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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: STFG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245556**
2.STATE VENDOR OR MEDICAID NO.
(L2) **376724800**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF BLOOMINGTON**
(L4) **9889 PENN AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **98** (L18)
13.Total Certified Beds **98** (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
	98			
(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 :
Eva Loch, Unit Supervisor 05/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Michaelyn Bruer, Enforcement Specialist 05/24/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1991
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245556

May 24, 2018

Ms. Rebecca Ballard, Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

Dear Ms. Ballard:

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

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

Effective May 1, 2018 the above facility is certified for:

98 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 98 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 24, 2018

Ms. Rebecca Ballard, Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: Project Number S5556030

Dear Ms. Ballard:

On April 6, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 11, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 14, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2018, effective May 1, 2018 and therefore remedies outlined in our letter to you dated April 6, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: STFG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245556**

2.STATE VENDOR OR MEDICAID NO.
(L2) **376724800**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF BLOOMINGTON**
(L4) **9889 PENN AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55431**

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 **03/22/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **98** (L18)
13.Total Certified Beds **98** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	98			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HPR - Dietary Specialist 04/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 04/26/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1991
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 6, 2018

Ms. Rebecca Ballard, Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: Project Number S5556030

Dear Ms. Ballard:

On March 22, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

<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;

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

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 1, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 1, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 22, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/19/18 through 3/22/2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/19/18 through 3/22/2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		5/1/18

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

Electronically Signed | 04/13/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(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 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a dignified dining experience for 2 of 17 residents (R30, R40) who needed feeding assistance but were left unattended multiple times during the meal service.	F 550	Resident # 30 was reassessed and a significant change completed per policy. Care plan updated to reflect assessment changes and reflect feeding assist. Residents #40 care plan review was completed to ensure feeding assist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(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 550	Continued From page 2 Findings include: The breakfast meal service on the memory care unit was observed on 3/21/18, from 8:32 a.m. to 9:46 a.m. At 8:57 a.m. NA-B brought R30 into the dining room to a table by the window. At 9:06 a.m. the administrator set up R30's meal in front of her, cut up her scrambled eggs and left. R30 did not begin eating independently. At 9:08 a.m. the licensed practical nurse (LPN)-A was standing on the other side of the dining room at the medication cart. LPN-A called across the dining room to R30 and encouraged her to take a few bits of food and said she would be there shortly. At 9:10 a.m. LPN-A walked over to R30 and gave her the morning pills, and while standing gave R30 a few bites of food and left. R30 did not make any attempts to eat independently after LPN-A left. At 9:24 a.m. NA-B pulled up a chair and sat down to start feeding R30. At 9:25 a.m. NA-B left to assist other residents in the dining room. At 9:31 a.m. NA-B sat down again and continued to feed R30. At 9:37 a.m. NA-B left to assist other residents in the dining room. At 9:38 a.m. NA-B sat down again with R30, and 9:41 a.m. left to assist another resident in the dining room with food set up. At 9:43 a.m. NA-B sat down again to assist feeding R30 until 9:46 a.m. when R30 was done. Staff was observed to have left R30 five times during assistance with breakfast. During interview with R30 on 3/21/18, at 9:50 a.m. when asked if she needed help eating she stated, "probably." R30 was not able to elaborate any more on her dining experience. During interview on 3/21/18, at 10:56 a.m. LPN-A	F 550	remains accurate. A facility wide audit completed on all residents to ensure feeding assist is accurate. The Dining Room Protocol policy was reviewed and all staff re educated on the policy to ensure that residents that require dining assistance are receiving assistance in a dignified, timely manner. The Dignity policy was reviewed and all staff re educated on the policy to ensure that residents that require dining assistance are receiving assistance in a dignified and timely manner. Audits will be completed on 10% of residents in the facility to ensure residents are assisted with dining in a dignified manner and ensure compliance. The results of the audits will be reported to the Quality Assurance team who will then determine the need for ongoing audits. Clinical administrator or designee will be responsible for ongoing compliance; date of compliance is 5/1/18	

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	245556	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

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F 550	Continued From page 3	F 550		

stated the acuity on the memory care unit was currently high and caused a delay in feeding some of the residents. LPN-A stated there was a schedule for feeding assistance with breakfast which usually started at 8:00 a.m..LPN-A explained the schedule was for the LPN to assist in the dining room from 8:00 a.m. to 8:30 a.m., one NA from 8:30 a.m. to 9:00 a.m., two NA's from 9:00 a.m. to 9:30 a.m., and three NA's from 9:30-10:00 a.m.. LPN-A further explained that she was usually doing medication passes during the LPN scheduled time and would help with breakfast when she was able to. LPN-A further stated lunch was served at 12:00 p.m. and usually was less busy. LPN-A also stated R30 had recently become sleepier at breakfast and stated she tried to run over and give R30 bites to eat in between medication passes.

During interview on 3/21/18, at 11:15 a.m. NA-A stated R30 had declined in the past few weeks and had demonstrated increased sleepiness. NA-A stated R30 used to be able to eat independently after initial set up but presently needed assistance to eat, otherwise R30 just would just sit there and not eat after the meal was set up.

On 3/22/18, the breakfast meal service was observed again on the memory care unit from 9:04 a.m. to 10:13 a.m. The activities director (AD) was observed to be the only staff present in the dining room who was assisting the residents. During that time there were eight residents in the dining room, all of whom required set up and/or supervision, and three residents who required feeding assistance. AD was observed going in between multiple residents, assisting them with eating and other needs. From 9:04 a.m. to 9:27

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	245556	A. BUILDING _____ B. WING _____	03/22/2018

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F 550	Continued From page 4	F 550		

a.m. AD assisted R40 to eat. At 9:21 a.m. R30 arrived in dining room for breakfast. At 9:23 a.m. R30 was served French toast. At 9:27 a.m. AD went to R30's table and sat down to feed her. At 9:33 a.m. AD left R30 to assist a resident who needed urgent assistance. R30 did not eat independently when left alone. At 9:41 a.m. AD was done assisting the other resident and went back to feed R40 again. At 9:51 a.m. AD moved R30 to another table and resumed feeding her until she was done eating.
On 3/22/18, at 10:18 a.m. AD stated the memory care unit acuity was high right now. AD stated she did not like to see residents waiting so long for food,so she has told the staff to call her when they need help with feeding residents. AD said she has been helping out with feeding residents breakfast almost every day.

Interview was attempted with R40 on 3/19/18, at 1:33 p.m. R40 was unable to engage in meaningful conversation about her cares.

R30's annual Minimum Data Set (MDS) dated 1/22/18, indicated R30 had severely impaired cognition. R30's care plan dated 2/6/18, indicated R30 was able to feed herself independently after set up.

R40's annual MDS dated 11/1/17, indicated R40 had severely impaired cognition. R40's care plan dated 2/6/18, included a focus problem area of self-care deficit with activities of daily living as a focus. Interventions included: needs assistance of one staff while eating.

During interview with the administrator and director of nursing (DON) on 3/22/18, at 12:49 p.m. the DON stated she has had discussions

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F 550	Continued From page 5 with staff on providing feeding assistance in a dignified manner, including not leaving residents when they started feeding them. DON further stated she expected staff to sit down continuously with residents during their meals if the residents needed assistance with eating beyond meal set up. The facility's Dining Room Protocol Policy dated February 2016, indicated after all residents were served, to proceed to assigned tables to provide eating assistance as indicated or appropriate. The facility's Dignity policy dated 12/14, indicated residents were cared for in a manner and in an environment that promoted maintenance and/or enhancement of each resident's quality of life. The policy further indicated it was the organizations commitment to an atmosphere that humanized and individualized each resident and their experience.	F 550		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		5/1/18

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F 725	Continued From page 6 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff to provide timely assistance with eating for 1 of 8 residents (R29) who needed staff's assistance with eating. In addition, the facility failed to ensure sufficient nursing staff to provide a dignified dining experience for 2 of 8 residents (R30, R40) who needed staff's assistance with eating. This deficient practice had the potential to affect all 17 residents on the memory care unit. Findings include: During interview on 3/19/18, at 5:03 p.m. R29's family member (FM)-A stated there was not enough nursing staff on the memory care unit, especially in the mornings. FM-A stated there were many days when breakfast was not done until 10:30 a.m.-11:00 a.m. FM-A stated many residents needed assistance with eating and there was not enough staff to provide this assistance. FM-A stated R29 needed assistance with eating due to her dementia, and many times	F 725	Resident # 30 was reassessed and a significant change completed per policy. Care plan updated to reflect assessment changes and reflect feeding assist. Residents #40 and #29 care plan review was completed to ensure feeding assist remains accurate. A facility wide audit completed on all residents to ensure feeding assist is accurate. A review of staffing needs inclusive of resident care needs was completed on the dining process on the Memory Care community, process was revised and reeducated on to ensure sufficient and timely feeding assistance. Follow up with R29 family member completed to identify concerns, RSS to meet weekly and prn to ensure R29 feeding assist is being met to their satisfaction. Audits will be completed on 10% of residents in the facility to ensure residents are assisted with dining in a dignified	

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F 725	Continued From page 7 FM-B visited R29 in the morning to ensure R29 was assisted with breakfast so as to be finished by at least by 9:30 a.m. FM-A said if FM-B couldn't come in, she didn't think R29 would receive assistance with her breakfast by 9:30 a.m. On 3/21/18 at 8:32 a.m., FM-B was assisting R29 with breakfast in the dining room. FM-B stated there was "more staff assisting with breakfast today" and that it was "not the usual number of staff available for feeding assistance." FM-B stated she had expressed concerns regarding nurse staffing on the dementia unit with the facility's administration staff in January [2018]. The breakfast meal service on the memory care unit was observed on 3/21/18, from 8:32 a.m. to 9:46 a.m. At 8:57 a.m. NA-B brought R30 into the dining room to a table by the window. At 9:06 a.m. the administrator set up R30's meal in front of her, cut up her scrambled eggs and left. R30 did not begin eating independently. At 9:08 a.m. the licensed practical nurse (LPN)-A was standing on the other side of the dining room at the medication cart. LPN-A called across the dining room to R30 and encouraged her to take a few bits of food and said she would be there shortly. At 9:10 a.m. LPN-A walked over to R30 and gave her the morning pills, and while standing gave R30 a few bites of food and left. R30 did not make any attempts to eat independently after LPN-A left. At 9:24 a.m. NA-B pulled up a chair and sat down to start feeding R30. At 9:25 a.m. NA-B left to assist other residents in the dining room. At 9:31 a.m. NA-B sat down again and continued to feed R30. At 9:37 a.m. NA-B left to assist other residents in the dining room. At 9:38 a.m. NA-B sat down again with R30, and 9:41	F 725	manner and ensure compliance. The results of the audits will be reported to the Quality Assurance team who will then determine the need for ongoing audits. Clinical administrator or designee will be responsible for ongoing compliance; date of compliance is 5/1/18	

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F 725	Continued From page 8	F 725		

a.m. left to assist another resident in the dining room with food set up. At 9:43 a.m. NA-B sat down again to assist feeding R30 until 9:46 a.m. when R30 was done. Staff was observed to have left R30 five times during assistance with breakfast.

R30 was interviewed on 3/21/18, at 9:50 a.m., and when asked if she needed help eating, stated "probably." R30 was not able to elaborate any more on her dining experience.

During interview on 3/21/18, at 10:56 a.m. LPN-A stated the acuity on the memory care unit was currently high and caused a delay in feeding some of the residents. LPN-A stated there was a schedule for feeding assistance with breakfast which usually started at 8:00 a.m..LPN-A explained the schedule was for the LPN to assist in the dining room from 8:00 a.m. to 8:30 a.m., one NA from 8:30 a.m. to 9:00 a.m., two NA's from 9:00 a.m. to 9:30 a.m., and three NA's from 9:30-10:00 a.m.. LPN-A further explained that she was usually doing medication passes during the LPN scheduled time and would help with breakfast when she was able to. LPN-A further stated lunch was served at 12:00 p.m. and usually was less busy. LPN-A also stated R30 had recently become sleepier at breakfast and stated she tried to run over and give R30 bites to eat in between medication passes.

During interview on 3/21/18, at 11:15 a.m. NA-A stated R30 had declined in the past few weeks and had demonstrated increased sleepiness. NA-A stated R30 used to be able to eat independently after initial set up but presently needed assistance to eat, otherwise R30 just would just sit there and not eat after the meal was

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F 725	Continued From page 9	F 725		

set up.

On 3/22/18, the breakfast meal service was observed again on the memory care unit from 9:04 a.m. to 10:13 a.m. The activities director (AD) was observed to be the only staff present in the dining room who was assisting the residents. During that time there were eight residents in the dining room, all of whom required set up and/or supervision, and three residents who required feeding assistance. AD was observed going in between multiple residents, assisting them with eating and other needs. From 9:04 a.m. to 9:27 a.m. AD assisted R40 to eat. At 9:21 a.m. R30 arrived in dining room for breakfast. At 9:23 a.m. R30 was served French toast. At 9:27 a.m. AD went to R30's table and sat down to feed her. At 9:33 a.m. AD left R30 to assist a resident who needed urgent assistance. R30 did not eat independently when left alone. At 9:41 a.m. the AD was done assisting the other resident and went back to feed R40 again. At 9:51 a.m. the AD moved R30 to another table and resumed feeding her until she was done eating.

Additional observation revealed on 3/22/18, at 9:09 a.m. R29 was awake and nursing assistant (NA)-C was assisting R29 with morning cares. R29 was not brought into the dining room for breakfast until 10:00 a.m..

On 3/22/18, at 10:18 a.m., the AD stated the memory care unit acuity was high right now. The AD stated she did not like to see residents waiting so long for food, so she has told the staff to call her when they need help with feeding residents, and has been helping out with feeding residents' breakfast almost every day.

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F 725	Continued From page 10	F 725		

On 3/22/18, at 10:20 a.m. NA-C stated there was not enough staff for them to get their work done in the morning on the memory care unit. NA-C further stated many times they were not done feeding residents breakfast until 11 a.m. NA-C stated the nursing assistants were not able to feed residents in the morning because they were busy with morning cares. NA-C stated there used to be a nursing assistant who worked from 9:00 a.m. to 1:00 p.m. but that position was cut. NA-C explained the unit had high acuity with many residents who needed two person assist for mobility, and who were agitated from confusion and needed multiple different approaches in the morning which was time consuming. NA-C stated "we [staff] feel bad because we feel like we are not able to give the quality care we want to give." NA-C further stated she talked to management about staffing issues in the past.

During interview on 3/22/18, at 10:47 a.m. NA-D stated they have not had enough staff to provide care for residents on the memory care unit and it was "stressful for residents and staff." NA-D stated finishing breakfast around "this time was normal." NA-D also stated she had spoken with the director of nursing (DON) on more than one occasion about staffing concerns, but did not feel that the staffing concern had been resolved. NA-D explained most residents on the unit needed assist of two staff and NAs were not able to complete morning cares and assist with feeding residents in a timely manner. NA-D stated she felt bad for the residents who had to wait for these cares.

The nursing assistant (NA) care sheet for the memory care unit dated 3/22/18, indicated 11 residents needed assist of two to provide

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F 725	Continued From page 11	F 725		

activities of daily living care, and six residents needed assistance with eating including R29 and R40.

The administrator (A) and DON were interviewed on 3/22/18, at 12:49 p.m. The DON stated they were trying to rearrange processes in the memory care unit such as changing break times and auditing residents' wake times, to reduce some of the concerns with dining assistance during breakfast. The DON stated breakfast service on the unit was supposed to begin at 8:00 a.m., but did not identify the goal time for it to be finished. The DON stated there was no set schedule for extra assistance in the dining room but stated she would help out routinely and there were others who have helped including the nursing supervisor and AD. The DON verified the memory care unit census as 17 and stated the day shift routine staffing included one LPN and 3 NAs. The DON stated NAs were expected to complete the morning cares for all residents, and NAs along with LPN were supposed to ensure all residents had breakfast. DON stated there was additional help from other staff that came to assist with dining as needed such as herself but there was no specific plan to address the staffing concern.

A facility's policy titled Presbyterian Homes & Services Care Center/TCU [transitional care unit] and Assisted Lining Clinical Staffing Policies updated September 2017, indicated clinical leadership would work together to develop schedules that meet the needs of our residents.

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	245556	A. BUILDING **1N - NEW BUILDING** B. WING _____	**03/21/2018**

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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 FORM 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 21, 2018. At the time of this survey, Presbyterian Homes of Bloomington was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/13/2018

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

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K 000	Continued From page 1	K 000		

IS NOT REQUIRED.

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Presbyterian Homes of Bloomington Care Center is a 3-story building with a full basement that was built in 2005 determined to be of Type II(222) construction. The facility is separated from an assisted living occupancy by 2-hour fire rated construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification.

The facility has a capacity of 98 beds and had a census of 91 at time of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING **1N - NEW BUILDING** B. WING _____	**03/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(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 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not properly enclose stairways used for exits. NFPA 101 (2012) 19.2.2.3, 19.2.2.4, 7.2. This deficient practice could affect all 91 residents. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on March 21, 2018, it was revealed that the two exit stairwells had exposed gaps in the corners between the corridor and exterior fire rated walls that were open to the nursing home corridor system. This deficient practice was verified by the Engineering Manager at the time of discovery.	K 225	A contractor has been hired to repair all areas of the two stairways that do not have proper separation. We will be using two products to make needed repairs. Roxul safe insulation then covered with 3M Fire Barrier sealant FD 150+. These two products are to be placed in all gaps located in stairwells A and B. This should be a one time correction. We will monitor this area annually as part of our smoke barrier inspections. Tom Draeger, Engineering Manager, is responsible for ensuring completion by May 1st, 2018.	5/1/18
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals	K 352		5/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING **1N - NEW BUILDING** B. WING _____	**03/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(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 352	Continued From page 3 Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not install automatic sprinkler system supervisory attachments in accordance with NFPA 72, National Fire Alarm and Signaling Code, that are displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. NFPA 72, 9.7.2.1. This deficient practice could affect all 91 residents. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on March 21, 2018, it was revealed that the facility does not have a remote fire alarm annunciator panel installed in a area that is continuously supervised by staff. This deficient practice was verified by the Engineering Manager at the time of discovery.	K 352	The facility will install an additional annunciator panel at the Pathway nursing station which is continuously supervised by staff. Tom Draeger, Engineering Manager, will be responsible for ensuring the completion of this on April 13th, 2018.	