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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: R0HT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00102

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245189**

2.STATE VENDOR OR MEDICAID NO.
(L2) **798240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTHVIEW ACRES HEALTH CARE CENTER INC**
(L4) **2000 OAKDALE AVENUE**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

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 **03/02/2015** (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)
12/31

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

12.Total Facility Beds **241** (L18)

13.Total Certified Beds **241** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	241			
(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 :
Sue Reuss, Supervisor 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/02/2015 (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
04/15/1974
(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
02/13/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5189

Electronically Delivered: March 2, 2015

Ms. Shelly Weiss, Administrator
Southview Acres Health Care Center Inc
2000 Oakdale Avenue
West Saint Paul, Minnesota 55118

Dear Ms. Weiss:

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 February 24, 2015 the above facility is certified for:

241 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 241 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 feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 2, 2015

Ms. Shelly Weiss, Administrator
Southview Acres Health Care Center Inc
2000 Oakdale Avenue
West Saint Paul, Minnesota 55118

RE: Project Number S5189025

Dear Ms. Weiss:

On January 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 15, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 15, 2015, effective February 24, 2015 and therefore remedies outlined in our letter to you dated January 27, 2015, 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.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

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

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
245189	A. Building B. Wing	3/2/2015

Name of Facility	Street Address, City, State, Zip Code
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/24/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/24/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **02/24/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/24/2015**	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** SR/AK	**Date:** 03/02/2015	**Signature of Surveyor:** 16022	**Date:** 03/02/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/15/2015

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: R0HT

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Facility ID: 00102

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2.STATE VENDOR OR MEDICAID NO.
(L2) **798240200**

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(L3) **SOUTHVIEW ACRES HEALTH CARE CENTER INC**
(L4) **2000 OAKDALE AVENUE**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

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 **01/15/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
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)
12/31

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To (b) :

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___ 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: **X**
* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	241			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 02/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/12/2015 (L20)

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

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3. Both of the Above :
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04/15/1974
(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
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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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 27, 2015

Ms. Shelly Weiss, Administrator
Southview Acres Health Care Center Inc
2000 Oakdale Avenue
West Saint Paul, Minnesota 55118

RE: Project Number S5189025

Dear Ms. Weiss:

On January 15, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and
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 a "F" tag), i.e., the plan of correction should be directed to:

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

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 24, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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 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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 April 15, 2015 (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 July 15, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified

for compliance or the imposition of remedies.

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

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

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure 2 of 3 residents (R20 and R337) identified at risk for pressure ulcers (PU) received timely positioning and urinary incontinence care as directed by the plan of care. Findings include: R20 did not receive position change or incontinence check for three hours and thirty minutes and four hours and twenty eight minutes. R20 has a recurrent shearing area to the coccyx.	F 282	Resident R20's area of shearing was noted as healed by the wound team on 1/20/15. Continuing to cover the area with hydrocolloid to aid in promoting tensile strength. Clinical manager completed another Tissue Tolerance test and Bowel and Bladder assessment for resident R20. Care plan and assignment sheet were reviewed and updated as well. Resident R20 was assessed by OT and placed in tilt and space chair in April 2014.	2/24/15

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

Electronically Signed | 02/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTH CARE CENTER INC	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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 282	Continued From page 1 R20's Care Area Assessment (CAA) dated 12/22/14, directed staff: "Resident has an area of shearing [Shear occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage] on her coccyx. Her Braden scale score is 14 and this score is indicative of the resident being at a high risk for the development of pressure ulcers. Resident is incontinent of bowel and urine. She is cognitively impaired due to her dx [diagnosis] of dementia." The plan of care dated 9/16/13, read, "At risk for skin breakdown R/T [related to] impaired mobility, diabetes,CVA,[cerebral vascular accident] hx [history] of healed wounds, dementia, total assist with mobility." The policy titled, Bladder and Bowel Assessment dated 5/15/14, and Positioning Assessment dated 2/14, directed staff to follow the aide assignment sheet for the individualized bowel, bladder and positioning plans. The aide assignment sheet dated 1/12/15, read: "Get up by 7:30 a / Nap after brunch til [sic] 2p / Res may get ready for bed when requested by family after evening meal is complete for the unit. Repo [reposition] q2H [every two hours]." For the incontinence of bowel and bladder the aide assignment sheet read "check and change brief upon rising, after brunch and after nap, HS [hour of sleep] and prn [whenever necessary]." The form dated 12/17/14 and titled, Tissue Tolerance Observation, directed staff to turn and reposition every 2 hours. The annual Minimum Data Set (MDS) dated 12/24/14, directed staff following the incontinence assessment that R20 was always incontinent of	F 282	Staff began having difficulty keeping resident in good alignment in chair and resident was once again referred to OT. During the first week of January 2015 a new Guiditta specialty chair was ordered. This chair arrived during the survey on January 13, 2015. The resident was placed in the chair at that time. New specialty cushion was placed on 2/6/2015. Resident R337's cushion was replaced during the survey on 1/14/15. Resident R337 was placed in a Broda chair on 1/22/15 to assist with positioning and promoting comfort. Resident 337 was on Hospice during her stay at the facility and continued to decline and has now past away. Nursing assistants were re-educated regarding following assignment sheets, which are derived from each residents individualized plan of care regarding repositioning, toileting and providing incontinence care. Nursing assistants and licensed nurses were re-educated on offloading residents to relieve pressure. Licensed nurses were re-educated regarding Tissue Tolerance testing, Bowel and Bladder assessments and care plan development. Licensed nurses were also re-educated on supervision and follow up regarding repositioning, toileting and providing incontinence care. Nursing assistants and licensed nurses were re-educated by Rehabilitation department on cushions and appropriate	

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F 282	Continued From page 2 bowel and bladder. The goal of the plan of care for bowel and bladder incontinence dated 12/31/14, read, "will be clean, dry and odor free." During a continuous observation on 1/12/15, from 2:30 p.m. until 6:00 p.m., R20 was seated in a specialty wheel chair with three cushions propped under both feet. The chair did not allow for R20's knees to fit under the dining room table. During a continuous observation on 1/14/15, from 7:30 a.m. until 11:57 a.m. R20 was seated in a different wheel chair that did not require cushions under her feet, and did allow her knees to fit under the dining room table. R20 remained seated without an offer to position change and without a check for incontinence for four hours and twenty eight minutes. R337 did not receive position change or incontinence check for two hours and thirty minutes and two hours and fifty-four minutes. R337 has a pressure ulcer on the left front lateral hip which measures 1.7 cm [centimeter] by 1.5 cm. The open area was covered with slough [necrotic/avascular tissue in the process of separating from the viable portions of the body and is usually light colored, soft, moist, and stingy (at times) and eschar [Thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound] and was not staged by the facility. R337's CAA dated 12/29/14, directed staff, "has an unstageable pressure ulcer on her left hip. Her Braden scale score is 15. Her mobility is impaired due to her dx [diagnosis] DJD [degenerative joint	F 282	use and placement. Random audits will be completed and followed up on by Licensed nurses, Clinical Managers, and Clinical Coordinators. Results will be forwarded to DON and QA committee for review and recommendations. Clinical Managers are responsible for monitoring	

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F 282	Continued From page 3	F 282		

disease] and a T12 [thoracic] compression fx [fracture]. She is cognitively impaired due to her dx of Alzheimer/dementia. She requires extensive assistance with bed mobility. She is incontinent of bowel and urine." The policy titled, Bladder and Bowel Assessment dated 5/15/14, and Positioning Assessment dated 2/14, directed staff to follow the aide assignment sheet for the individualized bowel, bladder and positioning plans. The aide assignment sheet dated 1/12/15, read: "Toilet routinely." Furthermore the aide assignment sheet read: "Lay down after brunch, O/A [open area] on left hip-Needs to be REPO [repositioned] q2h."
The form dated 9/20/14 and titled, Tissue Tolerance Observation, directed staff to turn and reposition every 2 hours.

During a continuous observation on 1/14/15, from 7:00 a.m. until 8:30 a.m. R337 had been lying on the left hip. Registered nurse (RN)-C removed the bed covers which revealed a large ring of urine, twelve to fifteen inches of incontinence area on the bottom sheet, surrounded by a 2-3 inch ring of brown stain, and the incontinence brief was saturated. RN-B called the night aides responsible for R337's care and reported they changed her [R337's] position and incontinence brief just before 6:00 a.m..

During a continuous observation on 1/14/15, from 9:00 a.m. until 11:54 a.m. R337 was up in the wheel chair sitting on a specialty cushion which seemed to be one inch of thickness on the left side and two inches of thickness on the right side. The surveyor questioned staff if the application of the pressure relieving cushion was correct in the wheel chair. The licensed practical nurse (LPN)-A and nursing assistant (NA)-A,

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F 282	Continued From page 4 were not sure. On 1/14/15, at 11:54 a.m. NA-A assisted LPN-A in using the mechanical stand to transfer R337 to bed. A request was made to visualize R337's buttocks due to a lack of repositioning. R337's buttocks and posterior thighs had deep red crevices and wrinkling of the skin. R337 was incontinent a large amount of urine. NA-A verified R337 should have had her position changed every two hours and thought it was ok to just pull on the mechanical sling to shift the position. LPN-A and NA-A did not know how many minutes to offload a resident from a sitting position. They would need to check and get back to surveyor. Surveyor again question the cushion in the wheel chair and LPN-A and NA-A realized the cushion was put in the wheel chair wrong and verified the way the cushion was in the wheel chair would cause more pressure to R337's left hip decubitus. A review of the policy dated 11/1/14, and titled Tissue Tolerance Evaluation read: "Per current standard of practice repositioning includes off loading for a minimum of one minute."	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		2/24/15

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F 314	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R20 and R337) in the sample reviewed for pressure ulcers received care and services necessary to minimize the risk for development of pressure ulcers and heal existing pressure ulcers. Findings include: R20 did not receive position change for three hours and thirty minutes and four hours and twenty eight minutes. R20 has a recurrent shearing to the coccyx. During a continuous observation on 1/12/15, from 2:30 p.m. until 6:00 p.m., R20 was seated in a specialty wheel chair with three cushions propped under both feet. The chair did not allow for R20's knees to fit under the dining room table and family was standing to assist with feeding R20. During a family (F)-A interview on 1/12/15, at 5:37 p.m. the wheel chair was referred to as a "Tilt in Space" and F-A indicated R20 remained seated without an offer to position change and without a check for incontinence until after 6:00 p.m. and that was the "routine" for the facility. F-A expressed concern and stated, "She has a new open area on her bottom again." The F-A further expressed dissatisfaction with the wheelchair and expressed frustration to staff for a different chair at the past couple of care conferences, one where [R20] would be able to fit her knees under the dining table and more accommodating so the	F 314	For resident R20 this is a rollover tag from F282.Please cross reference Plan of Correction for F314 from F282 for resident R20 as it is the same. For resident R337 this is a rollover tag from F282. Please cross reference Plan of Correction for F314 from F282 for resident R337 as it is the same.	

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F 314	Continued From page 6 family would not have to stand to feed [R20]. During a continuous observation on 1/14/15, from 7:30 a.m. until 11:57 a.m., R20 was seated in a different wheel chair that did not require cushions under her feet, and did allow her knees to fit under the dining room table. R20 remained seated without an offer to position change for four hours and twenty eight minutes. R20's Care Area Assessment (CAA) dated 12/22/14, directed staff: "Resident has an area of shearing [Shear occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage] on her coccyx. Her Braden scale score is 14 and this score is indicative of the resident being at a high risk for the development of pressure ulcers. She is cognitively impaired due to her dx [diagnosis] of dementia." The plan of care dated 9/16/13, read, "At risk for skin breakdown R/T [related to] impaired mobility, diabetes,CVA,[cerebral vascular accident] hx [history] of healed wounds, dementia, total assist with mobility." The facility document titled, Skin Condition Report-Unhealed Daily Wound Assessment, dated 12/17/14, at 2:41 p.m. read, "Present on the coccyx is a Shearing, Length in cm [centimeter]=0.4, Width in cm=1.0." On 1/13/15, at 3:08 p.m. the notes read, "Present on the coccyx is a Shearing, Area measures 0.7x1.4 cm." The policy titled, Positioning Assessment dated 2/14, directed staff to follow the aide assignment	F 314		

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F 314	Continued From page 7	F 314		

sheet for the individualized positioning plans. The aide assignment sheet dated 1/12/15, read: Repo [reposition] q2H [every two hours]." The form dated 12/17/14 and titled, Tissue Tolerance Observation, directed staff to turn and reposition every 2 hours. Furthermore, the policy directed staff if the area remains red, initiate protocol for stage 1 pressure ulcer and decrease repositioning interval as appropriate.

R337 did not receive position change for two hours and thirty minutes and two hours and fifty-four minutes. R337 had a pressure ulcer on the left front lateral hip which measures 1.7 cm [centimeter] by 1.5 cm. open area covered with slough [necrotic/avascular tissue in the process of separating from the viable portions iof the body and is usually light colored, soft, moist, and stringy (at times) and eschar [Thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound] and was not staged by the facility.

During a continuous observation on 1/14/15, from 7:00 a.m. until 8:30 a.m. R337 had been lying on the left hip. Registered nurse (RN)-C removed the bed covers which revealed a large ring of urine, twelve to fifteen inches of incontinence area on the bottom sheet surrounded by a 2-3 inch ring of brown stain and the incontinence brief was saturated. RN-B called the night aides responsible for R337's care and reported they changed her [R337's] position and incontinence brief just before 6:00 a.m..

During a continuous observation on 1/14/15, from 9:00 a.m. until 11:54 a.m. R337 was up in

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F 314	Continued From page 8	F 314		

the wheel chair sitting on a specialty cushion which seemed to be one inch of thickness on the left side and two inches of thickness on the right side. The surveyor questioned staff if the application of the pressure relieving cushion was correct in the wheel chair. The licensed practical nurse (LPN)-A and nursing assistant (NA)-A, were not sure. On 1/14/15, at 11:54 a.m. NA-A assisted LPN-A in using the mechanical stand to transfer R337 to bed. A request was made to visualize R337's buttocks due to a lack of repositioning. R337's buttocks and posterior thighs had deep red crevices and wrinkling of the skin.

R337's CAA dated 12/29/14, directed staff, "has an unstageable pressure ulcer on her left hip. Her Braden scale score is 15. Her mobility is impaired due to her dx [diagnosis] DJD [degenerative joint disease] and a T12 [thoracic] compression fx [fracture]. She is cognitively impaired due to her dx of Alzheimer/dementia. She requires extensive assistance with bed mobility." The policy titled, Positioning Assessment dated 2/14, directed staff to follow the aide assignment sheet for the individualized positioning plans. The aide assignment sheet dated 1/12/15, read: "O/A [open area] on left hip-Needs to be REPO [repositioned] q2h."
The form dated 9/20/14 and titled, Tissue Tolerance Observation, directed staff to turn and reposition every 2 hours. Furthermore the policy directed staff If the area remains red, initiate protocol for stage 1 pressure ulcer and decrease repositioning interval as appropriate.

When interviewed on 1/14/15, at 11:57 a.m. NA-A verified R337 should have had her position changed every two hours and thought it was ok to

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F 314	Continued From page 9 just pull on the mechanical sling to shift the position. LPN-A and NA-A did not know how many minutes to offload a resident from a sitting position. They would need to check and get back to surveyor. Surveyor again questioned the cushion in the wheel chair and LPN-A and NA-A realized the cushion was put in the wheel chair wrong and verified the way the cushion was in the wheel chair would cause more pressure to R337's left hip decubitus. A review of the policy dated 11/1/14, and titled Tissue Tolerance Evaluation read: "Per current standard of practice repositioning includes off loading for a minimum of one minute."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R20 and R337) in the sample,who were identified as incontinent of urine, received the necessary care and services to manage incontinence.	F 315	For resident R20 this is a rollover tag from F282. Please cross reference Plan of Correction for resident R20 for F315 from F282 as it is the same.	2/24/15

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F 315	Continued From page 10 Findings include: R20 did not receive incontinence care for three hours and thirty minutes and four hours and twenty eight minutes during two observations. During a continuous observation on 1/12/15, from 2:30 p.m. until 6:00 p.m., R20 was seated up in a wheel chair and was not checked for incontinence or changed. During a family (F)-A interview on 1/12/15, at 5:37 p.m. F-A indicated R20 remained seated without a check for incontinence until after 6:00 p.m. and that was the "routine" for the facility. F-A expressed concern and stated, "She has a new open area on her bottom again." During a continuous observation on 1/14/15, from 7:30 a.m. until 11:57 a.m. R20 remained seated without an offer to check for incontinence or change for four hours and twenty eight minutes. R20 was incontinent of urine and the coccyx wound dressing was wrinkled on the skin and saturated with urine when changed at 11:57 a.m. R20's buttocks and posterior thighs had bright red areas with crevices and craters from the urine saturated incontinence brief. LPN-A and NA-A verified the condition of R20's skin at the time of the observation. R337 did not receive incontinence care for two hours and thirty minutes and two hours and fifty-four minutes during two observations. During a continuous observation on 1/14/15, from 7:00 a.m. until 8:30 a.m. R337 had been lying on the left hip. Registered nurse (RN)-C removed	F 315	For resident R337 this is a rollover tag from F282. Please cross reference Plan of Correction for resident R337 for F315 from F282 as it is the same.	

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F 315	Continued From page 11	F 315		

the bed covers which revealed a large ring of urine, twelve to fifteen inches of urine incontinence area on the bottom sheet surrounded by a 2-3 inch ring of brown stain and the incontinence brief was saturated. RN-B called the night aides responsible for R337's care and reported they changed her [R337's] incontinence brief just before 6:00 a.m.. The left hip wound dressing was wrinkled and saturated with urine. RN-C verified the condition of the resident's skin at the time of the observation.

During a continuous observation on 1/14/15, from 9:00 a.m. until 11:54 a.m. R337 was up in the wheel chair and there were no checks for incontinence or changing. NA-A assisted LPN-A in using the mechanical stand to transfer R337 to bed. R337's buttocks and posterior thighs had deep red crevices and wrinkling of the skin. The incontinence brief was saturated a large amount of urine and the left hip wound dressing was wrinkled and saturated with urine. NA-A and LPN-A verified the condition of the resident's skin at the time of the observation

R337's CAA dated 12/29/14, directed staff, "has an unstageable pressure ulcer on her left hip. Her mobility is impaired due to her dx [diagnosis] DJD [degenerative joint disease] and a T12 [thoracic] compression fx [fracture]. She is cognitively impaired due to her dx of Alzheimer/dementia. She requires extensive assistance with bed mobility."

The Minimum Data Set (MDS) dated 12/24/14, directed staff following the incontinence assessment that R20 was always incontinent of bowel and bladder.

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F 315	Continued From page 12 When interviewed on 1/14/15, at 11:57 a.m. LPN-A and NA-A verified R337 should be checked for incontinence every two hours or sooner due to the existing wound on the left hip. Furthermore, LPN-A and NA-A verified a resident who is always incontinent of urine with a open wound needs more frequent skin cleansing to keep the area clean and dry from urine and feces.	F 315		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		2/24/15

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(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 356	Continued From page 13 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing hours were posted to note which actual hours were worked by each category of nursing staff. This had the potential to minimally impact all 217 residents and any visitors wishing to review posted nursing hours. Findings include: On 1/12/15 at 11:30 a.m. the Direct Resident Care Staff Posting was observed posted near the front entrance. Review of the Direct Resident Care Staff Posting for 1/12/15 through 1/15/15 revealed shift hours (actual hours) were listed, but it was not clear which category of nursing staff worked each shift. For example, on 1/13/15, Shifts were listed as: 2:30 p.m. to 11:00 p.m., 3:00 p.m. to 11:30 p.m. and 4:00 p.m. to 10:00 p.m. Total number of staff and total numbers of hours worked for each category of nursing staff (registered nurse, licensed practical nurse, nursing assistant and trained medication assistant) were noted below the shift hours. However, it was not clear which category of nursing staff worked each shift listed. It was also unclear how many of each category of nursing staff were on during the short shift (4:00 p.m. to 10:00 p.m.) versus the entire shift (2:30 p.m. to 11:00 p.m. and 3:00 p.m. to 11:30 p.m.).	F 356	The facility posts this information daily at the beginning of each shift. The Direct Resident Care Staff Posting sheets were updated on 1/12/12 during a previous survey. At that time they were deemed compliant with this requirement. The sheets were updated again on 1/15/15 to reflect hours worked by each category of nursing staff. Staffing Coordinator was re-educated and the updated sheets were implemented. Building Charge / Supervisors/ Clinical managers have been re-educated on use and posting of the updated forms. Random audits will be completed by the Clinical Management Team and forwarded to the DON and QA committee for review and recommendations. DON is responsible to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	01/15/2015

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F 356	Continued From page 14 On 1/15/15 at 3:26 p.m. the director of nursing (DON) explained licensed nurses and unlicensed nursing staff worked different hours. DON confirmed this was not clear to the average visitor or resident who may wish to view posted nursing staff hours.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Southview Acres Health Care Center was found 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. The Southview Acres Health Care Center is a 4-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1961 and was determined to be of Type II(222) construction. In 1973, 1978 additions were constructed to the West Wing that was determined to be of Type II(222) construction. In 2000, additions were added to the East Wing that were determined to be of Type II (222) construction. Because the original building and the 3 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 241 beds and had a census of 225 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2015**

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K 000	Continued From page 1 MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		