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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PMP7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 33301

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245637**

2.STATE VENDOR OR MEDICAID NO.
(L2) **602610700**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORRIS SQUARE**
(L4) **6993 80TH STREET SOUTH**
(L5) **COTTAGE GROVE, MN** (L6) **55016**

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 **11/02/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 12/10/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/10/2021 (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
05/13/2019
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2021

CMS Certification Number (CCN): 245637

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

Dear Administrator:

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

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

Effective October 28, 2021 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2021

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: July 20, 2021

Dear Administrator:

On October 15, 2021, we notified you a remedy was imposed. On November 2, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 28, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 20, 2021. be discontinued as of October 28, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 15, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 20, 2021.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PMP7

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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 **09/23/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Pete Cole, HFE NE II 11/08/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/19/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :

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05/13/2019
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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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
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00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

October 15, 2021

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: July 20, 2021

Dear Administrator:

On August 4, 2021, we informed you that we may impose enforcement remedies.

On September 22, 2021, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 20, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 20, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 20, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 20, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Norris Square will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 20, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 2022 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing

before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/20/21, through 9/23/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		10/19/21

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

Electronically Signed | 10/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide an essential electrical system in accordance with NFPA 99 (2012) Health Care Facilities Code and NFPA 110	E 041	Upon identification of the issue, the facility contacted its third-party contractor to schedule replacement of the battery. Battery has been replaced as of 10/19/21.	

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	245637	A. BUILDING _____ B. WING _____	C 09/23/2021

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E 041	Continued From page 3 (2010) Standard for Emergency and Standby Power Systems. This had the potential to affect all 40 residents who resided at the facility. Findings include: During visual inspection of the facility generator on 9/22/21, by the state fire marshall it was revealed the battery was installed in October 2018 which exceeded the 24-30 month indicated battery life span. During interview on 9/22/21, at 2:42 p.m. environmental services director (ESD) stated the facility had a third party contractor service the generator this year and the facility failed to check the battery had been changed out at the end of the battery life span following the generator servicing. ESD stated the facility did not have a policy or procedure for changing out the generator batteries when they were expired.	E 041	Facility has ensured ongoing compliance by adding a visual audit of the battery and its replacement date during its annual preventative maintenance service with vendor and on its own preventative maintenance schedule for facility staff. Date of compliance is 10/19/21. Facility maintenance director or designee is responsible for ongoing compliance.	
F 000	INITIAL COMMENTS On 9/20/21, through 9/23/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5637019C (MN00070616) H5637020C (MN00069972) H5637021C (MN00052032)	F 000		

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F 000	Continued From page 4 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		10/28/21

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F 550	Continued From page 5 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a dignified dining experience for residents during meals in the dining room for 4 of 4 residents (R7, R12, R38, R41) reviewed for assistance meals. Findings include: R7's admission Minimum Data Set (MDS) dated 6/21/21, indicated R7 was cognitively intact, required supervision for eating . R7's care plan dated 9/7/21, nutritional problem related Parkinson's disease and dementia. Interventions included provide, serve diet as ordered. Monitor intake per facility policy. Staff were to offer additional fluids as ordered and assist with all feeding needs. R12's admission MDS dated 3/21/21, indicated R12 had severe cognitive impairment and	F 550	The policies titled Dignity and Resident Rights Policy have been reviewed and deemed current. R7 has had been reassessed for current level of assistance through RN observation and requires assistance of 1 with eating. The care plan has been updated to reflect current needs. R 12 has been reassessed for current level of assistance through RN observation and continues to require assistance of 1 with eating. The care plan remains current. R38 has been reassessed for current level of assistance through RN observation and continues to require assistance of 1 with eating. The care plan remains current. R41 has been reassessed for current level of assistance through RN observation and require assistance PRN.	

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F 550	Continued From page 6 required extensive assist with eating. R12's care plan dated 3/29/21, indicated interventions that included serve diet as ordered. Staff were to monitor intake per facility policy. R38's significant change MDS dated 8/25/21, indicated R38 had severe cognitive impairment and required extensive assistance with eating. R38's care plan dated 8/23/21, indicated nutritional problem with interventions that included assistance with all feeding needs. R41's significant change MDS dated 6/3/21, indicated R41 had severe cognitive impairment, and required extensive assist with eating. R41's care plan dated 5/5/21, indicated encourage and assist with oral intake as needed. During dining observation on 9/22/21, between 8:34 a.m. to 9:08 a.m. nursing assistant (NA)- A stood at the dining table and assisted residents R12, R38 and R41 with their meal. NA- A would move between the three residents (R12, R38, R41) during the breakfast meal as she stood and walked around the table from one resident to the next and assisted the residents to eat. During lunch observation on 9/22/21, between 12:11 p.m. to 12: 48 p.m. NA-A stood up in the dining room and moved from one resident (R7, R12, R41) to another resident and provided assistance to eat. NA-A walked around the table, moved from resident to resident and assisted the residents to eat. NA-A also discussed non resident related topics with a dietary staff as she walked around the dining room area from table to	F 550	The care plan has been updated to reflect current needs. All other residents have had their level of eating assistance reassessed for current level of assistance needed through RN observation and care plans updated as indicated to reflect current needs. Coordination of staff presence in the Dining Rooms has been restructured to assure staff are available to assist diners as determined by their plan of care. Full Time and Part Time Clinical staff will receive education on the Dignity and Resident Rights policy regarding assisting residents with their dining experience to include being seated at the table with the resident while assisting them, rather than standing up and moving around to assist residents during the meal. Staff will also receive education about expectations to discuss resident related/focused topics during the meal, rather than non-resident related topics. On-call staff will receive education prior to the start of their next shift. Dining Room Dignity audits will be completed daily at alternating meals x 4 weeks to monitor compliance. Audit results will be reported to the QAPI Committee to determine if further auditing schedules are needed to assure compliance. Clinical Administrator/designee is responsible for monitoring compliance. Completion Date: October 28, 2021	

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F 550	Continued From page 7	F 550		

table and assisted the residents to eat.

During interview on 9/22/21, at 1:17 p.m. nursing assistant (NA)-A stated she usually had to assist several residents who required assistance by herself during breakfast and lunch because the other nursing assistants were still getting other residents up and were assisting residents to get ready for meals. NA-A also stated there were two other nursing assistants that worked with her that shift, but she usually had to assist the residents by herself when she worked the morning shift. NA-A further stated no one had talked to her about standing up and moving around to assist residents during meals although she had no other alternative since she was the only person available to assist the residents during that shift's meals.

During interview on 9/23/21, at 1:02 p.m. director of nursing (DON) stated the nursing assistants were trained to sit and could then assist two residents with the goal to be at the conversation level.

The facility Dignity Policy dated 12/14, indicated residents were cared for in a manner and in an environment that promoted maintenance and/or enhancement of each resident's quality of life. Facility was committed to an atmosphere and humanized and individualized each resident and their experiences.

The facility Dining Room Protocol Policy dated 1/13, indicated staff were to participate in the delivery of meal service and purpose included to provide a dignified, prompt meal service. After all residents were served, proceed to assigned tables to provide eating assistance, as indicated

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F 550	Continued From page 8 or as appropriate.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure weights were monitored for 1 of 1 resident (R6) reviewed for weights. Findings Include: R6's Face Sheet dated 12/23/20, indicated R6 had unspecified dementia without behavioral disturbance, bullous pemphigoid (a rare skin condition that usually starts with an itchy, raised rash, then develops into large blisters on the skin) and abnormal weight loss. R6's significant change Minimum Data Set (MDS) dated 6/25/21, indicated R6 had severe cognitive impairment, required extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene. R6's care plan dated 1/7/21, R6 had significant weight lost with interventions that included obtain weight per policy or doctor or nurse practitioner's (NP) order.	F 684	The policy titled Weight Policy has been reviewed and deemed current. R6 has a weight of 154.9 pounds recorded on 7/22/21 via a mechanical lift. Weights were completed on 9/21/21 via wheelchair and recorded as 145.0 pounds and 145.4 pounds. These weights were determined to be a technical error by the RD and the resident was re-weighted on 9/22/21 via mechanical lift with a recorded weight of 153.7 pounds. R6 had a Clinical Nutrition Assessment completed on 10/11/21 following a hospital return. The RD assessed R6 to have no significant weight loss and was within his ideal body weight. The care plan has been updated to reflect current needs. R6 has had his weight order changed from weekly to a monthly weight effective 10/18/21 and is receiving Hospice services. An additional order has been added to report any refusals from the	10/28/21

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F 684	Continued From page 9 R6's careplan updated 7/30/21, indicated weight to be maintained greater than 150 lbs in three months. R6's Physician Orders Report dated 12/22/20, indicated an active order to enter weekly weight. For five pounds (lbs.) difference from previous weight notify doctor or NP. Wednesdays for weight monitoring. R6's treatment administration record (TAR) had an unreadable printed date indicated weekly weight. For five lbs. difference from previous weight notify doctor or NP. Only one weight was documented on the TAR for the month of 9/2021, at 153.7 lbs. R6's nutritional progress notes dated 9/20/21, indicated R6 had not been weighed in almost two months since he does not leave his bed. R6 had visually appeared to have stabilized. R6 continued to have many open areas on skin due to bullous pemphigoid. R6's nutritional assessment dated 9/20/21, indicated R6 ideal body weight of 171.6 lbs. R6's weight and vitals summary printed 9/23/21, indicated weight documentation as follows: - 9/22/21, weight 153.7 lbs.(mechanical lift) - 9/21/21, weight 145 lbs. (wheel chair) with notation of technical error - 7/22/21, weight 154.9 lbs. (mechanical lift) - 4/7/21, weight 150.5 lbs. (mechanical lift) - 3/31/21, weight 152.9 lbs. (mechanical lift) - 3/3/21, weight 167.5 lbs (mechanical lift) - 2/24/21, weight 169.2 lbs. (mechanical lift) - 2/17/21, weight 166.6 lbs. (wheelchair) - 2/3/21, weight 176.4 lbs. (wheelchair)	F 684	resident to obtain his weight. All residents have had their current weights reviewed by the RD. There were no residents assessed to have significant weight loss. RD's will complete a monthly weight report to assure every resident has been weighed or has appropriate documentation of any refusals to be weighed. Staff responsible for obtaining weights have received education on the Weight policy and the expectation to inform the nurse if a resident refuses to be weighed so documentation can be made in the resident record. The nurse will notify the provider of the refusal. Weekly audits will be completed x 4 weeks to assure residents are being weighed per the policy, or as ordered by the physician, and there is documentation if any residents refused to be weighed. Audit results will be reported to the QAPI Committee to determine if further auditing schedules are needed to assure compliance. Registered Dietician/designee is responsible for monitoring compliance Completion Date: October 28, 2021	

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F 684	Continued From page 10	F 684		

During interview on 9/22/21, at 1:42 p.m. nursing assistant (NA)-B stated, R6 had not been weighed recently although he was scheduled to be weighed every Wednesday. NA-B also stated if resident agreed to get out of bed he was weighed, however staff had not offered to weigh him in bed and use the mechanical lift.

During interview on 9/22/21, at 1:52 p.m. registered nurse (RN)-E stated, R6 had not been weighed and had refused to be weighed on 9/21/21. RN-E also stated staff used the mechanical lift to weigh R6 on Wednesday mornings. RN-B further stated R6 was usually approached and encouraged to get out of bed and he would refuse. RN-B stated that R6 was not asked if staff could weigh him in bed with use of the mechanical lift to check his weight. RN-E was unable to provide documentation that R6 refused to be weighed in bed with use of mechanical lift.

During interview on 9/23/21, at 9:27 a.m. director of nursing (DON), stated the best practice would have been for nursing staff to discuss with the NP so that an order was given to hold off weights for R6 due to skin/wound issues. DON also stated, could not find any documentation that R6's weights were not completed due to his refusals to be weighed.

During interview on 9/23/21, at 12:08 p.m. registered dietician (RD)-E stated he had visually assessed R6 and R6 did not seem to have lost weight in the last 3 months, although he had not been weighed since 7/22/21, and then again on 9/22/21. RD-E also stated it was good practice for staff to monitor residents weights weekly per

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F 684	Continued From page 11 physician orders. The Facility Weight Policy modified 12/2015, indicated. significant weight changes will be documented in the resident's medical record and reported to the doctor/NP involved family member and registered dietitian by the nurse.	F 684		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 761	The policy Storage and Expiration Dating	10/28/21

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F 761	Continued From page 12 review, the facility failed to ensure stock medication were discarded after expiration on 1 of 3 medication carts, potentially affecting 13 of 13 residents on that unit. In addition, the facility failed to ensure resident's personal medication was discarded after expiration for 1 of 13 residents (R28). Findings include: During the medication tour of the 2-south unit on 9/22/21, at 1:41 p.m. with registered nurse (RN)-A multiple expired medications were observed in the medication cart. The following concerns were identified: R28's acetaminophen suppositories 650 milligram (mg) with expiration date of 5/4/21. R28's physician order dated 5/16/20 indicated, acetaminophen suppository -insert 650 mg rectally every 4 hours as needed for pain/fever give if resident cannot take oral medicines. Stock medication Mucinex 600 mg with expiration of 1/2021 and Cepacol lozenges with expiration 11/3/19. When interviewed on 9/22/21, at 1:41 p.m. RN-A stated the medications were expired and should not be given to residents. RN-A further stated the expiration date should be checked prior to administration but there was not a process of checking the medication cart on a regular basis for expired medications. When interviewed on 9/22/21, at 1:52 p.m. RN-B stated not being familiar with a specific process to check the medication carts. RN-B stated, "The	F 761	of Medications has been reviewed and deemed current. R 28 had the expired acetaminophen suppositories removed from the medication cart. The medication was destroyed per facility policy. The expired stock Mucinex 600 and Cepacol lozenges were removed from the medication cart and destroyed per facility policy. A medication cart/medication room audit was completed on October 11,2021 to check for expired medications. Full Time and Part Time Nurses will be educated on The Storage and Expiration Dating of Medications policy and the procedure for checking the medication cart and medication rooms for expired medications on a weekly basis. On-call Nurses will be educated before their next shift. The NOC Nurse for each household will check the medication cart and medication room for expired medications weekly. Medication Cart and Medication Room audits checking for expired medications will be completed daily x 2 weeks, and then weekly ongoing. Audits will be turned in to the Clinical Administrator/designee for review. Audit results will be reported to the QAPI Committee to determine if further auditing schedules are needed to assure compliance. Clinical Administrator/designee is responsible for monitoring compliance. Completions Date: October 28, 2021	

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F 761	Continued From page 13 infection preventionist I think has done it before, but no schedule set to do it on a regular basis that I know of." RN-B further stated she would expect the nurses to check the medication expiration prior to administration. When interviewed on 9/22/21, at 2:05 p.m. RN-C stated there was no process for going through the medication carts on a regular basis to check for expired medications. When interviewed on 9/23/21, at 8:06 a.m. interim care center clinical coordinator stated the facility did not currently have a policy regarding a process for regularly checking medication carts for expired medications, however they were establishing a new task for nursing staff to check each cart for expired medications every Sunday night. When interviewed on 9/23/21, at 8:50 a.m. administrator stated the expectation was no expired medications in the medication carts. The facility provided Medication Storage Guidance dated March 2020, indicated "Unless otherwise noted by the manufacturer, standards of practice, or facility policy (whichever is more stringent), all multi-dose container will be considered to be expired on the date on the actual container as indicated by the manufacturer unless there is suspected or obvious product contamination." of medication policy revised 04/2019 indicated "Discontinue, outdated, or deteriorated drugs or biological's are returned to the dispensing pharmacy or destroyed."	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		10/28/21

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	245637	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(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 880	Continued From page 14 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 15 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure hand hygiene was performed by staff during assistance with meals in the dining room for 4 of 4 residents (R7, R12, R38, R41) reviewed for dining. Findings include: R7's admission Minimum Data Set (MDS) dated 6/21/21, indicated R7 was cognitively intact, required supervision for eating.	F 880	The policy Infection Control Standard Precautions: Hand Hygiene has been reviewed by the Infection Control Preventionist and Clinical Administrator and deemed current in meeting CDC guidelines and CMS requirements. R7 has had been reassessed for current level of assistance through RN observation and requires assistance of 1 with eating. The care plan has been updated to reflect current needs.	

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F 880	Continued From page 16 R12's admission MDS dated 3/21/21, indicated R12 had severe cognitive impairment and required extensive assist with eating. R38's significant change MDS dated 8/25/21, indicated R38 had severe cognitive impairment and required extensive assistance with eating. R41's significant change MDS dated 6/3/21, indicated R41 had severe cognitive impairment, and required extensive assist with eating. During dining observation on 9/22/21, between 8:34 a.m. to 9:08 a.m. the following was observed: nursing assistant (NA)-A stood at the dining table and assisted residents R12, R38 and R41 with their meal. NA-A was the only nursing staff that helped the residents in the dining room. NA- A moved between the three residents (R12, R38, R41) during the breakfast meal and stood and walked around the table from one resident to the next to assist with the meal. NA-A was not observed to perform hand hygiene after she assisted one resident and then assisted another resident. During lunch observation on 9/22/21, between 12:11 p.m. to 12: 48 p.m. the following was observed: -NA-A stood in the dining room and moved from one resident (R7, R12, R41) to another resident and provided assistance to eat. NA-A was the only nursing staff in the dining room to assist the residents with their meal. -At 12:11 p.m. NA-A stood and assisted R12. NA-A touched R12's Broda chair after she assisted R12 with a drink of water.	F 880	R 12 has been reassessed for current level of assistance through RN observation and continues to require assistance of 1 with eating. The care plan remains current. R38 has been reassessed for current level of assistance through RN observation and continues to require assistance of 1 with eating. The care plan remains current. R41 has been reassessed for current level of assistance through RN observation and require assistance PRN. The care plan has been updated to reflect current needs. All other residents have had their level of eating assistance reassessed for current level of assistance needed through RN observation and care plans updated as indicated to reflect current needs. The Infection Control Preventionist and Clinical Administrator have implemented competency assessments for staff on proper hand hygiene. Full Time and Part Time Clinical staff will receive education on the Infection Control Standard Precautions: Hand Hygiene policy and must successfully perform a demonstration for handwashing with soap and water and use of hand sanitizer. On-call staff will receive training before their next shift. Full Time and Part Time Clinical staff will receive education about proper handwashing/use of hand sanitizer when assisting residents with their meals. On-call staff will receive training before their next shift. The Clinical Administrator, Infection Control Preventionist and other facility	

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F 880	Continued From page 17 - At 12:15 p.m. NA-A sat near R12 while R12 coughed intermittently at dining table. NA-A wiped R12's running nose with napkin. NA-A did not perform hand hygiene. NA-A placed the dirty napkin on the dining table near R12's plate of food. NA-A then wiped R12's mouth after giving a bite of her meal with a cloth napkin. NA-A then stood up and reached across the dining table to R41's food area and touched R41's plate of food and stated to R41, "put it right here" and removed cup from near R41's plate mat. NA-A did not perform hand hygiene. -At 12:29 p.m. NA-A touched face mask to adjust while NA-A stood and assisted R12. No hand hygiene was observed. - At 12:30 p.m. NA-A touched R41's water cup and placed closer to R41. - At 12:31 p.m. when NA-A left R12's table no hand hygiene was noted. NA-A then went to R7's table, touched his Broda chair, and gave R7 several bites of food. At 12:33 p.m. NA-A then went back to assist R12 and offered R12 a drink. R12 coughed and when done, NA-A wiped R12's mouth. No hand hygiene was observed. NA-A then went to assist R41. - At 12:35 p.m. NA-A then went to assist R7. No hand hygiene was noted. NA-A was observed to provide hand hygiene once during the lunch observation. During interview on 9/22/21, at 1:17 p.m. NA-A stated there were two other nursing assistants that worked with her that shift, but she usually had to assist the residents by herself when she worked the morning shift. NA-A further stated she sometimes got busy with having to assist several residents and sometimes forgot to sanitize hands frequently.	F 880	leadership will conduct hand hygiene dining audits daily at alternating meals x 7 days. Audits will continue until 100% compliance is met. Audit results will be reported to the QAPI Committee to determine if further auditing schedules are needed to assure compliance. Clinical Administrator/designee is responsible for monitoring compliance. Completion Date: October 28, 2021	

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F 880	Continued From page 18 During interview on 9/23/21, at 1:02 p.m. director of nursing (DON) stated it was the requirement that hand hygiene was done between residents and was implemented by staff per facility policy. The facility Hand Washing Policy updated 5/2019, indicated to assure the safety of guests and visitor staff were expected to wash hands frequently to prevent bacteria and viruses from easily traveling from one person to another person or from people to food and food contact surfaces. Staff directed to always wash hands after coughing, sneezing, blowing nose or using tobacco.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/22/2021. At the time of this survey, NORRIS SQUARE was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2021

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

NORRIS SQUARE is a two-story building with no basement. The facility was constructed in 2018 and was determined to be Type II (222) construction.

The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, resident rooms, and spaces open to the corridors

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K 000	Continued From page 2 that is monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3and 9.6.1.5 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.6.2, 14.4.5 These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that no documentation was presented to review to confirm the most recent annual fire alarm testing	K 345	On 9/23/21, the Maintenance Director printed the annual fire alarm testing documents and placed them in the Life safety manual. The Maintenance Director has updated the TELS PM Tasks due date. Audits of TELS PM Tasks will conducted and monitor by the Maintenance Director monthly. Correction date: 09/23/21	9/23/21

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K 345	Continued From page 3 2. On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that no documentation was presented to review to confirm the most recent fire alarm device sensitivity testing These deficient conditions were verified by the Maintenance Director.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition)	K 353	On 10/11/21, the Maintenance Director undated the TELS PM Task requirements for testing the sprinkler system quarterly. Audits of TELS PM Tasks will conducted and monitor by the Maintenance Director	10/28/21

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K 353	Continued From page 4 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2. NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that no records were available to review to confirm that quarterly fire sprinkler inspections were being conducted. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	monthly and quarterly testing will be completed by a contractor at the next required due date. Correction date: 10/28/21.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview,	K 712	On 10/22/21, the Maintenance Director	10/28/21

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K 712	Continued From page 5 the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, 4.7.4, and 4.7.6. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that 3rd shift fire drills conducted in Quarter 1 thru Quarter 3 were not randomized in the dates on which they were conducted and time separation. 2. On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that the 3rd shift fire drills did not include the transmission of a fire alarm signal. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 712	will conduct fire drills at random date, time, and locations so that no pattern is detected in the same month or shift. two of the four drill times in the same shift are within 1½ hours of each other. This corrective action will begin with our November fire drills for 2021 also a fire drill Matrix has been completed and added to the Life safety manual. The Maintenance Director will ensure that this practice continues for future fire drills. Correction date: 10/28/21	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		10/22/21

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K 761	Continued From page 6 maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the doors in the facility per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 8.3.3.1 and NFPA 80 (2010 edition), sections 5.1, 5.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that no records were available to review to confirm that annual door inspections had been completed. This deficient condition was verified by the Maintenance Director.	K 761	On 10/19/21 The Maintenance Director adjusted the TELS PM Task due date for annual Maintenance and inspection of doors. The Maintenance Director is responsible to make sure this task is completed and all documents for all fire door assemblies follow compliancy of NFPA 101 & 80. Complete inspection and maintenance of fire doors completed and documented on 10/22/21.	
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a policy regarding portable	K 781	On 9/23/21, the Maintenance Director printed Presbyterian Homes and Services document for Portable space Heaters and	9/23/21

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	245637	A. BUILDING **01 - PRESBYTERIAN HOMES OF COTTAGE GROVE** B. WING _____	**09/22/2021**

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NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

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K 781	Continued From page 7 space heaters per NFPA 101 (2012 edition),), Life Safety Code, section 19.7.8 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that no evidence was presented to confirm that the facility has a portable space heater policy. This deficient condition was verified by the Maintenance Director.	K 781	placed it in the Life safety manual. The Maintenance Director will be responsible for annual reviewing and updating this document. Correction date: 9/23/21.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		9/23/21

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K 914	Continued From page 8 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to complete receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 and 6.3.4.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that no evidence was presented to review to confirm that electrical outlet testing of resident rooms had been completed This deficient condition was verified by the Maintenance Director.	K 914	On 9/23/21, the Maintenance Director found and printed the document for electrical maintenance and testing in TELS reports which was completed on 10/20/2021 and placed it in the Life safety manual. Audits of TELS PM Tasks will conducted and monitor by the Maintenance Director monthly. Correction date: 9/23/21.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		10/21/21

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K 918	Continued From page 9 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3, 5.6.5.6, 5.6.6 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/22/2021, between 09:30 AM to 02:30 PM, it was revealed that the generator remote annunciator panel for the emergency power supply system was located at the nurse's station in the unoccupied and closed memory care unit of	K 918	On 9/23/21, the Maintenance director placed a call to the contractor to order a second generator Annunciator panel and fire Annunciator panel for the second-floor nurse station. The contractor moved the panels from the closed unoccupied nurse's station to the occupied second-floor nurse station until parts come in. Correction date: 10/21/21	

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K 918	Continued From page 10 the facility. This deficient condition was verified by the Maintenance Director.	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement the usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These	K 920	On 9/23/2021, the Maintenance Director removed the multi-tap adapters from the appliances on the 1st, 2nd floor Med rooms and the Clinical Coordinators office that an appliance was connected to. The Maintenance Director will conduct	9/23/21

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K 920	Continued From page 11 deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 09/22/2021, between 09:30 AM to 02:30 PM, it was revealed in the 1st and 2nd floor Med. Rooms that appliances were connected to multi-tap adapters. 2. On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed in the Clinical Coordinators Office that an appliance was connected to a power strip. These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 920	quarterly audits and Education will be completed with all staff during fire drills. The Maintenance Director will ensure that no appliances are plugged into power strips and that no combinations of power strips and extension cords exist in the facility. Correction date: 9/23/21	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		9/23/21

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K 923	Continued From page 12 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store medical gas equipment per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2, 11.3.2.3, 11.3.4, 11.6.2, 11.6.5. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/22/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that the 1st Floor, Med Gas Storage Room had free-standing cylinders that were not secured from tipping. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 923	On 9/23/21, the Maintenance Director added the proper secured tank strapping for free-standing cylinders to the 1st floor Med Gas storage room. The Director of Nursing will ensure ongoing compliance. Correction date: 09/23/21.	