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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PF8C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245418**

2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BELGRADE NURSING HOME**
(L4) **103 SCHOOL STREET, PO BOX 340**
(L5) **BELGRADE, MN** (L6) **56312**

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 **08/14/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
X 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
	49			
(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 :
Jessica Sellner, Unit Supervisor — 08/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/11/2014 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/28/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245418

September 11, 2014

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

Dear Mr. Lord:

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

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

Effective August 8, 2014 the above facility is certified for or recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 27, 2014

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

RE: Project Number F5418022

Dear Mr. Lord:

On July 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 2, 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 August 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 22, 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 July 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 2, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2014, effective August 8, 2014 and therefore remedies outlined in our letter to you dated July 22, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. This letter replaces our letters dated August 14 and August 25.

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

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
245418	A. Building B. Wing	8/14/2014

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **08/08/2014**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **08/08/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/08/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **08/08/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	08/19/2014	29249	08/14/2014
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
7/2/2014			

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
245418	A. Building / B. Wing: 01 - MAIN BUILDING 01	8/22/2014

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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 K0052	07/02/2014	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	08/19/2014	22373	08/22/2014
CMS RO				

Followup to Survey Completed on: 7/1/2014

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	(Y3) Date of Revisit
245418	A. Building B. Wing **02 - PT-E THERPY**	8/22/2014

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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 K0052	**07/02/2014**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	08/19/2014	22373	08/22/2014
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
7/1/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PF8C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245418**

2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3)**BELGRADE NURSING HOME**
(L4)**103 SCHOOL STREET, PO BOX 340**
(L5)**BELGRADE, MN** (L6) **56312**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (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
X 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
	49			
(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 :
Marilyn Kaelke, HFE NE II — 08/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 08/25/2014 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

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

Certified Mail # 701 2000 0002 5143 0457

July 21, 2014

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

RE: Project Number S5418024

Dear Mr. Lord:

On July 2, 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:

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

<u>Plan of Correction</u> - 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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 8, 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 August 8, 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 October 2, 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 January 2, 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 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

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

From: **Phil Lord** phillord@usa.com
Subject: Updated PoC Belgrade Nursing Home
Date: August 12, 2014 at 11:59 PM
To: jessica.sellner@state.mn.us

Attached is a .pdf of the pages that have been updated per your email of 8/6/14 which I received 8/11/14.

I will mail the hard copies Wednesday, 8/13, before the outgoing mail deadline of 3:00 PM.

Please contact me prior to that time if any additional changes are needed.

RECEIVED

AUG 14 2014

MN Dept of Health
St.Cloud

Thank you,

Philip Lord

Phil Lord
Administrator
Belgrade Nursing Home

Cellular: (320) 250-2095 (a St. Cloud local number.)

PDF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	RECEIVED 07/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

AUG 14 2014

MN Dept of Health St Cloud

(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 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	8/17/14 Action taken to correct deficiency: Of the four residents that were monitored, three: R59, R62, and R14, have been discharged. The fourth, R60, is no longer being monitored. The use of resident video monitors has been discontinued at this time. The Video Monitor policy, the statement of need for video monitoring following resident assessment and determination if a resident will benefit from using a video monitor, evaluation and procedure for	08/08/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Philip Lord	Administrator	8.2.14

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 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure privacy and confidentiality for 4 of 4 residents (R60, R59, R62, R14) reviewed who were being monitored by video camera. In addition, the facility failed to provide personal privacy for 1 of 1 resident (R28) during weekly weights. Findings include: R60 was observed to have a video camera in his shared bedroom on 6/29/14 at 6:30 pm. The camera was sitting on his bedside stand. The receiving screen was stationed at the nurse's desk, which was adjacent to the resident/visitor visiting and TV area, and the center of three wings where residents resided. The nurse's desk had no doors and any visitor or resident had access to the area and could visualize the screen and see the resident and their activities. In addition, the video camera had the capability for audio, which according to nursing assistant (NA)-E interviewed at this time, was used at times during the evening and night shift. R60 was admitted to the facility on 6/19/14, and had diagnoses listed on the admission face sheet including malaise and fatigue, history of malignant neoplasm of the large intestine, paralysis agitans (Parkinson's disease), and dementia unspecified with behavioral	F 164	assessment, procedure to be used for notification and consent of the resident and/or responsible party, and the consent form, were reviewed and updated should monitoring be used in the future. All staff will be informed and be required to sign off documenting their knowledge of the use of video monitors throughout the facility. Nurses will be educated on the Video Monitor policy and procedure. A sign will be placed on all entry doors indicating the use of video monitors in this facility. The resident weight scale has been moved to a room that will ensure privacy for our residents. Corrective action will be monitored so that the deficiency does not reoccur: Audits will be performed by the	

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F 164	Continued From page 2 disturbance. An Admission Minimum Data set (MDS) dated 6/26/14, identified R60 as cognitively intact, no signs or symptoms of delirium, psychosis,or behavioral disturbance. He needed extensive assistance of two staff with bed mobility, transfers, ambulation, and toilet use. He needed extensive assistance one staff with locomotion throughout the facility, dressing, eating, and personal hygiene. The care area assessment (CAA), completed on 7/1/14, noted R60 had dementia and some memory loss. He was able to tell staff what he wanted but attempted to do things on his own. Due to his weakness, he needed assistance with his activity of daily living (ADL)s. The resident had some incontinence of urine. He had been improving slightly in his need for assistance and self-performance of ADLs and staff were to encourage his independence without sacrificing his safety. The CAA summary noted the resident was at risk for falls and had falls prior to his admission to the facility. It also noted R60 did not always use his call light and staff needed to anticipate his needs. The resident had four falls in the previous two weeks, and had a low bed with a mat on the floor. He also had generalized lower extremity weakness and was working with physical therapy on strengthening. R60's plan of care, developed on 6/21/14, identified the resident's high risk for falls and the goal was for the resident not to sustain any serious injuries. The interventions included the use of the video monitor. Facility staff discussed with R60's daughter the	F 164	Director of Nursing or designee to ensure the Video Monitor policy and procedures are being followed. These audits will be performed for the next six months. Results of the audits will be reported at QA meetings.	

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F 164	Continued From page 13 away after all the weights have been done. She reported the facility does not have any room to keep the scale which would be more private for the residents. The DON acknowledged visitors and other residents potentially could view the resident's weights. The facility's Dignity policy from the Resident Rights and Abuse Prevention Policy and Procedure Manual, revised August 2011, specified staff shall promote, maintain and protect resident privacy, during assistance with personal care and during treatment procedures.	F 164		
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 and interview, the facility did not ensure the most current survey results were posted in the facility and accessible to residents. This had the potential to affect all 48 residents currently residing in the facility. Findings include: During the initial tour of the facility on 6/29/14, at	F 167	Action taken to correct deficiency: A revision to the current Examination of Survey Results policy and procedure was updated to reflect the addition of a sign posted on the Resident's Bulletin Board stating: "Please do not remove the "Survey Results / Plan of Correction" of the Minnesota Department of Health. If the posted "Survey Results / Plan of Correction" has been removed from this location, please notify the Charge Nurse and/or the Administrator and request the replacement of the	08/08/14

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F 167	Continued From page 14 1:05 p.m. the facility's most recent survey results were not posted and could not be located in an area accessible to residents. During interview on 6/29/14, at 1:28 p.m. registered nurse (RN)-A stated she was unaware where survey results would be posted in the facility. During interview on 6/30/14, at 9:33 a.m. the director of nursing (DON) stated survey results were usually posted on the East Wing bulletin board of the facility. The DON looked on the bulletin board and verified the survey results were not posted in the usual location, and stated she was not sure what had happened to them or when they had been removed.	F 167	"Survey Results / Plan of Correction" on the Resident's Information Center bulletin board. Copies of the current "Survey Results / Plan of Correction" are also available at the Nurse's Station for review." Staff will be educated on the location of these survey results. Education will also be added to our staff orientation process. Corrective action will be monitored so that the deficiency does not reoccur: Audits will be performed by the Director of Nursing to ensure that staff has knowledge of where the survey results are posted and how they are to obtain a copy if they are asked, or to replace a missing posted copy that has been removed. All residents have been given a written reminder of the location of the posted Survey Results / Plan of Correction. Information will be given at Resident	

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			Council meetings. New residents will be informed of the location of the Survey Results / Plan of Correction. Reminders will be made by the Activities Department staff that will benefit current and future residents. Results of the audits will be reported at QA meetings.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 3 residents (R17, R19, R35) who currently smoked in the facility smoking room, received adequate supervision and utilized safety devices as assessed to prevent potential injury.	F 323	Action taken to correct deficiency: The Smoking Policy and Smoking Evaluation procedure were reviewed and updated. The evaluation includes cognitive ability of the resident and their demonstration of the safe smoking process. A new smoking evaluation was conducted on the three residents, R17, R19, and R35, and will be conducted on new	08/08/14

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F 323	Continued From page 15 Findings include: R17 was admitted to the facility on 7/11/08. R17's current diagnoses according to the current plan of care dated 6/18/13, included pneumonia, loss of weight, anemia, iron deficiency anemia, cataract, ectropion (turning out of the eye lid), chronic airway obstruction, depressive disorder, congestive heart failure, and anxiety. R17's quarterly Minimum Data Set (MDS), dated 3/4/14, identified R17 was cognitively intact, had adequate vision, needed supervision with locomotion on and off the unit, and needed extensive assistance of one with dressing and personal hygiene. R17's annual MDS, dated 6/3/14, identified R17 had impaired vision, needed extensive assistance with locomotion on and off the unit, and had moderate cognitive impairment, all which were changes from the quarterly MDS which had been completed 3 months prior. R17's most recent smoking assessment, dated 6/3/14, indicated R17 had cognitive loss, with a comment indicating, "BIMS score declined since last quarter." R17 had a visual deficit, with a comment indicating, "has glasses though states he rarely wears them anymore." R17 had a dexterity problem, with a comment indicating, "Difficulty to completely straighten his fingers." R17 smoked 2-5 cigarettes per day during the morning, afternoon, and evenings. R17 can light his own cigarette. There was no indication R17 needed any adaptive equipment such as a smoking apron, cigarette holder, supervision, or one-on-one assistance. According to the smoking assessment findings, R17 did not need the facility to store his lighter or cigarettes. The smoking	F 323	residents who smoke tobacco. A new smoking evaluation will be performed by a Registered Nurse when a change in condition of a resident occurs. An observed sign of risk made by any staff member will be reported to the Charge Nurse for further evaluation of the resident's ability to safely continue smoking. Education will be provided to all affected staff on the smoking policy with emphasis of the placement of the smoking apron, safety of the resident, and the importance of ensuring that the resident's assessment and care plan related to smoking is being followed. Registered Nurses will be educated on the changes made to the smoking evaluation.	

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F 323	Continued From page 16 assessment indicated R17 was safe to smoke without supervision and the resident was, "Grandfathered in from old policy, so he can have his matches and cigarettes on him." The assessment also included R17, "Remains safe at this time to store, light, and smoke his own cigarettes without staff supervision. No concerns or issues at this time." R17's plan of care dated 6/18/13, indicated, "The resident is a smoker." Goals included, "The resident will not suffer injury from unsafe smoking practices through the review date." Interventions included, "Instruct resident about the facility policy on smoking, observe clothing and skin for signs of cigarette burns. The resident can smoke UNSUPERVISED. The resident is able to light own cigarette, and keep lighter at bedside in locked night stand. The resident's smoking supplies are stored in his room." During an observation on 6/29/14, at 3:34 p.m., R17 had a cigarette package in the chest pocket of his shirt. R17 was wearing a pair of gray slacks that had two pea-sized holes in the left thigh area. R17 stated the holes were, "Probably from smoking," and the resident thought the holes had, "Been there for a couple years." R17 stated he smoked about once a day, and was allowed to smoke in the facility's, "Smoke room." R17 stated there were rules that had to be followed when smoking in the smoke room which included having his oxygen off for at least 5 minutes before going into the smoke room, and wearing an apron. R17 stated he doesn't wear the apron while smoking because, "I've done this [smoking] for about 87 years so I know what to do." During interview on 7/1/14, at 7:28 a.m., laundry	F 323	Corrective action will be monitored so that the deficiency does not reoccur: Staff audits will be performed by the Director of Nursing, or designee, to ensure compliance with the smoking policy. Results of the audits will be reported at QA meetings.	

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F 323	Continued From page 25 in the smoke room. The smoke apron was covering his lap only and NA-F entered the room, gave R35 a cigarette, lit the cigarette, and left the room without instructing R35 to ensure the smoking apron was on safetly. The facility's policy Smoking-Residents dated 3/14/13, directed staff to supervise all residents at all times while smoking and ensure all residents wore a smoking apron in the smoke room while smoking and the facility was to impose smoking restrictions on resident's at any time the resident could not smoke safely with the available levels of support and supervision. The facility failed to follow their policy regarding smoking and supervision.	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334	Action taken to correct deficiency: All current resident Flu vaccination records were reviewed and updated as needed. Flu vaccination policy and procedure were reviewed. Nurses will be educated on the flu vaccination policy and procedure with an emphasis on documentation requirements.	08/08/14

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F 334	Continued From page 26 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334	Corrective action will be monitored so that the deficiency does not reoccur: A monthly flu vaccination report will be run during the flu season to ensure that all residents who have not yet received the vaccine are offered one if they so wish to accept. Results of the audits will be reported at QA meetings.	

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	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/01/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 1, 2014. At the time of this survey, Building 01 of Belgrade Nursing Home was found not to be 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 Occupancies PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok JS 8-8-14 RECEIVED AUG - 6 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

See Bldg 2 for signature + date

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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BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340** **BELGRADE, MN 56312**

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K 000	Continued From page 1 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. Building 01 of Belgrade Nursing Home was constructed as follows: The original building was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1968 addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1981 addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1987 addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction; The 1988 addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The 1988 building addition consists of seven (7) senior apartments. Because the 1988 addition was not separated from the nursing home by	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340** **BELGRADE, MN 56312**

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K 000	Continued From page 2 2-hour construction, the senior apartments were surveyed as part of the nursing home. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 49 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET, as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 49 of 49 residents.	K 052	Action taken to correct deficiency: The company that conducted the facility's annual fire alarm inspection & test report was contacted and was asked to provide an updated Detector Status report. The updated report was received 07/02/14 that indicated that the identified Detectors were tested and that they were all within compliance of NFPA 72 requirements.	07/02/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/01/2014**

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K 052	Continued From page 3 FINDINGS INCLUDE: On 07/01/2014 at 1:20 PM, during a review of the facility's annual fire alarm inspection & test report dated 06/09/2014, ninety-three (93) alarm initiating devices were noted on the system, however, no documentation was provided identifying the locations and functional testing outcomes for each of these alarm initiating devices. As such, it could not be verified that inspection and testing of the complete fire alarm system had been properly conducted. This finding was confirmed with the plant operations manager.	K 052	Corrective action will be monitored so that the deficiency does not reoccur: The Plant Operations Manager will monitor the printed reports received from the inspection company to assure that they are completed correctly and that all needed documentation is accurately completed.	

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

F54180222

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING 02 - PT-E THERPY B. WING _____	07/01/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 1, 2014. At the time of this survey, Building 02 of Belgrade Nursing Home was found not to be 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 Occupancies PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	Pack 8-8-14 RECEIVED AUG - 6 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 8-8-14
EXIT: 7-8-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Philip Lord
TITLE: Administrator
(X6) DATE: 8.2.14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **02 - PT-E THERPY** B. WING _____	**07/01/2014**

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K 000	Continued From page 1 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. Building 02 of Belgrade Nursing Home consists of the 2013 Physical Therapy addition. This addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 49 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET, as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	K 052	Action taken to correct deficiency: The company that conducted the facility's annual fire alarm	07/02/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **02 - PT-E THERPY** B. WING _____	**07/01/2014**

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K 052	Continued From page 2 requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 18, Section 18.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 49 of 49 residents. FINDINGS INCLUDE: On 07/01/2014 at 1:20 PM, during a review of the facility's annual fire alarm inspection & test report dated 06/09/2014, ninety-three (93) alarm initiating devices were noted on the system, however, no documentation was provided identifying the locations and functional testing outcomes for each of these alarm initiating devices. As such, it could not be verified that inspection and testing of the complete fire alarm system had been properly conducted. This finding was confirmed with the plant operations manager.	K 052	inspection & test report was contacted and was asked to provide an updated Detector Status report. The updated report was received 07/02/14 that indicated that the identified Detectors were tested and that they were all within compliance of NFPA 72 requirements. Corrective action will be monitored so that the deficiency does not reoccur: The Plant Operations Manager will monitor the printed reports received from the inspection company to assure that they are completed correctly and that all needed documentation is accurately completed.	