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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SIQS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**

2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVERGREEN TERRACE**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 **10/30/2015** (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 **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(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 :
Katie Killoran, HFE NEII — 11/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/04/2015 (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
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/13/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245495

December 4, 2015

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

Dear Mr. Roche:

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

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

Effective October 21, 2015 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered
November 28, 2015

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495025

Dear Mr. Roche:

On October 1, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 18, 2015. 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 October 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 13, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 18, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 18, 2015, effective October 21, 2015 and therefore remedies outlined in our letter to you dated October 1, 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
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
245495	A. Building B. Wing	10/30/2015

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	**10/21/2015**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	**10/21/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**10/21/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**10/21/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**10/21/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**10/21/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**10/21/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**10/21/2015**	ID Prefix **F0372** Reg. # **483.35(i)(3)** LSC	**10/21/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	**10/21/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	11/30/2015	29625	10/30/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/18/2015

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**

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(L3) **EVERGREEN TERRACE**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 **09/17/2015** (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 **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(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 :
Kathie Killoran, HFE NEII — 10/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 11/13/2015 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 1, 2015

Mr. Shane Roche, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495025, H5495044

Dear Mr. Roche:

On September 17, 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. In addition, at the time of the September 17, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495044.

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 September 17, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5495044 that was found to be substantiated.

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

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

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

<u>Electronic Plan of Correction</u> - 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:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

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 October 27, 2015, 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 October 27, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 17, 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 March 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5495044 was completed. The complaint was not substantiated. 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 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		10/21/15

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

Electronically Signed | 10/09/2015

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
	245495	A. BUILDING _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide appropriate notice for room changes to the resident and or their representative for 4 of 4 residents (R52, R47, R101, R89) reviewed for notification of change. Findings include: Residents were moved off of the memory care unit (MCU) without an opportunity for notice. In an interview on 9/17/15, at 9:29 a.m., the Director of Nursing (DON) stated that no formal notice was provided to residents who were moved off of the MCU. The DON stated when they identified the error, they sent out notices "after the fact". The DON confirmed the facility did not provide written seven day notices. In an interview on 9/1715, at 9:59 a.m., Social	F 157	F 157 (E) ¿ 1. For Residents R52, R47, R101, R89, verbal notifications were obtained and documented in individual residents electronic records on 8/24/2015. Written notifications were mailed out to resident [R52, R47, R101, and R89] representatives on 8/28/2015. These notifications are now returned and are retained in individual resident medical records. 2. Resident room changes will be discussed at the morning quality conference meeting. The resident will not be relocated until the ¿Notification of room Relocation¿ form is completely filled out, with signature of resident or legal representative, and staff signature. Other management and licensed staff will be	

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F 157	Continued From page 2 Services Designee (SSD)-A stated that moving residents out of the memory care unit was "spur of the moment". SSD-A stated families were contacted verbally at the time and LPN-A mailed out notices later. In an interview on 9/17/15, at 2:58 p.m., LPN-A stated she communicated with families over the phone about the room changes and MCU closure. LPN-A stated she sent out a written notice after receiving verbal consent. In an interview on 9/17/15, at 3:18 p.m., with the administrator and corporate clinical consultant, the administrator stated the nurse managers and the IDT team met to review each resident prior to moving them. When asked about provision of a seven day notice for room changes, the administrator stated, "I think there was an email trail" and the facility received "verbal" approval from responsible parties to waive the seven day notice. A Room Change Policy, revised on 4/13/12, indicated residents had the right to a 7 day notice of room change unless situations outside of the facility's control occurred, such as newly admitted residents or a change in medical status or treatments. The policy continued that a resident may also waive their right to the 7 day notice if they wish to move sooner and the facility can accommodate. R101's Admission Record identified diagnoses including dementia and memory loss. R101's OBRA Quarterly Minimum Data Set (MDS), dated 6/10/15, indicated severe cognitive impairment. R101's Safety/Going Home Care Plan, initiated	F 157	in-serviced on room change notification. 3. To ensure ongoing compliance is sustained, the Social Services Director or designee shall audit room change notifications two times a week. 4. The results of the Notification of Change audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audit. Correction date 10-21-15. Responsible person is the SSD or Designee.	

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on 11/3/14, indicated a diagnosis of memory loss and housing in the memory care unit for "my safety." The Safety/Going Home Care Plan further stated R101 will wander. The goal of R101's Safety/Going Home Care Plan stated to reside in the memory care unit for continued safety related to wandering and elopement issues.

A progress note dated 8/24/15, at 4:15 p.m., read "Notified family resident will be moving to a different room". A daily census sheet for 8/24/15, no longer identified R101 as a resident of the memory care unit (MCU).

A memo form provided by the facility read "verbalized on 8/24/15" related to the room change for R101. The form was signed by Licensed Practical Nurse (LPN)-A. The form was signed and dated by R101's responsible party on 9/3/15.

R47's Diagnosis Report dated 9/17/15, indicated R47's diagnoses included behavioral problems and depression. The Psycho-social care plan dated 3/17/10, indicated R47's short and long term memory were severely impaired. R47 was alert and orientated to self and family but was not aware of time, place or situation.

The Daily Census sheet indicated R47 transferred from the MCU into the general population of the facility on 8/25/15. A Progress Note dated 8/28/15, indicated R47 agreed to the room change. A Progress Note dated 9/2/15, indicated R47's family representative was called and a message was left regarding the room change paperwork.

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A Notification of Room Change form signed by R47 on 8/28/15, indicated the expected transfer date was 8/24/15. R47 agreed to the move and was waiving the right to a seven day notice.

R89's Diagnosis Report dated 9/17/15, indicated R89's diagnoses included altered mental state, depression, anxiety and dementia. The Psycho-social care plan revised on 5/13/14, indicated R89's long and short term memory were impaired. R89 was alert and orientated with varied cognition.

The Daily Census sheet indicated R89 transferred from the MCU into the general population of the facility on 8/24/15. A Progress Note dated 8/24/15, indicated R89's family representative was called and a message was left regarding moving R89 to a different unit. A Notice of Room Change dated 8/28/15, indicated verbal consent was obtained on 8/25/15, and R89's power of attorney (POA) signed the notice on 9/1/15.

R52's significant change Minimum Data Set (MDS) dated 7/21/15, indicated R52 was severely cognitively impaired with diagnoses of dementia and schizophrenia.

Upon reviewing electronic mail (email) it was discovered that R52 was transferred to a new room on 8/25/15. The facility could not provide supporting documentation that timely notice of room change was provided to R52's representative.

An email was sent to R52's representative from the SSD-A on 8/24/15, at 5:36 p.m. explaining the facility would like to move R52 to wing four as

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F 157	Continued From page 5 the facility was looking at doing some changes to the MCU. The email did not notify the representative of what room R52 was going to be in or the date the move would take place. A reply email from R52's representative to the SSD-A on 8/24/15, at 7:37 p.m. included a response of thanks for letting me know. On 8/25/15, at 4:48 p.m. SSD-A sent another email to R52's representatives letting them know R52 had been transferred to wing four. The email did not include a specific location for the transfer. When interviewed on 9/17/15, at 3:01 p.m. SSD-A confirmed an email was sent to R52's representative and that the email lacked information for the representative to make an informed decision, regarding R52 being transferred to another wing and room. SSD-A also reported she sent the email as a follow up to a phone call licensed practical nurse (LPN)-A made to R52's representative. On 9/17/15, at 3:32 p.m. LPN-A reported she contacted R52's representative regarding the facility wanting to transfer R52 to a different room, on another wing, but could not confirm a date the phone call was placed. It was not documented in the resident's record. LPN-A reported she sent out a form for signature regarding the room change but had not yet received the signed form.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221		10/21/15

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F 221	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess and provide ongoing monitoring/evaluation and care planning for the use of a restraint for 1 of 1 residents (R33) reviewed for physical restraints. Findings include: R33's care plan dated 6/8/15, identified diagnoses that included dementia without behavioral disturbances and falls. The cognition care plan dated 7/3/15, indicated R33 had impaired cognition, needed the assistance of one staff with transfers and ambulation and used a wheelchair. R33's falls care plan revised on 9/9/15, indicated R33 was at risk for falls due to weakness, decreased safety awareness and noncompliance with transfers. R33 self transferred due to dementia. Interventions included a velcro seat belt when in the wheelchair, initiated 6/18/15. A Physical Device Assessment dated 9/9/15, indicated no devices needed. The assessment plan or revision was to continue with the current plan of care, follow up and update as needed. An Interdisciplinary Team (IDT) Fall Review Committee report dated 7/16/15, indicated R33 had a fall on 7/15/15, while attempting to transfer from one chair to another chair in the dining room. The report indicated R33 had three previous falls on 6/13/15, 7/2/15, and 7/7/15, in his room and one fall on 7/10/15 in the bathroom.	F 221	F 221 (D)- 1. For R33 Physical Device Assessment was completed on 9/24/2015, by a Licensed Nurse. A restraint reduction trial will be started to determine if the restraint is beneficial. 2. A physical device assessment will be completed for other residents with restraints. Other licensed nursing staff will be educated on physical device assessments. 3. Restraint audits will be conducted two times a week. 4. The results of the Restraint audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audit. 5. Correction date 10-21-15. Responsible Person is the DON or Designee.	

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F 221	Continued From page 7 The report identified an additional intervention of a seatbelt alarm in the wheelchair. During continuous observation of R33 on 9/17/15, at 8:35 a.m. R33 was brought to the main dining room (MDR) accompanied by his spouse. Licensed practical nurse (LPN)-A removed a transfer belt from R33, checked the seatbelt alarm and placed a clothing protector on R33's lap. R33 was observed sitting at a table within 12 feet of the medication cart where LPN-A was present. Other staff present in the immediate area was activity and nursing staff. The director of nursing (DON) was also present and sat at the table with R33 and his spouse. The alarmed seat belt was not released until 9:20 a.m. when LPN-A and a nursing assistant (NA) released the seat belt and stood R33 for one minute. On 9/17/15, at 9:30 a.m. LPN-A stated they do not release R33's belt at any time. LPN-A stated R33 was able to release the belt himself. LPN-A stated staff did not routinely ask R33 to open the alarmed velcro seat belt. LPN-A asked R33 to open the alarmed seat belt as did R33's spouse. They prompted him for several minutes and R33 was unable to open the seat belt. LPN-A and R33's spouse stated R33 opened the wheelchair belt all the time. On 9/17/15, at 9:55 a.m. the DON stated there were no restraints in the building. R33 was the only resident with a wheelchair seat belt. The DON stated she did not consider R33's alarmed seat belt a restraint because he released it himself and did all the time. The DON stated staff did not release the belt or monitor if R33 could open the belt when asked because he opened the belt all the time.	F 221		

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F 221	Continued From page 8 On 9/17/15, at 3:10 p.m. LPN-A was interviewed again. LPN-A verified the alarmed seat belt was applied to R33's wheelchair on 6/18/15. The alarmed seat belt was a fall intervention and was not placed to restrain R33. The seat belt was an attempt to have staff assist R33 more quickly. The LPN stated R33 had a tab alarm prior to the application of the alarmed seat belt. The LPN verified there was not a medical symptom for the alarmed seat belt and no attempts were made to reduce to a less restrictive device. The LPN stated the facility had put other interventions in place since 6/18/15. The facility's Abuse Prevention Plan reviewed and revised on 5/10, described a physical restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the body which cannot be removed easily and restricted freedom of movement or normal access to the body. The plan directed staff to follow protocol to loosen, reposition or remove restraints. The plan listed restraints to include lap cushions, trays, bars or belts.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident	F 241	F 241 (D) ¿ 1. For R95, the wanderguard will be	10/21/15

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F 241	Continued From page 9 individuality and dignity was maintained by placing a wander guard device without resident consent for 1 of 1 residents (R95). Findings include: R95's Diagnoses Report, printed on 9/17/15, indicated acute and chronic respiratory failure, muscle weakness, hypotension, diabetes, and congestive heart failure. According to R95's 6/30/15, quarterly Minimum Data Set (MDS), he was cognitively intact and did not wander. R95's MDS indicated he was independent with bed mobility, transfers, dressing, eating, walking in the room, corridor and on and off the unit. The MDS further indicated R95 used a walker and a wheelchair for mobility. A 5/5/15 Risk/Benefit statement indicated R95 was alert and oriented and would leave the facility to run errands. The Risk/Benefit stated that R95 took a portable oxygen tank on outings and had the potential to run out of oxygen. The statement indicated the risks were explained to R95 and he understood the risks of leaving the facility. A review of R95's record revealed a Safety Care Plan initiated on 5/5/15 which indicated R95 would leave the facility to run errands or go shopping. Staff was to anticipate and meet all of David's safety needs. The care plan stated R95 understood the risks of leaving the facility with his oxygen dependency and he chose to leave for hours at a time. A review of the facility's sign out book on 9/17/15, revealed since 7/15, R95 had only signed himself	F 241	removed. 2. Other licensed nurses will be educated on wanderguard placement. 3. New resident initiation of wander guard device will be audited two times a week to ensure that proper assessment is completed and documented. 4. The results of the wander guard audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audits. 5. Correction date 10-21-15. Responsible person is the DON or Designee.	

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out on 8/31/15, 7/27/15 and 7/13/15. In an interview on 9/16/15, at 11:19 a.m., R95 stated he goes out of the facility on Mondays.

A progress note dated 9/14/15, at 5:35 p.m. read that R95 went shopping that morning without signing himself out. The noted stated that R95 was out of oxygen and short of breathe upon his return, with an oxygen saturation level of 68%. The note continued that R95's saturation level a ½ hour later was 89%. The resident was reminded he needs to let staff know when he is going out so they can make sure his portable oxygen tank is full and he needs to sign out.

In an interview on 9/16/15, at 7:18 a.m., R95 stated he needs a staff person to fill his oxygen tank. R95 stated he is on 6 liters continuous and he wants to go shopping again today. R95 stated that he has to let staff know before he leaves the facility and he goes shopping to get the food he likes.

In an interview on 9/16/15, at 11:19 a.m., R95 stated he goes out of the facility on Mondays. R95 stated he likes to go to the bank and to Walmart. R95 stated on Monday 9/14/15 he left the facility at about 9:40 a.m. and was back in time for lunch. R95 stated he called for the bus himself and took the bus "there and back." R95 stated he uses a wheelchair and a single-end cane. He uses a motorized cart when he shops at Walmart. R95 stated he ran out of oxygen on Monday when he was out and he "just about passed out". R95 continued that the facility knows he goes to the bank and shopping afterwards every Monday.

In an interview on 9/16/15, at 11:48 a.m., nursing

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assistant (NA)-A stated R95 goes out on Mondays. NA-A stated R95 is supposed to tell a nurse when he leaves so the nurse can check his oxygen tanks.

A progress note, listed as a Care Plan note, dated 9/16/15, at 6:28 p.m. indicated a Wanderguard was applied in order to alert staff to resident attempts to leave facility. The note continued that leave of absense (LOA) policy was reviewed with the resident and he stated undersanding and agreed to sign out for all LOA's and to alert staff to fill up two oxygen tanks for him prior to leaving the facility. The note stated that the risk versus the benefits were reviewed with R95 and he verblaized understadning.

In an interview on 9/17/15, at 8:01 a.m., Licensed Practical Nurse (LPN)-B stated she knew R95 was going to be out on Monday. LPN-B stated she told R95 to check in with the nurse before he left. LPN-B stated she did not know if R95 did that or not. LPN-B stated the cart nurse did assess R95 when he returned. LPN-B stated she was not involved with the placement of the wander guard on 9/16/15.

In an interview on 9/17/15, at 9:21 a.m., the Director of Nursing (DON) stated that she left the facility shortly before noon on 9/14/15, and R95 was sitting on the park bench outside the facility. The DON stated she completed an Incident Report on 9/16/15 describing the incident; that this was not done immediately due the State Survey Team's arrival at the facility.

In the interview, the DON stated she did not know R95 had been shopping on Monday, but thought perhaps he was just sitting outside enjoying the

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weather. According to the DON, R95 told her he was not feeling well, and she checked his oxygen tank. The DON stated the oxygen tank was "low" and so she brought R95 to the charge nurse for oxygen and an assessment.

The DON confirmed that R95 is not an elopement risk and that he goes shopping every Monday and he's "safe." The DON stated R95 sometimes forgets to sign out and forgets to inform staff. The DON stated the facility thought they'd put an alarm on R95 to be "proactive". The DON stated she did not put the wander guard on R95 and was not aware that it was on his left wrist. The DON stated it was to be put on his wheelchair. The DON stated, "I think my regional nurse said go ahead and do it."

In an interview on 9/17/15, at 8:33 a.m., R95 stated he doesn't like the wander guard on his wrist. R95 stated he was upset about it and said several times, "I'm going to cut it off! I don't need that! I don't want that!" R95 stated he's not good about signing out but he lets the nurses know.

In an interview on 9/17/15, at 9:50 a.m., Director of Nursing (DON) stated the facility ' s admission staff (Social Services [SS]-A) is providing social services. When asked if SS-A was providing all of the social services responsibilities and not just admissions, the DON replied, " yes. "

In the interview on 9/17/15, at 9:59 a.m., SS-A also stated she works as the admission coordinator, as an aide on the floor in the mornings and as the social services person as well. SS-A stated she had worked as a Social Service Designee in the past, in 2013 and 2014, under the direction of the facility social worker at

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F 241	Continued From page 13 the time. SS-A stated she schedules and coordinates care conferences, does the Minimum Data Set (MDS) assessments and admissions. SS-A also stated she will " pitch in " if anything comes up. SS-A stated she was not given the social services job description when she starting providing social services to the facility; she stated she is " just doing what comes up. "	F 241		
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 observation, interview, and document review, the facility failed to ensure oral hygiene was provided according to the care plan for 1 of 3 residents (R48) who was reviewed for dental. Findings include: R48's quarterly Minimum Data Set (MDS) assessment dated 8/21/15, indicated R48 had a severe cognitive impairment and required extensive assistance with personal hygiene. R48's face sheet printed 9/17/15, indicated diagnoses included dementia and anxiety state. R48's care plan dated 12/21/13, directed staff to assist in cleaning R48's upper and lower partials and to assist her in brushing her own teeth. The pocket care plan used by direct care givers dated 9/12/15, directed staff to assist with brushing	F 282	F 282 (D) (oral hygiene) 1. For R48, proper oral hygiene was completed according to the care plan. 2. Other residents will be audited to ensure proper hygiene is completed per individual care 3. Other nursing staff will be educated regarding oral hygiene completion. Oral Hygiene audits will be conducted two times a week to ensure compliance. 4. The results of the oral hygiene audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audits. 5. Correction date 10-21-15. Responsible person is the DON or Designee.	10/21/15

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F 282	Continued From page 14	F 282		

teeth and dentures. The pocket care plan also indicated R48 required cues to get started with her cares and may require set-up for cares.

During an observation on 9/15/15, at 3:28 p.m. R48 had a large amount of debris on her teeth along the gum line.

During an observation on 9/16/15, at 3:45 p.m. R48 had a large amount of debris on her bottom teeth, near the gums, similar to the previous day. The partials were not in and there were missing teeth.

During an observation on 9/17/15, at 8:55 a.m. R48 had eaten breakfast and was assisted back to bed. R48 continued to have a large amount of debris embedded around the base of her teeth, similar to the previous two days. R48 was observed to have one broken tooth on the upper right and her front upper teeth were missing. R48 denied brushing her teeth this morning and the previous night.

During an interview on 9/17/15, at 2:01 p.m. nursing assistant (NA)-C stated she had gotten R48 up in the morning and was going to set her up to brush her teeth, but R48 wanted to wait until after breakfast. NA-C was not sure if she had partials and stated she did not put them in. NA-C stated another staff must have assisted R48 back to bed after breakfast.

During an interview on 9/17/15, at 2:09 p.m. NA-A stated she usually sets R48 up in the bathroom to brush her teeth when she gets her up in the morning before breakfast.

During an interview on 9/17/15, at 3:17 p.m.

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F 282	Continued From page 15 licensed practical nurse (LPN)-B stated oral care should be done with morning and evening cares. LPN-B verified oral hygiene had been a concern expressed by R48's family. The facility did not provide a policy and procedure for following the care plan.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral hygiene was provided according to the care plan for 1 of 3 residents (R48) who was reviewed for oral care. Findings include: R48's quarterly Minimum Data Set (MDS) assessment dated 8/21/15, indicated R48 had a severe cognitive impairment and required extensive assistance with personal hygiene. R48's face sheet printed 9/17/15, indicated diagnoses included dementia and anxiety state. R48's care plan dated 12/21/13, directed staff to assist in cleaning R48's upper and lower partials and to assist her in brushing her own teeth. The pocket care plan used by direct care givers dated 9/12/15, directed staff to assist with brushing	F 312	F 312 (D) (oral hygiene) 1. For R48, proper oral hygiene was completed according to the care plan. 2. Other residents will be audited to ensure proper hygiene is completed per individual care 3. Other nursing staff will be educated regarding oral hygiene completion. Oral Hygiene audits will be conducted three times a week to ensure compliance. 4. The results of the oral hygiene audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audits. 5. Correction date 10-21-15. Responsible person is the DON or Designee.	10/21/15

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F 312	Continued From page 16	F 312		

teeth and dentures. The pocket care plan also indicated R48 required cues to get started with her cares and may require set-up for cares.

The Oral/Dental Status assessment dated 8/10/15, indicated R48 had upper and lower partials, and used partials. Poor dentition was noted and indicated dentures appeared to fit properly.

The Multidisciplinary Care Conference form dated 6/2/15, indicated R48's family was concerned about her teeth being cleaned and requested better oral care.

During an observation on 9/15/15, at 3:28 p.m. R48 had a large amount of debris on her teeth along the gum line.

During an observation on 9/16/15, at 3:45 p.m. R48 had a large amount of debris on her bottom teeth, near the gums, similar to the previous day. The partials were not in and there were missing teeth.

During an observation on 9/17/15, at 8:55 a.m. R48 had eaten breakfast and was assisted back to bed. R48 continued to have a large amount of debris embedded around the base of her teeth, similar to the previous two days. R48 was observed to have one broken tooth on the upper right and her front upper teeth were missing. R48 denied brushing her teeth this morning and the previous night.

During an interview on 9/17/15, at 2:01 p.m. nursing assistant (NA)-C stated she had gotten R48 up in the morning and was going to set her up to brush her teeth, but R48 wanted to wait until

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F 312	Continued From page 17 after breakfast. NA-C was not sure if she had partials and stated she did not put them in. NA-C stated another staff must have assisted R48 back to bed after breakfast. During an interview on 9/17/15, at 2:09 p.m. NA-A stated she usually sets R48 up in the bathroom to brush her teeth when she got her up in the morning before breakfast. During an interview on 9/17/15, at 2:14 a.m. R48's family friend (FF)-G stated they had requested more assistance for oral hygiene during the last care conference because her teeth had not been clean. FF-G stated the staff have been slacking off with oral hygiene again. During an interview on 9/17/15, at 3:17 p.m. licensed practical nurse (LPN)-B stated oral care should be done with morning and evening cares. LPN-B verified oral hygiene had been a concern expressed by R48's family. The facility policy and procedure for nursing care standards revised 8/09, directed staff to provide assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		10/21/15

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F 329	Continued From page 18 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 monitor efficacy for an antidepressant for 1 of 5 residents (R133) reviewed for unnecessary medications. Findings include: R133's admission Minimum Data Set (MDS) dated 8/20/15, indicated R133 had severe cognitive impairment with a diagnosis of dementia. Mood impairment assessment showed no indication of depressive behavior. R133 had a physician's order dated 8/13/15, for paroxetine hydrochloride (Paxil, an antidepressant) 10 mg daily for senile dementia. R133's clinical record did not provide an appropriate diagnosis or monitoring for mood, behavior or side effect symptoms for Paxil.	F 329	F 329 (D) ¿Monitoring efficacy antidepressants 1. R 133 will be provided with monitoring for efficacy of antidepressant use. 2. Other residents with antidepressants will be provided for monitoring for efficacy. 3. Other licensed nurses will be provided with education on monitoring the efficacy of antidepressants. Audits will be conducted two times a week to monitor compliance 4. The results of the antidepressant audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audits. Correction date 10-21-15. Responsible person is the DON or Designee.	

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F 329	Continued From page 19 R133's Psychopharmacological Drug Assessment and Psychopharmacological Medication Side Effect Monitoring both dated 8/17/15, did not address the use of an antidepressant. When interviewed on 9/17/15, at 4:19 p.m. licensed practical nurse (LPN)-B confirmed there was no mood, behavior or side effect symptom monitoring in place for R133 for the use of an antidepressant. LPN-B also acknowledged that the Psychopharmacological Drug Assessment and Psychopharmacological Medication Side Effect Monitoring assessments were not completed to include the use of an antidepressant. On 9/17/15, at 4:20 p.m. director of nursing (DON) confirmed that there was no current monitoring in place for this resident. The Behavior Assessment and Monitoring policy dated 2/14, instructed nursing staff for residents that are being treated for behavior or mood, the staff and physician would obtain and document ongoing reassessments of changes (positive or negative) on the individual's behavior, mood and function. The nursing staff and the physician will monitor for side effects and complications related to psychoactive medication: for example lethargy, abnormal involuntary movements, anorexia or recurrent falling.	F 329		
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.	F 356		10/21/15

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F 356	Continued From page 20 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. 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 the nurse staff posting clearly defined all shifts of actual hours worked. This had the potential to affect all 73 residents who resided in the facility as well as all visitors. Findings include:	F 356	F 356 (C) ¿ Staff Posting 1. A new form for the ¿Nursing¿ daily staff posting was implemented. 2. Staffing Coordinator will be trained regarding the new form, and how to accurately document on the form. The form will be posted daily. The Administrator or designee will audit two times a week for ongoing compliance with	

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F 356	Continued From page 21 During initial tour on 9/14/15, at 2:28 p.m. the facility Daily Posting of Hours (staff posting) was displayed in the entry way. The posting included the facility name, current date, current census, and the total number of staff and hours worked on the day 6:00 a.m. to 2:30 p.m. , evening, 2:00 p.m. to 10:30 p.m. and night 10:00 p.m. to 6:30 a.m. shifts for registered nurses (RN), licensed practical nurses (LPN), trained medical assistants (TMA) and nursing assistants (NA). The posting lacked detailed shift information for staff assigned to partial shifts and not the complete shift as posted. The nurse posting listed 7.5 NA's for the day shift and 6.5 NA's for evening shift. On 9/15/15, at 8:59 the nurse posting listed 7.5 NA's for the day shift , 2.5 LPN's and 1.5 TMA's for the evening shift and 2.5 NA's for the night shift. On 9/16/15, at 6:55 a.m. the nurse posting listed 6.75 NA's for the evening shift. On 9/17/15, at 6:57 a.m. the staff posting listed 6.5 NA's on the evening shift and 0.25 TMA's on the night shift. When interviewed on 9/17/15, at 4:03 p.m. the administrator reported that the nurse posting was accurate to the numbers, but needed to be more specific to what shifts are being worked.	F 356	the requirement. Management staff and licensed nurses will be educated on the new form. 3. The results of the Nurse Daily Staff Posting audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audit. 4. Correction date 10-21-15. Responsible person is the Administrator or Designee.	
F 371 SS=F	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	F 371		10/21/15

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F 371	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the can openers were free from food debris. This had the potential to affect all 69 of 69 residents who received food from the kitchen. Findings include: During a tour of the kitchen on 9/14/15, at 2:07 p.m., the can opener had dark debris on the blade and one lighter strand of debris on the blade. The dietary manager (DM)-C verified the can opener had been cleaned and was ready for use and also verified the can opener blade had food debris on it. In addition, during the kitchen tour, the hand-held can opener had greasy food debris on the outside and inside, near the gears. The hand-held opener had been in the clean tray of utensils. DM-C verified the can opener was dirty and needed to be scoured. The facility policy and procedure for Sanitization revised 12/2008, directed all utensils, counters, shelves and equipment shall be kept clean. The policy and procedure further directed that all equipment, food contact surfaces and utensils were to be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. In addition, the policy directed kitchen surfaces not in contact	F 371	F 371 (F) ¿ Can Opener/Plate Warmer 1. The can opener was immediately cleaned. Other utensils will be cleaned on a regular schedule. 2. The Dietary Manager shall audit cleanliness of the can opener and other utensils two times a week. Other dietary staff will be reeducated on cleaning the can opener and utensils. 3. The results of the can opener and utensil cleaning audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audit. 4. Correction date 10-21-15. Responsible person is the Dietary Manager or Designee.	

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F 371	Continued From page 23 with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. The facility policy and procedure for Cleaning Instructions: Can Opener dated 2010, directed the can opener would be cleaned after each use. The step-by-step procedure included directives to be sure to remove all food particles from the blade and base.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the garbage bins were properly covered to secure the garbage. This had the potential to affect all 73 residents residing in the facility. Findings include: During a tour on 9/14/15, at 2:07 a.m. p.m. the outside garbage dumpsters were open. The garbage bin was approximately 2/3 full with bags of garbage that contained resident care and incontinent products and kitchen garbage. The recycling bin was approximately 1/2 full with cardboard. Loose garbage was on the ground around the garbage bins. The dietary manager (DM)-C verified the bins were open. During observations on 9/14/15, at 6:23 p.m. the	F 372	F 372 (C) ¿ Garbage Bins 1. The garbage bins were immediately closed. 2. The Environmental Services Director shall audit (for closure) the outside garbage bins, using an audit tool, two times a week. Environmental Services Staff will be educated on keeping the bins closed. 3. The results of the garbage bin closure audit will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing monitoring shall continue based on the results of the audit. 4. Correction date 10-21-15. Responsible person is the Environmental Services Director of Designee.	10/21/15

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F 372	Continued From page 24 garbage dumpsters were open. During observations on 9/15/15, at 10:22 a.m. the garbage dumpsters were open. During an environmental tour on 9/17/15, at 9:00 a.m. the garbage dumpsters were closed, but one corner of the garbage bin was lifted by a garbage bag. The environmental services manager (ESM)-D verified the garbage bins should be closed. A facility policy and procedure for Food-Related Garbage and Rubbish revised 12/2008, directed outside dumpsters provided by garbage pick up services would be kept closed and free of surrounding litter.	F 372		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		10/21/15

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F 441	Continued From page 25 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 observation, interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control surveillance program related to the tracking and trending of infections. This had the potential to effect all 73 residents who resided in the facility. In addition, the facility failed to ensure appropriate hand washing and gloving practices were provided during a dressing change for 1 of 4 residents (R51) observed during dressing changes. Findings include: On 9/17/15, at 1:44 p.m. director of nursing (DON) confirmed she was responsible for the infection control program. The facility's Line Listing of Resident Infections (March	F 441	F 441 (F) ¿ Infection control. Surveillance and cross contamination. 1. A comprehensive infection control system will be implemented to track and trend infections for residents affected. Appropriate hand washing and gloving practices will be used for wound care treatments. 2. Education will be provided to other nursing staff on maintaining an infection control system and proper infection control practices to include proper hand washing and gloving. Weekly audits will be conducted two times a week for monitoring compliance. 3. The results of the audits will be brought to the monthly QAPI meeting. The IDT team shall determine if ongoing	

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F 441	Continued From page 26 2015-September 2015) were reviewed with the DON, and contained the following information: · Month and year of review · Resident name · Resident room number/unit · Type of Infection · Symptoms/Date · Culture: Date/Site/Results · Treatment · Other Actions (if needed) · Hospital or Community Acquired The DON verified the facility did not thoroughly complete the Line Listing of Resident Infections for the past 6 months. The DON confirmed she had not been conducting an ongoing, concurrent review of infection control concerns. In addition, the DON verified she had not been conducting symptomology tracking/trending of residents who had symptoms but who were not placed on an antibiotic. The Prevention Surveillance policy dated 4/9/14, directed the facility to conduct surveillance of resident infections to analyze data collection in order to guide prevention activities. The Infection Preventionist/designee will complete surveillance of infections for residents. The Infection Preventionist will complete surveillance of healthcare-associated infections through: review of culture reports and other pertinent lab data, nurse and other employee consultation and/or referral from nurse, chart review,review of the Infection Surveillance Data Collection Form, Line Listing of Resident Infections, Multi-Drug Resistant Organism (MDRO) line listing, 24 hour report, and/or morning start-up meeting. R51's quarterly Minimum Data Set (MDS) dated	F 441	monitoring shall continue based on the results of the audit. 4. Correction date 10-21-15. Responsible person is the DON or Designee	

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F 441	Continued From page 27 6/23/15, indicated R51 was cognitively intact, required total assistance with bed mobility, and had two Stage IV (full thickness tissue loss, exposing muscle, tendons or bone) pressure ulcers. The physician orders dated 9/3/15, indicated R51 had diagnoses that included pressure ulcer of lower back, anemia, infections involving organisms Methicillin Resistant Staphylococcus Aureus (MRSA) , streptococcus, and enterococcus. Physician orders included wound care orders: "Sacral/lower back wounds: Cleanse with normal saline. AMD (antimicrobial) dressing packed into wound and cover with optilock. Change daily." R51's care plan dated 8/27/15, directed the nurse to measure and evaluate active wounds and treatment protocols weekly and as needed. Treatments were to be completed as ordered. During an observation of wound care on 9/16/15, at 10:27 a.m. licensed practical nurse (LPN)-B washed her hands, put on gloves and began preparation for wound care to the pressure ulcers on lower back/sacrum and coccyx. LPN moved R51's urinary catheter bag from where it was hanging on the right side of the bed frame and hung it on the lip of the right side of the mattress. LPN-B then used the same gloved hands to spread out and smooth the top of a clean blue pad on the bed, under R51's side and buttocks. LPN-B continued with the same gloves to remove the soiled dressing that had a moderate amount of serosanguineous (liquid portion of serum and blood) drainage on it. LPN-B then removed the packing from the wound bed and the tunneled area of the wound using the same gloves by	F 441		

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F 441	Continued From page 28	F 441		

inserting her index fingers into the tunnel to remove the packing gauze from both pressure ulcers. The smaller wound was actively bleeding. LPN-B measured both wounds and then removed the blue pad, placed it in a garbage bag, and closed the bag with the same soiled gloves. LPN-B then removed the soiled gloves, put them in the garbage can, put the garbage bag she had handled with soiled gloves in the garbage can and pushed it down with ungloved hands. LPN-B opened the bathroom door with her hands and washed her hands in the bathroom.

During an interview on 9/16/15, at 10:48 a.m. the director of nursing (DON) who had witnessed the wound care, verified LPN-B should have washed her hands and re-gloved after touching the catheter bag and before continuing with the wound care. The DON further verified the breach in infection control had the potential to contaminate the wound.

During an interview on 9/16/15, at 11:54 a.m. LPN-B verified she had moved the catheter bag and then removed the dressing and packing with the same gloved hands. LPN-B further verified she had closed the garbage bag with soiled gloved hands, touched the contaminated bag with ungloved hands, then washed her hands in the bathroom, after opening the bathroom door with contaminated hands.

The facility policy and procedure for Dressings Clean/Aseptic revised 4/2014, directed the nurse to wash hands, arrange supplies, position resident and adjust clothing, and then wash hands and put on clean gloves before loosening tape and removing soiled dressing. Remove gloves and discard in the garbage bag. Wash or

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F 441	Continued From page 29 sanitize hands, put on clean gloves. Discard disposable items into the designated containers and wash hands.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey Evergreen Terrace 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

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

Electronically Signed | 10/09/2015

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

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K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Evergreen Terrace is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be	K 000		

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K 000	Continued From page 2 Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke zones by 30-minute and 2-hour fire barriers. This building is partially fire sprinklered because of the missing fire sprinkler heads as cited in K56. The facility has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms installed in accordance with NFPA 72 "The National Fire Alarm Code 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 109 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		10/21/15

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 2:00 PM on 09/22/2015, observation revealed, that there were 2 vertical penetrations located in the maintenance office. This deficient condition was verified by the Maintenance Supervisor.	K 029	1. The two vertical penetrations have been sealed. 2. A facility audit will be conducted to identify any other penetration issues. If any are found, these will be sealed. 3. Date of compliance is 10-21-15. 4. The Environmental Services Director is the responsible person.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038		10/21/15

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K 038	Continued From page 4 Based on observation and staff interview, the facility failed to provide a hard surfaced path to the public way for 1 of several means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d), 7.7.2 (1) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect residents, staff, and visitors. Findings include: On facility tour between 10:00 AM to 2:00 PM on 09/22/2015, observation revealed that the exit discharge located by the chapel had an uneven 1/2 inch drop in exit discharge hard surface. This deficient condition was verified by the Maintenance Supervisor.	K 038	1. The exit discharge located by the chapel will be repaired to smooth the exit discharge surface 2. A facility audit will be conducted to identify any other areas out of compliance. If any are found, these will be corrected or bids obtained and scheduled to be corrected. 3. Date of compliance is 10-21-15. 4. The Environmental Services Director is the responsible person.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		10/21/15

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K 056	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 09/22/2015, observations revealed the following deficient practices affecting the facility's fire sprinkler system: 1. There are 2 closets that are not equipped with fire sprinkler protection in resident room 218, 2. there are two different type of sprinkler heads located at the fireside nurses station 3, and 3. the facility did not have at least 2 of every style and type of sprinkler heads that are in use throughout the facility. This deficient condition was verified by the Maintenance Supervisor.	K 056	1. A bid for the closets will be secured and work order scheduled for the closets in room 218 to be sprinkled. The sprinkler heads will changed at that time to one type of sprinkler head in the fireside/nurses station 3. The facility will have at least 2 of every style and type of sprinkler heads kept available. 2. A facility audit will be conducted to identify any other areas not accessible for inspection. If any are found, these will be corrected. 3. Date of compliance will be a reasonable timeline not to exceed three months 4. The Environmental Services Director is the responsible person.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		10/21/15

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K 069	Continued From page 6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect residents, all kitchen staff and visitors. Findings Include: On facility tour between 10:00 AM to 2:00 PM on 09/22/2015, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor it was discovered that the hood ventilation cleaning and inspection was incomplete caused by a section of duct work that was inaccessible at the time of the hood servicing. This section could not be verified as being cleaned down to bare metal. This deficient condition was verified by the Maintenance Supervisor.	K 069	1. A bid for the duct work will be secured for making the area accessible for completion of inspection and cleaning. 2. A facility audit will be conducted to identify any other areas not accessible for inspection. If any are found, these will be corrected. 3. Date of compliance will be a reasonable timeline not to exceed three months. 4. The Environmental Services Director is the responsible person.	