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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: S5N4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00968

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245281**

2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CLAYCO CARE CENTER**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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) **08/01/2011**

6. DATE OF SURVEY **02/04/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NEII 02/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**
VOLUNTARY
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.
00140 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
02/15/2014 (L33)

DETERMINATION APPROVAL

CCN-24-5281

On February 7, 2014, a Post Certification Revisit was completed and verified correction of deficiencies issued pursuant to the standardy survey completed on December 18, 2013, effective January 27, 2014. Refer to the CMS 2567b for the results of this visit.

Effective January 27, 2014 the facility is certified for 35 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS CertificationNumber (CCN): 24-5281

April 13, 2014

Ms. Jessica Raad, Administrator
Clayco Care Center
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

Dear Ms. Raad:

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

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

Effective January 27, 2014 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8439

February 7, 2014

Ms. Jessica Raad, Administrator
Clayco Care Center
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

RE: Project Number S5281024

Dear Ms. Raad:

On January 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 18, 2013. 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 February 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 18, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 18, 2013, effective January 27, 2014 and therefore remedies outlined in our letter to you dated January 10, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697
Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245281	A. Building B. Wing	2/4/2014

Name of Facility	Street Address, City, State, Zip Code
CLAYCO CARE CENTER	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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 **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **01/24/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/24/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/27/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/27/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/27/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MT/kfd	02/07/2014	31593	02/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/18/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S5N4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

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(L1) **245281**

2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CLAYCO CARE CENTER**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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) **08/01/2011**

6. DATE OF SURVEY **12/18/2013** (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 **35** (L18)

13.Total Certified Beds **35** (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: * Code: B (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NE II 01/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/05/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN-24-5281

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

A complaint investigation had been completed at the time of the standard recertification survey. An investigation of complaint H5281025 had not been substantiated during this survey.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8361

Corrected Letter-Revised

January 30, 2014

Mr. Rustad, Administrator
Clayco Care Center
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

Please note this letter will replace the letter dated 1/10/2014. The corrections are as follows:
On page 4, the three months after identification of noncompliance date should be March 18, 2014 and on page 5, the six months after identification of noncompliance date should be June 18, 2014

RE: Project Number S5281024 and Complaint number H5281025

Dear Ms. Raad:

On December 18, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 18, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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;

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:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
Telephone: (218) 332-5140
Fax: (218) 332-5196

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 January 27, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 27, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

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

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

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

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

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

-Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 18, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYCO CARE CENTER	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation had been completed at the time of the standard recertification survey. An investigation of complaint H5281025 had not been substantiated during this survey.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure state agency survey results were available for residents, family members and visitors to review, for 20 of 20 residents who	F 167	F167: Survey Results. 1. Current survey results are posted in the entrance to the main dining room with a sign posted by the administrators office in the front lobby, directing all residents & visitors where the information is posted. 2. All residents are informed of the survey postings upon admission and during Resident Council Meetings. 3. The Administrator will audit the presence of the survey book daily for 14 days and weekly for 90 days thereafter. 4. Audit outcomes will be presented to the QAA Committee for review and/or comment. 5. Date of completion: 12/19/2014.	

1/29/14 - OK - addendum

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

Mark Rustad | Acting Administrator | 1-21-14

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

RECEIVED
JAN 22 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYCO CARE CENTER	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 167	Continued From page 1 resided in the facility. Findings include: During the initial tour on 12/15/13, at 12:30 p.m., an eight by 11.5 inch sign was observed, posted on the wall at the entrance to the facility, which instructed interested residents and visitors that the state agency survey results were located in the facility's dining room. Observation of the entrance to the dining room revealed a clear, plastic receptacle mounted on the wall; however, the receptacle did not contain the survey results. Upon observation of the entire dining room area, no posting of the survey results were located. During subsequent observations on 12/16/13, and 12/17/13, no posting of the survey results were found within the facility. During interview on 12/18/13, at 1:03 p.m., the facility administrator identified that recent survey results were to be in the plastic receptacle mounted on the wall, at the entrance to the dining room. The administrator confirmed the results were not available as was identified on the posted sign and confirmed he was aware the survey results were to be made readily available for residents and families to review.	F 167		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	F329: Unnecessary Meds. 1. R8's record including his overall plan of care has been reviewed and updated as needed to reflect his current regimen's for pain control. 2. All residents receiving analgesics or other pain relieving modalities shall have routine monitoring for pain control and have those modalities outlined in their overall plan of care which includes physician orders, medication and treatment sheets. 3. All staff who administer medications shall be educated on the documentation requirements of pain monitoring. The DON or designee[s] shall initially audit all resident records	

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F 329	Continued From page 2 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to justify the ongoing use of an pain medication, and provide ongoing monitoring for 1 of 3 residents (R8) who received daily pain medication. Findings include: R8's annual Minimum Data Set (MDS) dated 9/2/13, revealed diagnoses which included stiffness of joints, neuropathy, mononeuritis (inflammation of a nerve, causing pain) and osteoarthrosis. The MDS revealed R8's cognition was intact and he required assistance with activities of daily living. The MDS further identified R8 had no reports of pain, he had not received a routine dose of pain medication and	F 329	for those residents receiving pharmacological or other pain relieving modalities to assure appropriateness and effectiveness as well as routine assessments. Overall plans of care shall reflect these modalities. Thereafter, all resident records shall be audited for ongoing needs at least quarterly. 4. Audit outcomes shall be presented to the QAA Committee for review and/or comment. 5. Date of Correction: 01/24/14	

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F 329	Continued From page 3	F 329		

he had not received non-medication interventions for pain management.

The care plan revised 12/9/13, included a focus area related to pain; however, the care plan did not identify R8 used an routine dose of pain medication to manage his pain, nor did the care plan include any non-pharmaceutical interventions related to pain management.

Review of R8's medical record revealed a physician order, signed and dated 4/4/12, for Cymbalta (an antidepressant medication) 60 milligram (mg) daily, at bed time for mononeuritis pain.

Review of R8's medical record revealed a lack of documented analysis for or assessment of his pain.

The monthly consultant pharmacist's medication reviews were reviewed from 3/12/13, to 11/27/13. On 9/25/13, the notes indicated due to history of neuropathy and sexual inappropriateness, the Cymbalta dose was noted as appropriate for R8. However; the monthly review did not identify a routine pain assessment and non-pharmacological interventions were lacking.

During interview on 12/18/13, at 2:15 p.m. the interim administrator indicated he was unsure of the reason R8 was receiving Cymbalta and confirmed the clinical record lacked evidence of routine assessments and monitoring of R8's pain.

During interview on 12/19/13, at 4:00 p.m. the director of nursing (DON) confirmed R8's MDS, current care plan and facility policy. She indicated she understood R8 received Cymbalta to improve

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F 329	Continued From page 4 his mood, had not commonly had pain concerns and had not used supplemental pain medications in the past. The DON confirmed R8 had not had routine pain assessments completed and she stated she would expect routine pain assessments for a resident who received pain medications. The undated policy titled Pain Assessment identified a comprehensive pain assessment was to be completed as part of the initial nursing assessment with development of a pain management program. The assessment was to be reviewed quarterly and with significant changes. Assessment of pain management was to occur daily. In addition, pain was to be assessed and documented at regular intervals.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve resident meals in a sanitary manner for 14 of 14 residents (R4, R5, R10, R14, R15, R21, R23, R24, R26, R29, R30, R32, R33 and R44), who ate in the facility	F 371	F371: Dietary sanitation. 1. All residents shall be served their meals/food in a sanitary manner. 2. All staff serving and handling food shall be educated on the need to follow strict infection control practices including appropriate glove usage practices. 3. The ICC Nurse and Administrator or designee[s] shall do observational audits of meal service daily X7 days to assure appropriate compliance. Thereafter, audits will be completed at least weekly X30 days. 4. Audit outcomes shall be shared with the QAA Committee for review and/or comments. 5. Date of Correction: 01/27/2014	

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dining room.

Findings include:

During breakfast meal service on 12/17/13, from 8:00 a.m. to 8:45 a.m., the following was observed:

At 8:00 a.m., residents were gathering in the facility dining room for breakfast. A preparation table was noted at the northwest end of the dining room, set with breakfast items. Also on the northwest wall of the dining room, was a counter with a toaster and a small silver-colored refrigerator. The dietary manager (DM) and cook (C)-A served resident meals from this table, placing the plates/bowls on a tray and delivering them to the resident tables, where they removed the bowls/plates from the trays, setting them on the dining room tables in front of each resident.

At 8:01 a.m., wearing clear vinyl-type gloves on both hands, DM retrieved a slice of bread from a plastic container and placed it in the toaster. Wearing the same gloves, DM then picked up a container of brown sugar to be mixed with a resident's cereal. The DM began opening containers which included milk and a powdered food supplements, handling the outside of each container. The DM then retrieved the slice of toast from the toaster, handling the ready-to-eat toast with the same gloved hands, and placed the toast on a plate for a resident meal. The DM then pushed a plastic garbage can which contained terry cloth clothing protectors down the back hallway to the facility kitchen area, while still wearing the same gloves. When the DM returned to the table, he picked up silverware for resident use, handing the eating ends of the silverware

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F 371	Continued From page 6	F 371		

with the same gloves. DM then touched the edge of a bowl of cereal and served it to a resident. Wearing the same gloves, DM peeled and touched a ready to eat banana, picked up a slice of toast and placed both on a plate for a resident meal. The DM did not remove or change his gloves throughout this observation.

At 8:01 a.m., C-A wore clear vinyl gloves on both hands. In the process of preparing resident meals, C-A picked up a container of juice, and poured the juice into glasses for resident use. C-A then retrieved a slice of toast from the toaster, buttered it while holding the toast with the same gloved hands. C-A opened the refrigerator door, moved items around in the refrigerator, touching the outside of the items and brought a bottle of juice and a container of half and half to the table. C-A opened a bag of sliced bread and placed the bread slices into a plastic container on the table, handling the slices of bread with the same gloved hands. C-A then picked up a slice of bread from the container and placed it in the toaster. C-A retrieved the toast with the same gloved hands. She then placed butter and jelly on the toast and placed the toast on a plate to serve for a resident meal. C-A did not remove or change her gloves throughout this observation.

At 8:20 a.m., C-A walked to the main kitchen area and returned without gloves. C-A donned a pair of clear vinyl-type gloves and proceeded to pick up a resident's cell phone which had fallen on the floor. C-A then continued to prepare resident meals wearing the same gloves. C-A removed a slice of toast from the toaster and spread butter on the toast, holding the toast with the same gloved hands.

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F 371	Continued From page 7 On 12/18/13, at 8:40 a.m., DM verified he did not change gloves during the resident meal service. DM confirmed gloves were considered contaminated if they touched something contaminated and should not be used to touch ready-to-eat food for resident meals. On 12/18/13, at 8:45 a.m., C-A verified her gloves were not changed after they were contaminated by picking up the cell phone from the floor. C-A confirmed that gloves were to be changed if contaminated and were not be used to touch ready-to-eat food for resident meals. On 12/18/13, at 10:00 a.m., the facility administrator confirmed ready-to-eat foods for resident meals were not to be handled with bare hands or contaminated gloves. Review of the facility policy titled, Hand Washing and Glove Use, dated 6/17/09, revealed hands were to be washed following contact with any unsanitary surface which included opening doors. The policy further revealed gloves were to be changed as often as hands needed to be washed and it was important to remember that gloves could often give a false sense of security and could carry germs the same as hands. The policy identified hand washing and correct glove use were a priority for infection control to promote a safe and sanitary condition throughout the facility.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428	F428: Pharmacy Reviews. 1. RPh has reviewed R8's medication regimen which has included an updated pain assessment with the analysis of his pain relief needs.	

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F 428	Continued From page 8 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to identify irregularities during the monthly review related to assessment, ongoing monitoring for the continued use of routine pain medication for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: Review of R8's medical record revealed a physician order, signed and dated 4/4/12, for Cymbalta 60 milligram (mg) daily, at bed time for mononeuritis pain. Review of R8's medical record revealed a lack of documented analysis for or assessment of his pain. The monthly consultant pharmacist's monthly medication reviews were reviewed from 3/12/13 to 11/27/13. On 9/25/13, a note identified due to history of neuropathy and sexual inappropriateness, the Cymbalta dose was noted as appropriate for R8. However; the monthly review did not identify a routine pain assessment and non-pharmacological interventions were	F 428	2. Monthly reviews by the RPh have been completed on all in-house residents with a focus on medications to control resident's pain. 3. DON or designee shall review all RPh recommendations of all residents monthly with the attending medical practioner to assure timely and accurate responses to recommendations. 4. Audit outcomes will be reviewed by the QAA Committee for review &/or recommendations. 5. Date of correction: 01/27/14	

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F 428	Continued From page 9 lacking. During a telephone interview on 12/19/13, at 4:52 p.m. Pharmacist-A verified R8 received a daily dose of Cymbalta for pain management. Pharmacist-A confirmed there was a lack of assessment and documentation in R8's medical record to justify the continued use of Cymbalta for management of R8's pain. Pharmacist-A agreed that the facility should have completed a pain assessment for R8's pain management and verified these irregularities had not been brought to the attention of the facility. The undated policy titled Pain Assessment identified a comprehensive pain assessment was to be completed as part of the initial nursing assessment with development of a pain management program. The assessment was to be reviewed quarterly and with significant changes. Assessment of pain management was to occur daily. In addition, pain was to be assessed and documented at regular intervals.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F441: Infection Control. 1. Protocols have been established to identify; a. Location of resident in facility with reported infection, b. symptoms, diagnosis or cultures performed, c. treatment modalities incl. medications, and d. resolution of the infection.	

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F 441	Continued From page 10 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program that included comprehensive surveillance of resident and employee symptoms, analysis of that surveillance, and investigation of patterns identified through the analysis. This had the potential to affect 20 of 20 residents who resided in the facility. Finding included: During review of the facility's Quarterly Infection	F 441	Management/Charge personnel will attempt to have the ill employee indicate what symptoms are present to warrant an illness call-in and document same on an absence report for further analysis. 2. Quarterly, the ICC shall track and trend compiled data with an analysis to determine if there are commonalities to staff illnesses and/or resident symptoms of infection. All charge personnel who take absence calls shall be educated on the need to ascertain the Sx. related to illness absences. 3. The ICC/DON or designee shall perform observational audits of staff performing ADL cares daily X5 days on at least one resident with dependent ADL needs. Thereafter, audits will be conducted weekly X 4weeks to assure appropriate infection control practices were followed. 4. Summary data will be presented to the QAA Committee for further review &/or comment. 5. Date for correction: 01/27/14	

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Control Log(s) from January 2013, through September 2013, the following infections were identified: eight urinary tract infections (UTIs), nine respiratory infections, three skin/wound infections, and one eye infection. The facility's surveillance processes lacked the following: location of the resident within the facility, the specific symptoms, diagnoses, cultures performed, antibiotic use, and when the infection was resolved. The facility's infection control logs were being completed by the infection control coordinator (ICC); however, the ICC did not analyze the data to track and trend patterns of infections within the facility. Furthermore, the ICC lacked surveillance logs for employee infections/diseases for comparison to the resident logs during analysis and investigation.

On 12/18/13, at 12:28 p.m. the director of nursing (DON) confirmed that she did not have any documentation to support analysis of the infection control logs and was unable to produce any other documentation to support infection control surveillance within the facility to track and trend staff and resident infection/disease. In addition, she stated routine observations of resident cares were not conducted to ensure that infection control practices were being consistently followed.

Review of the facility policy titled Call in /Wellness Tracking Policy dated 3/1/10, indicated the ICC was to use employee absence forms to track infections and summarize infections in a report at the facility's Quarterly Quality Council.

Review of the facility policy titled Infection Control Program dated 6/19/12, indicated the infection control program was to prevent the transmission

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F 441	Continued From page 12 of infectious and communicable disease and to control healthcare acquired infections. Furthermore, the policy instructed the facility to collect and tabulate data to remain aware of trends or of an increase in prevalence of infectious conditions.	F 441		

Clayco Care Center

MDH Exit date: 12/18/2013

POC Addendum: F329

The DON, or designee, have reviewed all resident records for those residents receiving pharmacological, or other pain relieving modalities, to assure pain relief and effectiveness. Thereafter, all resident records shall be reviewed upon admission, and quarterly.

POC Addendum: F441

The DON, or designee, shall track and trend resident infections & employee reported illnesses as they occur. This will be ongoing, and be reviewed quarterly.

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

F5281022

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Clayco Care Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Clayco Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1980, a Sun Room addition was added to the south of the Dining Room/Day Room that was determined to be of Type V(000) construction. In 1994 an addition to the main entrance, to the west was constructed and was determined to be of Type II(111) construction. The building is divided into 5 smoke zones by 30-minute fire barriers. The building is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1`999 edition. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition.	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
	245281	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYCO CARE CENTER	**600 FIFTH STREET SOUTHEAST. BOX 129 BARNESVILLE, MN 56514**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The facility has a capacity of 35 beds and a census of 22 at the time of the survey.. Because of the lack of 2-hr fire separation between the Sun Room addition and the original building, the entire building is downgraded to Type V(000) and was surveyed as 1 building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		