.	K 017	compliance with fire stopping.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the exits in accordance with NFPA 101 (2000), Chapter 7, Section 7.1 and Chapter 18, Section 18.2. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 08/28/2014, observation revealed that the stairwell doors on the fourth floor are maglocked with a keypad. There is no signage indicating how to unlock the door. This deficient practice was verified by the facility director at the time of the inspection.	K 038	K038 LIFE SAFETY CODE STANDARD 1. Fourth floor stairwell door signage, indicating how to unlock the door, was immediately replaced. All other stairwell doors were checked and verified to have appropriate signage present. 2. Completed on August 28, 2014. 3. The physical plant director or designee will check signage at all stairwell exit doors as a component of ongoing environmental rounds.	8/28/14