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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QP7P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00193

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245282**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CHARTER HOUSE**
(L4) **211 NORTHWEST SECOND STREET**
(L5) **ROCHESTER, MN** (L6) **55901**

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 **1/3/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (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)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
32				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/252014 (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
07/01/1985
(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
01/24/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5282

Charter House was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on November 14, 2013. On January 3, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on January 9, 2014, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on November 14, 2013, effective January 2, 2014. Refer to the CMS-2567B for both health and life safety code.

Effective January 2, 2014, the facility is certified for 32 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5282

March 10, 2014

Mr. Tony Enquist, Administrator
Charter House
211 Northwest Second Street
Rochester, Minnesota 55901

Dear Mr. Enquist:

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

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

Effective January 2, 2014, the above facility is certified for:

32 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 22, 2014

Mr. Tony Enquist, Administrator Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: Project Number S5282023

Dear Mr. Enquist:

On December 6, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 14, 2013 that included an investigation of complaint number . 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 January 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 9, 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 November 14, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 14, 2013, effective January 2, 2014 and therefore remedies outlined in our letter to you dated December 6, 2013, 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. Feel free to contact me if you have questions.

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Telephone: 507-206-2731 Fax: 507-206-2711

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245282	A. Building B. Wing	1/3/2014

Name of Facility	Street Address, City, State, Zip Code
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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 F0329 Reg. # 483.25(l) LSC	12/24/2013	ID Prefix F0441 Reg. # 483.65 LSC	12/24/2013	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	16022	1-22-14	10160	1-3-14
CMS RO				

Followup to Survey Completed on: 11/14/2013

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245282	A. Building B. Wing 01 - MAIN BUILDING 01	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0064	Correction Completed 01/02/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	16022	1-22-14	25822	1-22-14
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
11/13/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245282	01 - MAIN BUILDING 01	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0064	Correction Completed 01/02/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	16022	1-22-14	25822	1-22-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
11/13/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QP7P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00193

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245282**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CHARTER HOUSE**
(L4) **211 NORTHWEST SECOND STREET**
(L5) **ROCHESTER, MN** (L6) **55901**

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 **11/14/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (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)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
32				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 1/3/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(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

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

CCN-245282

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. 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), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7722

December 20, 2013

Mr. Tony Enquist, Administrator
Charter House
211 Northwest Second Street
Rochester, Minnesota 55901

RE: Project Number S5282023

Dear Mr. Enquist:

On November 14, 2013, 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731
Fax: (507) 206-2711

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 December 24, 2013, 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 December 24, 2013 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 February 14, 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 May 14, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 12/06/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245282	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(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 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	SEE attachments 1-3-2014 sph	12-24-13 sph

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

ADMINISTRATOR 1/2/14

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.

Charter House Skilled Nursing
MDH State Survey of 11/12/2013 – 11/14/2013

Facility Statement
The Statement of Deficiencies and Plan of Correction Form CMS-2567 was received on 12/24/2013.

Deficiency:

F329 §483.25(l) Unnecessary Drugs

1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that:

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions,

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

R171 personal health record was reviewed for PRN pain medication parameters and appropriate follow-up on 12/3/13; R172 dismissed the facility on 11/19/13.

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

RN/Nurse Manager completed a pain management review of all admitted residents (15 residents as of audit initiation, 12/3/13 @ 1424) for established PRN parameters and correct completion of follow-up via the facility "Pain Management Audit Worksheet".

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

Nursing Management will review the applicable policy, "Pain Assessment and Management" and update policy regarding use of parameters and appropriate completion of timely follow-up documentation within the electronic medical record. RN/Nursing Educator and RN/Nurse Manager will complete education to staff regarding policy changes and correct procedure by 1/31/2014.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

M. E. 1/3/14

Nursing Management or designee will complete routine audits monthly on random sampling of patients to ensure that process and policy is being completed as described.

Completion date:

12/24/2013

M. Sy 1/3/14

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F 329	Continued From page 1	F 329		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to follow the identified parameters for the use of as needed (PRN) pain medication for 2 of 5 residents (R172 and R171) reviewed for unnecessary.

Findings include: R172 lacked the use of identified parameters for prescribed PRN pain medication and lacked monitoring of the effectiveness for prescribed PRN pain medication.

R172 diagnoses include degenerative joint disease (DJD) and right total knee arthroplasty (RTKA). Clinical note dated 11/08/2013 at 11:12 a.m. indicated that resident was alert and oriented and admitted for pain control, physical therapy and occupational therapy.
R172's physician orders dated 11/08/2013 included oxycodone HCL (narcotic pain medication used for moderate to severe pain) 5 mg (1-2 tabs) oral (po) every 4 hours. The order directed staff to give 1 tablet for pain rated less than 5 out of 10 (with 10 being the worse pain) and 2 tablets for pain equal to or greater than 5 out of 10.
R172's plan of care (POC) effective date 11/08/2013, identified the problem of pain. The goal indicated that the resident would verbalize pain relief or show minimal signs of discomfort within a reasonable time after medication or other intervention. The interventions directed staff to provide pain medications as ordered.
Review of R172 ' s medication administration

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F 329	Continued From page 2 record (MAR) from 11/0/2013 through 11/12/2013 indicated that oxycodone had been administered 7 times. This included: 11/9/2013 9:00 a.m. 10 mg administered with no documentation of pain level or documentation in the nurse's notes of why 10 mg was administered or the effect of the medication. 11/10/2013 5:40 a.m. 5 mg administered for pain rated 8/10 with no follow up of the effect of the medication or why 5 mg was given instead of 10 mg per the physician's order. 11/11/2013 3:31 a.m. 5 mg administered for pain rated at 8 out of a 10 with no follow up of the effect of the medication or the reasons why 5 mgs was administered instead of 10 mgs per the physician order. 11/11/2013 7:50 a.m. 5 mg administered with no documentation of pain level or effect of medication. 11/11/2013 1:30 p.m. 5 mg administered with no documentation of pain level or effect of medication. 11/12/2013 9:10 a.m. 5 mg administered with no documentation of pain level or effect of medication. 11/12/2013 1:30 p.m. 5 mg administered with no documentation of pain level or effect of medication. Review of the Clinical Notes dated 11/08/2013 through 11/13/2013 indicated no documentation of resident's response to pain medication. The nurses clinical notes dated 11/12/2013 indicated resident experienced pain in her right knee with the worse pain rated as 5 out of 10. During interview on 11/14/13 at 8:32 a.m. registered nurse (RN)-H stated that when she gave pain medication she asks the resident their pain level, documents what it is, and assesses what to give the resident for pain medication	F 329		

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F 329	Continued From page 3 along with input from the resident. RN-H then goes back later and writes a note regarding the effectiveness of the medication in the nurse's notes. No documentation for R172 was received to confirm this process. During interview on 11/14/2013 at 7:47 a.m. RN-G who had given PRN pain medication to R172 confirmed that she had no further documentation on the effectiveness of the pain medication given to R172. Review of the policy Pain Assessment and Management with release date of 8/31/2012 directed staff to assess the resident ' s pain and consequences of pain at least each shift for acute pain and implement the medication regimen as ordered, carefully documenting the results of the interventions. Staff is directed to monitor the resident within one hour after intervention, non-pharmacological and/or pharmacological, to assess effectiveness. R171 lacked parameters for use of an as needed pain medication Tramadol. R171 had been admitted on 11/12/13. R171's diagnoses included but not limited to post left knee surgery. R171's physician orders dated 11/12/13, identified an order for Tramadol (same as Ultram and it has a narcotic-like pain reliever) 50 milligrams (mg) tablet 1-2 tablets by mouth every 6 hours as needed (PRN) for pain. No parameters were included with this medication order. R171's medication administration record print date 11/13/13, identified R171 had received Tramadol 50 mg on 11/12/13.	F 329		

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F 329	Continued From page 4 During interview on 11/14/13 at 7:46 a.m., licensed practical nurse (LPN)-A verified the physician orders for Tramadol PRN pain medication had no parameters of when to give one or two tablets. LPN-A stated they would know how much to give according to pain rating scale. During interview on 11/14/13, at 8:05 a.m., registered nurse (RN)-E verified the physician orders for R171's Tramadol PRN pain medication had no parameters of when to give one or two tablets. RN-E sated nursing judgment used to decide when to give one or two tablets.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	SEE Attachments	12/24/13 JPN

Deficiency:

F441 §483.65 Infection Control

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

§483.65(a) Infection Control Program

The facility must establish an Infection Control Program under which it –

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

§483.65(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

§483.65(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

Facility Statement

It is policy of this facility to prevent, report, log, analyze and identify patterns and trends of infection.

Some of the many ways that this has been achieved for the residents noted during survey are by assessing for infection, treating and care planning, logging infections for type, treatment, site, and isolate as appropriate.

The facility logs and tracks employee illness reports sent to Mayo Clinical Occupational Health and implements recommendations for work restrictions.

In this case after surveyor reported inconsistent logging of resident and employee infections for surveillance, the facility completed the following.

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

Residents found to have been affected have all dismissed from facility. All actions taken are as stated in the following questions and answers.

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

1/3/14

Because all residents receiving care at Charter House are potentially affected by the cited deficiency found on 11/14/2013, the Director of Health Services reviewed infection control plan, all policies and processes, and completed three policies; 1) Prevention & Control of Seasonal Influenza, 2) Employee Infection & Vaccination Status and 3) Surveillance for Infections.

Audit of current infection control logs for consistent completion of all areas of log.

Log initiated to track employee illnesses (symptoms) at Charter House.

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

In order to enhance and ensure operational compliance, under the direction of the Administrator, all Charter House staff will receive in-service training regarding state and federal requirements on the infection control plan for Charter House by 1/31/2014. The training will emphasize the importance of tracking, investigating and the surveillance of infections.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Under the supervision of the Director of Health Services, the monitoring of the infection control logs of residents and employees for surveillance of infection to analyze and trend infections will be done monthly through the Quality Assurance Program.

The Director of Health Services or designee will perform the following systemic changes; weekly audit of resident infection control log and employee system log to ensure consistent completion.

Any deficiencies will be corrected and findings of audits will be documented and submitted at the monthly QAPI committee meeting.

The Administrator or designee will ensure resident infection and employee symptom logs are submitted to QAA for surveillance by trending patterns of infections and action plan implementation.

Completion date:

12/24/2013

1/3/14

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F 441	Continued From page 5 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control (IC) program to include surveillance and investigation of infections that occur in the facility, track employee infections, and maintain accurate and comprehensive records at the time the infection occurred. This had the potential to affect all 23 residents in the facility, staff and visitors. Findings include: The facility did not comprehensively track resident and staff infections so they could have been analyzed for trends and patterns. A review of the facilities Resident Infections Log(s) from December 1, 2012, through November 12, 2013, revealed the log(s) lacked consistent indication of the following: Organism of infection, infection related diagnosis, resident location in the facility, whether the infection was community or facility acquired, antibiotic use, the	F 441		

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F 441	Continued From page 6	F 441		

effectiveness of the treatment, and which body system had been involved.

On 11/13/13, at 2:12 p.m. upon request of the facilities employee (IC) logs registered nurse (RN)-D reported the facility had not tracked employee illnesses with the exception of influenza like illness. RN-D further reported there had been no influenza illness of staff this last year.

During interview on 11/14/13, at 10:36 a.m. RN-B reported that employee illnesses had not been tracked by the facility but had been tracked by Mayo Clinic Human Resource (HR) Department. RN-B was unable to report if HR provided a report to the facility or how the information had been included in the facilities ability to analyze and identify trends in the nursing home. RN-B stated a monthly summary may be completed by IC nurse however was unable to provide the summary when requested. RN-B indicated resident infection logs were filled out by the nurses when an infection was identified. RN-B verified infection tracking forms were not fully completed to track and trend resident illness.

The facilities infection control policies were reviewed and identified the following:

· IC Health Services policy dated 9/2/13 indicated the purpose of the policy had been to establish a clear sequence of events in the surveillance, identification, reporting, prevention and control of infection to ensure appropriate services and timely action. The policy defined surveillance to be on-going monitoring of infections to detect changes in trends or distribution in order to initiate investigation or control measures for noted variances to include

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F 441	Continued From page 7 staff, residents, families and caregivers. The policy identified employee health had been a component of the facilities infection control program which included policies and procedures for surveillance, prevention and control of infection for staff. The policy further indicated the facilities process for identification of infections among patients, families, caregivers and staff had been to review and analyze infection data to identify unusual patterns and trends. · The facilities Infection Prevention and Control policy dated 3/25/13, directed staff who had been exposed to, or had an infectious disease to report that information to their supervisor and Occupational Health Services (OHS.) · The facilities Communicable Disease, Reporting of policy dated 4/10/13 indicated employees were to report communicable disease symptoms to OHS (office of health services) as soon as the diagnosis is suspected or confirmed.	F 441		

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

F5282022

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FORM APPROVED
OMB NO. 0938-0391

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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 FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Charter House Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC ok FB 1-3-14 RECEIVED JAN - 2 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-24-13

EMT: 11-14-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark A. Sall	ADMINISTRATOR	1/2/14

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MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Charter House Health Center is located on the 3rd floor of the 4-story building and has no basement The facility was built in 1984 and was determined to be of Type II(222) construction. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 22 beds at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all	K 064		1/9/14

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CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From page 2 health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. The deficient practice could affect all 22 residents. Findings include: On facility tour between 1:30 PM and 3:30 PM on 11/13/2013, the review of the fire extinguisher annual inspection documentation for the past 12 months revealed, that the facility failed to conduct the annual fire extinguisher inspection with-in 12 months. Inspection dates 2012 - 6/26/12 & 2013 - 7/23/13. This deficient practice was confirmed by the Director of Maintenance (RM) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 064		

Plan of Correction

Charter House – 245282
December 26, 2013
Richard M. Mulvihill – Facilities Maintenance supervisor

K064

The fire extinguisher annual inspection will be performed with-in 12 months of previous inspection date of 7/23/2013 by the fire extinguisher contractor.

Will complete annual inspection by July 23, 2013, by qualified contractor.

Facilities Maintenance supervisor will continue to monitor compliance. 1/3/14

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7722

December 20, 2013

Mr. Tony Enquist, Administrator
Charter House
211 Northwest Second Street
Rochester, Minnesota 55901

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5282023

Dear Mr. Enquist:

The above facility was surveyed on November 12, 2013 through November 14, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES

ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731
Fax: (507) 206-2711

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File