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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QYUU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00626

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/24/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Kathy Lucas, Unit Supervisor 05/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/29/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/03/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245418 May 29, 2018

Ms. Stephanie Fischer, Administrator
Belgrade Nursing Home
103 School Street, PO Box 340
Belgrade, MN 56312-0340

Dear Ms. Fischer:

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 May 4, 2018 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 29, 2018

Ms. Stephanie Fischer, Administrator
Belgrade Nursing Home
103 School Street, PO Box 340
Belgrade, MN 56312-0340

RE: Project Number S5418028

Dear Ms. Fischer:

On April 20, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 5, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 8, 2018 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 April 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 5, 2018, effective May 4, 2018 and therefore remedies outlined in our letter to you dated April 20, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: QYUU

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/05/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Ciesinski, HFE - NE II 05/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 05/02/2018 (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:

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 20, 2018

Ms. Stephanie Fischer, Administrator
Belgrade Nursing Home
103 School Street, PO Box 340
Belgrade, MN 56312-0340

RE: Project Number S5418028

Dear Ms. Fischer:

On April 5, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

Informal Dispute Resolution - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 5, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 5, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 5, 2018 (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 October 5, 2018 (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
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification Filee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	04/05/2018

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

(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 A post certification survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/2/218 to 4/5/18 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018		5/2/18

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

Electronically Signed | 04/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	04/05/2018

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

(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 018	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	04/05/2018

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

(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 018	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track the location of on-duty staff and sheltered residents that were relocated during an emergency, how to document the specific name and location of the receiving facility or other location. This had the potential to affect all 38 residents currently residing in the facility. Findings include: The facility's Rapid Response Guide undated, contained several policies required for emergency preparedness, however lacked documentation to include a system for tracking on-duty staff and residents that are relocated during an emergency. During an interview on 4/4/18, at 9:52 a.m. the plant operations manager stated I know I need to have the ability to track on-duty staff and residents relocated but I do not have one.	E 018	On April 26th a policy and form to track the location of on-duty staff and residents during an emergency situation/evacuation was developed. This policy was incorporated into the current Emergency Preparedness Plan. Facility managers and supervisors will be educated on the policy and form that has been added to the current Emergency Preparedness Plan.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.	E 035		5/1/18

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

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E 035	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their emergency preparedness communication plan included a method for sharing information the facility has determined appropriate, with residents and their families or representatives. This had the potential to affect all 38 residents residing in the facility and their families/representatives. Findings include: On 4/4/18, the Rapid Response Guide, undated, was reviewed with the plant operations manager. The guide contained communication information required under the communication plan, however, lacked information on informing residents and their families or representatives on the emergency preparedness plan. During an interview on 4/4/18, at 10:26 a.m. the plant operations manager stated the facility had not shared the emergency plan with the residents, their families or representatives.	E 035	On April 26th an Emergency Preparedness Program Fact Sheet was developed. This fact sheet will be communicated or provide to resident and their families or representatives. On April 26th, the Emergency Preparedness Program Fact Sheet was mailed to the designated resident representative. Residents will review the Emergency Preparedness Program Fact Sheet at the next resident council meeting. Also, The Emergency Preparedness Fact Sheet was also added to the new Resident Admission packet to ensure communication to new resident and their families or representatives of our Emergency Preparedness Plan.	
F 000	INITIAL COMMENTS On 4/2/18 to 4/5/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Belgrade Nursing Home was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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	F 000		

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F 000	Continued From page 4 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.	F 000		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure recommendations for high calorie/high protein snacks and supplements were implemented related to a significant weight loss for 1 of 1 residents (R25) reviewed for nutrition. Findings include:	F 692	On 4/6/18, R25 was offered high calorie/high protein snacks and supplements. R25 declines nutritional intervention at this time. Dietary Manager has reproached him on several occasions after 4/618, R25 still refusing high calorie/high protein snacks and supplements; however, weight remains stable.	4/30/18

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F 692	Continued From page 5 R25's Admission Minimum Data Set, dated 2/22/18, indicated R25 was independent with eating and ambulation. R25 had no identified weight loss and was moderately cognitively intact. R25's Care Area Assessment for nutrition, dated 2/26/18, identified diagnoses of metastatic cancer, depression, and anxiety. R25's care plan, dated 2/26/18, indicated R25 received chemotherapy related to metastatic bladder cancer. The resident ate independently. The care plan directed to monitor R25's nutritional status and intervene as indicate, to increase calories and protein as needed and to provide small meals through the day to improve tolerance and increase intake. The care plan also directed to monitor for weight changes. R25's medical record identified the following weights: 2/16/18: 219.6 pounds (lbs) 2/19/18: 217.4 lbs 2/26/18: 218.4 lbs 3/5/18: 211.4 lbs 3/7/18: 211 lbs 3/12/18: 207 lbs 3/19/18: 204.8 lbs 3/26/18: 204.8 lbs 4/2/18: 204.4 lbs A nutritional assessment, completed by registered dietician (RD)-A on 3/14/18, indicated R25 received a regular diet and was independent with eating. "Is consuming mostly 75-100% intakes w/some 0-75% at times as well." Weight declined 11.4 pounds since admission representing a 5.2% significant weight loss." [R25] appears nutritionally declined based on weight loss." R25's remains with a high body mass index (BMI). May	F 692	The past three months of dietary recommendations were reviewed by RN and all recommendation have been addressed. No other residents were affected by this deficient practice. The policy and procedure for addressing Dietary Recommendation was reviewed and revised. Director of Nursing and/or Dietary Manager will review dietary recommendation on a monthly basis to ensure that all dietary recommendation have been addressed. The Director of Nursing or Designee will report finding at the quarterly Quality Assurance Meeting.	

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benefit for high calorie/high protein snacks and supplements to assist with weight stability if accepted and desired.

During an interview on 4/2/18, at 2:18 p.m. R25 stated he had an appetite, but was losing weight because the food was "just bad." R25 stated he was not receiving a supplement. R25 stated he kept a supply of beanie weenies in the cupboard in his room. R25 went on to say "If it isn't for that, I would starve to death."

During observations on 4/4/18, at 8:42 a.m. R25 was observed walking outside. When asked about breakfast R25 stated "I don't eat breakfast here." R25 went on to say the food was "slop."

During an interview on 4/4/18, at 12:21 p.m. nursing assistant (NA)-A stated R25 does not always eat well. " [R25] is a picky eater." NA-A stated R25 has said things don't taste good because of the chemotherapy.

During an interview on 4/5/18, at 10:21 a.m. RD-A stated she comes to the facility monthly. RD-A stated each month she writes down her recommendations, then places those recommendations on the dietary manager's (DM) desk to follow up on. RD-A stated the DM was not at the facility during her March visit.

During an interview on 4/5/18, at 10:45 a.m. the dietary manager (DM) stated she works at the facility 2 times a week. The DM stated she reviews the dietician recommendations with registered nurse (RN)-A. When asked if they discussed the dietician's 3/14/18, recommendations for R25, the DM stated "I'm sure that I did." When asked about the

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recommendation, the DM stated she writes notes on the sheet of paper she receives from the dietician. The DM stated "The paper could be at my computer at home, I'm not sure."

During an interview on 4/5/18, at 10:46 a.m. RN-A stated when RD-A makes recommendations, she receives a copy of the recommendations, as well as the DM. RN-A stated the DM takes care of implementing recommendations unless the physician would need to be contacted for an order. When asked about RD-A's, 3/14/18, recommendations for R25, RN-A stated the follow up would have been completed by the DM. RN-A reviewed R25's medical record and stated she was unable to locate documentation of the DM's assessment of RD-A's recommendations.

During an interview on 4/5/18, at 10:34 a.m. cook-A stated R25 is not receiving a high calorie snack, a high protein snack, or a supplement.

During an interview on 4/5/18, at 11:52 a.m. the director of nursing (DON) stated the DON, the DM, and nursing staff get a copy of RD-A recommendations. The DON stated "I didn't get a paper last time she was here." The DON stated when RD-A recommends a supplement, we notify the physician for a supplement order. The DON stated high calorie and high protein snack recommendation are initiated without a physicians order. When asked about RD-A's recommendations for R25 from 3/14/18, the DON stated she could not positively say what was done, as it was not charted.

The facility's policy Nutritional Recommendations, undated, indicated "Nutritional recommendations from the resident/licensed dietitian will be

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F 692	Continued From page 8 followed through on a timely basis." 1. "All of the registered, licensed dietitian's nutritional recommendations for individual residents will be given to the food service supervisor (FSS), who will follow through and implement them in the facility. (Informing staff, making necessary changes on the diet tray card, etc.). The FFS will follow through on these recommendations within three bushiness days."	F 692		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the ice machine to prevent potential contamination for all 38 residents who received ice from the machine.	F 812	On April 9th, 2018, the ice machine was cleaned by the Plant Operations Manager. The policy and procedure for cleaning the Ice Machine was reviewed and revised.	4/30/18

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F 812	Continued From page 9 Findings include: During the kitchen tour on 4/2/18, at 01:15 p.m. the ice machine was observed to have had white, crusty substance, approximately 1/2 inch up around the the plastic tube where the ice flows out of the ice machine. In addition, the plastic tray that catches ice was covered with the same white, crusty, scaly, hard water buildup. During observation on 4/04/18, at 7:24 a.m. a sheet of paper was noted to be on the left side of ice machine. The paper was in a plastic sleeve. On the upper left corner of the paper was written, "2017". In addition, on the left side of the paper were columns with months of the year, January thru December. Across each month were spaces numbered 1-5. On the right side of the paper was a column labeled "quarterly" and spaces for 1-4. There was no other writing on the paper. During an interview on 4/4/18, at 7:25 a.m. cook-A stated kitchen staff did not clean the ice machine. Cook-A was not aware of whose responsibility it was, but thought it might be the maintenance department who cleans it. Cook-A stated the ice machine "looks really bad." During an observation on 4/04/18, at 7:47 a.m. dietary aide (DA)-A was observed filling pitchers from the ice machine. The top of the pitcher was observed to have touched the the plastic ice tube that was covered with white crusty substance. During an interview on 4/4/18, at 7:49 a.m. DA-A stated she thought the white scaly substance had been there awhile. DA-A stated she hadn't really noticed it.	F 812	Dietary staff were educated on the revised Ice Machine Cleaning policy and procedure and cleaning log. Dietary Manager or Designee will audit the cleaning log weekly to ensure compliance. The Dietary Manager or Designee will report finding at the quarterly Quality Assurance Meeting.	

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F 812	Continued From page 10 During an interview on 4/4/18, at 8:35 a.m. plant operations manager, (POM), stated he was responsible to clean the inside of the machine and that kitchen staff cleaned the outside. POM stated there was a sign off sheet on the ice machine to document when it was last cleaned. He stated he thought he had cleaned it earlier this year. The POM provided copy of Ice Machine Cleaning logs dated for 2016 and 2017. The POM then walked down to the kitchen to look at the ice machine and stated the sign off sheet currently on the machine was dated for 2017. POM again stated he would have cleaned the machine in January of this year but could not explain the cleaning log on the fridge dated for 2017 with no sign offs that it had been cleaned. Facility policy titled, Cleaning Ice Machine, Scoop and tray, undated, identified, the ice machine will be cleaned on a regular basis to maintain a clean sanitary condition. The policy did not identify who was responsible to clean the the ice machine.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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:	F 880		4/30/18

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F 880	Continued From page 11 §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: (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.	F 880		

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F 880	Continued From page 12 §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 interview and documentation review the facility failed to implement a comprehensive infection control program to include day to day tracking of signs and symptoms of infections not requiring antibiotics. This had the potential to affect all 38 residents at the facility, and staff and visitors in the facility. Findings include: The facility infection control data from January 2018 through March 2018 identified the following information: The infection control line by line log for January 2018, February 2018 and March 2018 indicated an area to document the resident name, unit, room number, admit date, infection type, body system of infection, if surveillance definition was met, community onset, facility onset, symptoms, onset date, devise types, date of infection, date of removal, device days, infection risk factors, collection date, type of test, specimen source, results, antibiotic resistive organisms, number of current antibiotic currently prescribed, drug dose	F 880	On April 9th, the Infection Control Policy and Log was reviewed and revised to include the day to day tracking of signs and symptoms of infections not requiring antibiotics. The Director of Nursing or Designee will review the Infection Control Logs monthly to ensure proper tracking is being conducted. The Director of Nursing or Designee will report finding at the quarterly Quality Assurance Meeting.	

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route and frequency, antibiotic prescription origination, start date, end date, total days of therapy, meets criteria, antibiotic reassessment, drug dose route, frequency, provider, antibiotic prescription origination. However, did not include an area to track illness or symptoms of infection that did not require antibiotic treatment.

January 2018 Antimicrobial Use Summary Report, summarized all systematic antibiotics prescribed during the month of January. A total number of 11 antibiotic courses in 6 patients were reviewed during this month period. The report did not identify infections that did not need antibiotics.

February 2018 Antimicrobial Use Summary Report, summarizes all systemic antibiotics prescribed between February 1, 2018 to February 28, 2018. A total number of three antibiotic courses in three residents were reviewed. The most common reason for starting antibiotic therapy were respiratory infections. One antibiotic was a preventive. The report did not identify infections that did not need antibiotics.

March 2018 Antimicrobial Use Summary Report, this report summarizes all systemic antibiotics prescribed between March 1, 2018 to March 31, 2018. A total number of 8 antibiotic courses in 6 residents were reviewed. The most common reasons for starting antibiotic therapy were skin and urinary infections. The report did not identify infections that did not need antibiotics.

Although the facility line by line infection control logs identified all the required areas for infections with antibiotics, the facility failed to track infections not requiring antibiotics.

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F 880	Continued From page 14 On 4/5/18 9:30 a.m. registered nurse (RN)-B stated she had infection control tracking for antibiotics but does not have infection control tracking for infections not requiring antibiotics. RN-B stated she will develop something to track infections not requiring antibiotics. The facility policy, Titled Infection Control Policy, revised October 27, 2017 indicated the objective of this requirement is for the facility to develop a comprehensive Infection Control Policy that establishes a facility- wide system for the prevention, identification, investigation and control of infections of residents, staff and visitors is based upon facility assessment, best practices and regulatory compliance's for the goal of quality systems for care.	F 880		

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 04, 2018. At the time of this survey, Belgrade Nursing Home was found not to be 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@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.
Belgrade Nursing Home was constructed as follows:
The original building was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction;
The 1968 addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction;
The 1981 addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction;
The 1987 addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction;
The 1988 addition is one story in height, has no

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K 000	Continued From page 2 basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The 1988 building addition consists of seven (7) senior apartments. Because the 1988 addition was not separated from the nursing home by 2-hour construction, the senior apartments were surveyed as part of the nursing home. The 2013 Physical Therapy addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. At the time of the survey all building were surveyed as one. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 39 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET, as evidenced by:	K 000		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		5/4/18

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	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2018**

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K 901	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between Noon and 3:00 PM on 04/04/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the Environmental Services Supervisor.	K 901	The NFPA 99 Facility Systems and Equipment Risk Assessment will be completed. The Plant Operations Manager will be responsible for completing the Risk Assessment and monitoring for compliance.	
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 1 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	K 914		5/4/18

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K 914	Continued From page 4 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. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2.4. This could negatively affect 39 of 39 patients as well as an undetermined number of staff, and visitors to the facility. Findings include: During documentation review on 04/04/2018 between Noon and 3:00 PM, documentation could not be located to show that an electrical outlet inspection had occurred throughout the facility. This deficient condition was confirmed by the Environmental Services Supervisor.	K 914	The NFPA 99 Gas and Electrical Equipment Risk Assessment will be completed. The Plant Operations Manager will be responsible for completing the Gas and Electrical Equipment Risk Assessment and monitoring for compliance.	