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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: U6IY

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 **11/07/2017** (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 **93** (L18)

13.Total Certified Beds **93** (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
	93			
(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 :
Terri Ament, Unit Supervisor 11/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 11/17/2017 (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
11/15/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245495 November 17, 2017

Ms. LeeAnn Harwarth, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

Dear Ms. Harwarth:

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 23, 2017 the above facility is recommended for:

93 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 93 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,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 17, 2017

Ms. LeeAnn Harwarth, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

RE: Project Number S5495027

Dear Ms. Harwarth:

On September 28, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 14, 2017. 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 November 7, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 7, 2017 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 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 14, 2017, effective October 23, 2017 and therefore remedies outlined in our letter to you dated September 28, 2017, 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,

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

cc: Licensing and Certification File

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

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(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 **09/14/2017** (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

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From (a) :
To (b) :

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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
	93			
(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-NE II 10/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 11/13/2017 (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
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 28, 2017

Ms. Lee Ann Harwarth, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

RE: Project Number S5495027

Dear Ms. Harwarth:

On September 14, 2017, 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@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 24, 2017, 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 24, 2017 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 December 14, 2017 (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 14, 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 related to this letter.

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

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
	245495	A. BUILDING _____ B. WING _____	09/14/2017

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 On 9/11/17, through 9/14/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) 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.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 242	R91 was not interviewable. Family were	10/23/17

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

Electronically Signed | 10/06/2017

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 _____	09/14/2017

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 242	Continued From page 1 review, the facility failed to accommodate waking and bathing preferences for 2 of 3 residents (R91, R124) reviewed for choices. Findings include: R91's Diagnosis Report printed on 9/13/17, identified diagnoses that included insomnia. R91's quarterly Minimum Data Set (MDS) dated 7/27/17, indicated R91 was rarely understood, never or rarely made decisions, had short and long term memory impairments, and required extensive assistance with all activities of daily living (ADLs). R91's care plan dated 8/25/17, indicated that R91 had a history of insomnia, had a goal of sleeping at least 6 hours a night, and directed staff to monitor the hours R91 slept. The care plan lacked identification of R91's preference for wake time. R91's Order Summary Report indicated R91 had an order for trazadone (an antidepressant medication often prescribed for insomnia) 125 milligrams (mg) by mouth at bedtime. On 9/12/17, at 9:50 a.m. family member (FM)-A was interviewed and stated R91 had lived in family care for 16 years prior to admission to the facility. FM-A stated during this time, R91 had always slept in late in the mornings. FM-A stated R91 had to get up earlier now in order to have breakfast in the facility. On 9/13/17, from 7:43 a.m. until 8:46 a.m. R91 was observed in bed, asleep and lying on his back, occasionally snoring. At 8:46 a.m. nursing	F 242	contacted and established waking preferences and care plan/care card were updated. Completed 9/29/17. R124 Assessment was redone 9/29/17, and establishes bathing preferences and care plan/care card were updated. Action as applies to others: The Policy and Procedure on Resident Choice is current. All residents will be interviewed by 10/23/17 to assure their choices for daily living are correctly addressed in their care plans/care cards. This will b e addressed with each new admission and at quarterly care conferences, ongoing. All nursing and activity staff will be educated on resident choice for activities of daily living which includes bathing and waking times by 10/23/17. Recurrence will be prevented by: Audits will be conducted on various units, 3 residents 3x/week x 90 days, to assure their daily living preferences are correctly identified in their care plans/care cards. The results of these audits will be shared with the facility QAPI committee monthly and input given on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON, Nurse Managers	

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 _____	09/14/2017

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 242	Continued From page 2	F 242		

assistant (NA)-B entered R91's room and proceeded to pick out an outfit and gather supplies to get R91 ready for the day. R91 continued to snore through the activity. At 8:49 a.m. NA-B stated she had been told in report that R91 had been awake a little while last night. NA-B talked quietly and encouragingly to R91 to wake him up, stating, "Stretch!" and "Good morning!" while using a warm, wet washcloth to wash R91's face. R91 was asleep and snoring at the beginning of the face wash, and awake by the end. NA-B proceeded to assist R91 in getting ready for the day, and assisted him to the dining room for breakfast.

On 9/13/17, at 9:00 a.m. NA-B stated if they slowly woke up R91, he would get up easily. NA-B stated if they don't get him up, he wouldn't get breakfast. NA-B stated she didn't know what R91's pattern and preferences had been prior to moving to the facility, and his waking preferences were not indicated on the care plan. NA-B stated she would leave R91 to last, and then slowly wake him up.

On 9/13/17, from 9:47 a.m. until 10:04 a.m. R91 was observed sitting in the Unit 2 hallway, with another resident in a wheelchair directly in front of him. R91 dozed on and off during this period.

On 9/13/17, at 11:04 a.m. R91 was observed asleep in his wheelchair in front of the TV in the living room area of the facility.

On 9/13/17, from 11:57 a.m. to 12:12 p.m. R91 was observed in the dining room. NA-B was assisting R91 with his lunch meal. NA-B made several comments about how sleepy he was. R91's right elbow was on the table and his head

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	245495	A. BUILDING _____ B. WING _____	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 3 was resting in his hand during the meal, and his eyes were closing at times. On 9/13/17, at 2:07 a.m. R91 was observed asleep in bed while a music group was playing in the dining room. On 9/14/17, at approximately 11:30 a.m. registered nurse (RN)-A stated resident concerns and needs are discussed at care conferences. RN-A stated if a resident wanted to sleep in, it would be care planned. RN-A further stated If a resident missed breakfast, they could be offered a snack after they get up. R124's Diagnosis Report printed 9/13/17, indicated diagnoses that included anoxic brain damage (an injury to the brain due to a lack of oxygen). R124's Care Area Assessment (CAA) dated 8/17/17, indicated R124's communication needed to be simple and direct, allowing R124 time to respond. The CAA further indicated R124 was able to respond adequately to simple direct questions, and her speech was clear R124's care plan revised 8/28/17, directed staff to provide extensive assistance with bathing. The care plan lacked R124's preference on frequency for bathing. R124's Activity Interview for Daily & Activity Preferences assessment dated 8/11/17, identified R124 had been interviewed by the facility, and identified it was "Very important" for	F 242		

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F 242	Continued From page 4 her to be able to choose a preference for bathing, and a shower was her preferred choice for bathing. The assessment lacked any identified preference for the number of showers R124 would like to have a week. On 9/12/17, at 9:06 a.m. R124 was interviewed and stated a choice in frequency of bathing was not offered. R124 stated a daily shower was preferred rather than the weekly shower she was offered. On 9/13/17, at 9:45 a.m. nursing assistant (NA)-A stated staff were assigned to complete weekly bathing based on resident room numbers, but if a resident requested an extra shower, they would try to accommodate the resident. NA-A stated resident requests for additional showers were communicated to management via weekly skin check sheets, and submitted with additional shower requests. On 9/13/17, at 10:22 a.m. the assistant director of nursing (ADON) stated bathing frequency preferences were not consistently noted. The ADON stated baths or showers were scheduled for twice a week, and most residents were happy with that. The ADON stated when resident preferences were identified, they were included in the care plan. The ADON verified R124's care plan lacked documentation of her bathing frequency preferences. On 9/13/17, at 1:09 p.m. the director of nursing (DON) verified the system for bathing frequency was to be set up according to room schedule, and residents would be bathed at least twice a week.	F 242		
F 282	483.21(b)(3)(ii) SERVICES BY QUALIFIED	F 282		10/23/17

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F 282 SS=D	Continued From page 5 PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 follow the care plan for repositioning for 2 of 2 residents (R91, R18) reviewed for pressure ulcers. Findings include: R91's Diagnosis Report printed 9/13/17, identified diagnoses that included seizures and muscle weakness. R91's quarterly Minimum Data Set (MDS) dated 7/27/17, indicated R91 had severe cognitive impairment, required extensive assistance with all activities of daily living (ADL's), and was at risk for pressure ulcer development. R91's Braden Scale Assessment for Predicting Pressure Sore Risk, dated 7/27/17, identified R91 to be at moderate risk of pressure ulcer development related to inability to respond to pain, moisture, only walking occasionally, and very limited mobility. R91's care plan reviewed on 8/25/17, indicated R91 was at risk for pressure ulcers due to restricted mobility, the need for assistance with	F 282	R#18 and R#91 were repositioned as soon as the discrepancy was identified. Action as it applies to others: The Policy for Assistance with ADLs including repositioning according to Care Plan remains current. All nursing staff will b e educated by 10/10/17 regarding accurate documentation of repositioning times and the need to ask for assistance I f they see they are going to be running behind schedule. Nurse Managers will round on their units daily to assure repositioning is occurring according to the Care Plan/Care Card and to determine if additional assistance is needed. Recurrence will be prevented by Visual audits will occur 3x weekly on all units or 3 residents at alternating times x 90 days to assure repositioning is occurring per Care Plan/Care Card. The results of the audits will be discussed	

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F 282	Continued From page 6 toileting, incontinence, and having cognitive loss that limited mobility. The care plan indicated R91 required to be turned and repositioned every 2 hours. On 9/13/17, from at 9:00 a.m. to 11:36 a.m. R91 was continually observed sitting in his wheelchair. At that time, NA-B stated R91 was to be repositioned every two hours. NA-B went to the Unit 2 utility room to check the repositioning sheet, returned and stated R91 was last repositioned at 9:00 a.m. (2 hours and 36 minutes without repositioning). NA-B and NA-D assisted R91 with repositioning at that time. On 9/14/17, at 9:51 a.m., RN-A stated residents are to be repositioned every 2 hours unless care planned differently. R18's Diagnosis Report printed on 9/13/17, identified diagnoses that included Parkinson's disease. R18's quarterly Minimum Data Set (MDS) dated 7/13/17, indicated R18 had severely impaired cognition, and required extensive assist of 2 for activities of daily living (ADL's) including bed mobility and transfers. The MDS further indicated R18 was at moderate risk for the development of pressure ulcers. R18's Braden Scale Assessment for Predicting Pressure Sore Risk, dated 9/13/17, identified R19 was at moderate risk of developing pressure ulcers development related to limited mobility, probably inadequate nutrition, and a potential problem with friction and shear. R18's care plan revised 8/11/17, indicated R18	F 282	monthly at the facility QAPI meeting for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Nurse Managers	

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F 282	Continued From page 7 was at risk for skin breakdown due to factors including restricted mobility, Parkinson's Disease, immobility, incontinence, and poor nutrition. The care plan directed staff to turn and reposition R18 every 2 hours. On 9/13/17, at 8:11 a.m. until 10:54 a.m. R18 was continually observed in his wheelchair. At 10:54 a.m. NA-B approached R18 to take him to the bathroom (2 hours and 43 minutes without repositioning). On 9/14/17, at 9:52 a.m. RN-A stated R18 should be repositioned every 2 hours. RN-A confirmed R18 was at risk of pressure ulcers. On 9/13/17, at 11:02 a.m. NA-B stated residents are to be repositioned every two hours unless noted to be more often on the care plan. On 9/13/17, at 11:08 a.m. RN-A stated residents are to be repositioned every 2 hours unless care planned differently. RN-A stated 2 hours and 36 minutes was too long for R91 to be in his wheelchair without repositioning and 2 hours, 43 minutes was too long for R18 to be in his wheelchair without repositioning.	F 282		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 285		9/19/17

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F 285	Continued From page 8 (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 285		

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F 285	Continued From page 9 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section-	F 285		

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F 285	Continued From page 10 (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (R91) reviewed for PASRR. Findings include: R91 was admitted on 1/31/17, with diagnoses that included Down Syndrome. Review of R91's care plan lacked identification of specialized services for his Down Syndrome diagnosis. On 9/13/17, at 11:23 a.m. Itasca County case worker (CW) was interviewed and stated the facility had called the county agency on Monday 9/11/17, to ask for a Level II PASRR to be completed for R91.	F 285	R#91 Level 2 PASRR was completed on 9/13/17. Action as it applies to others: The facility instructions from DHS for assuring Level 2 screenings as indicated from PASRR remain current. All residents will be reviewed by 9/19/17 to assure level 2 screenings indicated from pre-admission PASRR have been completed. The Social Services Director and Admissions Coordinator were re-educated on the Level 2 screening requirements on 9/18/17. Recurrence will be prevented by: The Social Worker will maintain a	

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F 285	Continued From page 11 On 9/13/17, at 2:26 p.m. the director of social services (SS-A) stated the facility had not realized the Level II PASRR had not been completed for R91 until the state surveyor asked for PASRR information on 9/11/17. SS-A provided a Level I Screening form for R91 completed on 2/2/17. Review of the Level I screening indicated that R91 was to be referred to the county offices for evaluation and determination of need for specialized services.	F 285	spreadsheet to be reviewed monthly at QAPI on all Level 2 screenings to assure these have been completed ad a copy maintained. this will be an ongoing process. The correction will be monitored by: Administrator	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to prevent the development of pressure ulcers 2 of 2 residents (R91, R18)	F 314	R#18 and R#91 were repositioned as soon as the discrepancy was identified. Action as it applies to others:	10/23/17

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F 314	Continued From page 12 reviewed for pressure ulcers. Findings include: R91's Diagnosis Report printed 9/13/17, identified diagnoses that included seizures and muscle weakness. R91's quarterly Minimum Data Set (MDS) dated 7/27/17, indicated R91 had severe cognitive impairment, required extensive assistance with all activities of daily living (ADL's), and was at risk for pressure ulcer development. R91's Braden Scale Assessment for Predicting Pressure Sore Risk, dated 7/27/17, identified R91 to be at moderate risk of pressure ulcer development related to inability to respond to pain, moisture, only walking occasionally, and very limited mobility. R91's care plan reviewed on 8/25/17, indicated R91 was at risk for pressure ulcers due to restricted mobility, the need for assistance with toileting, incontinence, and having cognitive loss that limited mobility. The care plan indicated R91 required to be turned and repositioned every 2 hours. On 9/13/17, at 9:00 a.m. R91 was observed transferring from his bed to his wheelchair with assistance from nursing assistant (NA)-B who then pushed him in his wheelchair to the dining room for breakfast. After breakfast, R91 was wheeled to the Unit 2 hallway and remained there until 10:06 a.m. when an activity staff person wheeled him to the chapel. R91 remained in the chapel until 10:38 a.m. when he was wheeled to the TV area. At 11:20 a.m. R91 was wheeled to	F 314	The Policy for Assistance with ADL's including repositioning according to Care Plan remains current. All nursing staff will be educated by 10/10/17 regarding accurate documentation of repositioning times and the need to ask for assistance if they see they are going to be running behind schedule. Nurse Managers will round o n their units daily to assure repositioning is occurring according to the Care Plan/Care Card and to determine if additional assistance is needed. Recurrence will b e prevented by: Visual audits will occur 3x weekly on all units for 3 residents at alternating times x 90 days to assure repositioning is occurring per Care Plan/Care Card. The results of the audits will be discussed monthly at the facility QAPI meeting for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Nurse Managers	

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	245495	A. BUILDING _____ B. WING _____	09/14/2017

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F 314	Continued From page 13	F 314		

the dining room for lunch, where he continued to sit in his wheelchair until intervention at 11:36 a.m.

On 9/13/17, at 11:36 a.m. NA-B stated R91 was to be repositioned every two hours. NA-B went to the Unit 2 utility room to check the repositioning sheet, returned and stated R91 was last repositioned at 9:00 a.m. (2 hours and 36 minutes). NA-B and NA-D assisted R91 the toilet in the Unit 2 hallway bathroom at 11:46 a.m. NA-B reported R91's buttocks to have no redness or clothing imprints and his incontinent product was dry.

On 9/14/17, at 9:51 a.m., RN-A stated residents are to be repositioned every 2 hours unless care planned differently. RN-A confirmed R91 was to be repositioned every 2 hours to prevent pressure ulcer development.

Review of R91's repositioning sheets from 8/14/17, through 9/12/17, revealed the following:
-8/14/17: 10:03 a.m. to 1:11 a.m. 3 hours, 8 minutes
-8/18/17: 7:28 a.m. to 10:06 a.m. 2 hours 38 minutes
-8/18/17: 10:06 a.m. to 1:55 p.m. 3 hours, 49 minutes
-8/19/17: 6:43 a.m. to 9:28 a.m. 2 hours, 45 minutes
-8/19/17: 6:10 p.m. to 9:30 p.m. 3 hours, 20 minutes
-8/22/17: 7:20 a.m. to 10:51 a.m. 3 hours, 31 minutes
-8/22/17: 10:51 a.m. to 1:53 p.m. 3 hours, 2 minutes
-8/23/17: 10:30 a.m. to 2:10 p.m. 3 hours, 34 minutes

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F 314	Continued From page 14 -8/23/17: 5:30 p.m. to 8:30 p.m. 3 hours -8/24/17: 11:15 a.m. to 2:00 p.m. 2 hours, 45 minutes R18's Diagnosis Report printed on 9/13/17, identified diagnoses that included Parkinson's disease. R18's quarterly Minimum Data Set (MDS) dated 7/13/17, indicated R18 had severely impaired cognition, and required extensive assist of 2 for activities of daily living (ADL's) including bed mobility and transfers. The MDS further indicated R18 was at moderate risk for the development of pressure ulcers. R18's Braden Scale Assessment for Predicting Pressure Sore Risk, dated 9/13/17, identified R19 was at moderate risk of developing pressure ulcers development related to limited mobility, probably inadequate nutrition, and a potential problem with friction and shear. R18's care plan revised 8/11/17, indicated R18 was at risk for skin breakdown due to factors including restricted mobility, Parkinson's Disease, immobility, incontinence, and poor nutrition. The care plan directed staff to turn and reposition R18 every 2 hours. On 9/13/17, at 8:11 a.m. R18 was observed getting out of bed and into his wheelchair by registered nurse (RN)-A and nursing assistant (NA). NA-C finished R18's morning cares, and wheeled him out to the public area at 8:23 a.m. RN-A assisted R18 with calling a family member, then brought him to the dining room for breakfast. At 9:05 a.m. R18 was wheeled to the Unit 2 nurses cart, and remained there until 9:20 a.m. At	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15 9:30 a.m. R18 was in the TV area sitting in his wheelchair, where he remained until being wheeled to the chapel at 9:45 a.m. R18 returned to the TV area from the chapel at 10:44 a.m. At 10:54 a.m. NA-B approached R18 to take him to the bathroom (2 hours and 43 minutes without repositioning). On 9/14/17, at 9:52 a.m. RN-A stated R18 should be repositioned every 2 hours. RN-A confirmed R18 was at risk of pressure ulcers. Review of R18's repositioning sheets revealed the following from 8/13/17 to 9/7/17: -8/13/17: 11:12 a.m. to 3:45 a.m. 2 hours, 33 minutes -8/14/17: 6:10 a.m. to 9:48 a.m. 2 hours, 38 minutes -8/14/17: 3:58 p.m. to 6:50 p.m. 2 hours, 52 minutes -8/15/17: 1:00 p.m. to 3:50 p.m. 2 hours, 50 minutes -8/16/17: 6:00 p.m. to 8:25 p.m. 2 hours, 25 minutes -8/19/17: 8:37 a.m. to 11:19 a.m. 2 hours, 42 minutes -8/24/17: 10:20 a.m. to 1:00 p.m. 2 hours, 40 minutes -8/29/17: 6:45 a.m. to 10:55 a.m. 4 hours, 10 minutes -9/3/17: 4:00 p.m. to 9:50 p.m. 5 hours, 50 minutes On 9/13/17, at 11:02 a.m. NA-B stated residents are to be repositioned every two hours unless noted to be more often on the care plan. On 9/13/17, at 11:08 a.m. RN-A stated residents are to be repositioned every 2 hours unless care	F 314		

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	245495	A. BUILDING _____ B. WING _____	09/14/2017

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F 314	Continued From page 16 planned differently. RN-A stated staff have a repositioning sheet in the linen room where they record repositioning times. RN-A stated 2 hours and 36 minutes was too long for R91 to be in his wheelchair without repositioning and 2 hours, 43 minutes was too long for R18 to be in his wheelchair without repositioning. The facility's Skin Program policy revised on 9/16, directed the facility is to provide care and services to prevent pressure ulcer development.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the proper therapeutic diet was provided as ordered by the physician for 1 of 1 residents (R79) reviewed for	F 325	R#79 diet was changed to Low Potassium on 8/24/17. Action as it applies to others:	9/14/17

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F 325	Continued From page 17 nutrition. Findings include: R79's Diagnosis Report printed 9/14/17, indicated R79's diagnoses included dependence on renal (kidney) dialysis, end stage renal disease, secondary hyperparathyroidism of renal origin (a common complication of chronic kidney disease characterized by elevated parathyroid hormone levels) R79's 5 day Minimum Data Set (MDS) dated 8/22/17, indicated R79 had a moderate cognitive impairment, was understood and usually understood others. R79's MDS further indicated R79 ate meals independently after set up, had no swallowing problems or significant weight change, and did not have a therapeutic diet. R79's care plan revised 7/6/17, indicated R79 had a regular diet and fluid restriction of 1200 milliliter (ml) daily. R79's signed physician Order Summary Report dated 7/17/17, indicated R79 had a regular diet with a 1200 ml fluid restriction. R79's Nutritional Review dated 3/16/17, indicated R79 was on a renal diet (diet low in sodium, phosphorous and protein) and had a 1500 ml fluid restriction. R79's Nutritional Review dated 5/10/17, indicated R79's potassium level was 5.1 (high limit of normal) on 4/27/17, and he was receiving a regular diet with a 2000 ml fluid restriction. R79's rounding report with physician orders dated	F 325	The Policy of two nursing staff checking any new orders remains current. All residents will be reviewed to assure all diet orders are accurate. Low Potassium diet was added to the menu drop down in the clinical software. All licensed nurses, medical records and dietary manager will be re-educated on entering new diet orders into Point Click Care to assure the new order is implemented timely. Recurrence will be prevented by: Audits of diet orders will be competed 3x weekly on 3 residents on each unit x 90 days to assure all updated orders are processed correctly and initiated timely. The results of these audits will b e shared with the monthly QAPI Committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Dietitian/Dietary Director/Medical Records	

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F 325	Continued From page 18 6/24/17, directed to restrict the potassium to 60 mlliequivalents (mEq) per liter daily. R79's nephrology Dialysis Followup visit report dated 7/17/17, indicated R79's potassium in July was 6.7 (moderately elevated potassium level). R79's physician note indicated R79 was to have restricted potassium in his diet due to hyperkalemia (elevated potassium in the blood), and the nephrologist further indicated he would again send instructions to the nursing home about restricting the potassium in R79's diet. A faxed physician order dated 7/19/17, directed the facility to change R79's diet to include fewer high potassium foods. This order was signed as noted by an RN. R79's Nutritional Review dated 8/10/17, indicated there were no current labs, and R79's diet was a 3 gram sodium diet. R79's Nutritional Review dated 8/24/17, indicated R79 had no current labs, and R79's diet was a regular diet low potassium. R79's Lab Report dated 9/11/17, indicated R79's potassium level was 5.8 (mild hyperkalemia). R79's dietary Progress Note dated 8/17/17, indicated R79 was at high nutritional risk related to dialysis, and was to have a regular, low potassium diet with a 1200 ml fluid restriction. The note further indicated R79 had poor nutritional intake since return from hospital. R79's dietary note indicated R79's diet was changed to regular with low potassium foods at that time. A meal ticket dated 9/14/17, indicated R79	F 325		

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F 325	Continued From page 19 received a regular no added salt diet, and under dislikes/substitutions for R79, restricted foods high in potassium. On 9/13/17, at 10:47 a.m. licensed practical nurse (LPN)-B stated R79 was non-compliant with his diet and fluid restriction, and would get chips and candy from the vending machine. On 9/14/17, at 8:33 a.m. R79 was observed to have eaten just bites of oatmeal, and a whole piece of toast and bacon remained on his plate. R79 drank a 4 ounce glass of milk. On 9/14/17, at 2:33 p.m. the dietary manager (DM) stated R79 was currently receiving a regular diet, and it had been, "OK' d" by the dialysis facility. DM stated she would check on the start date of that diet. On 9/14/17, at 2:50 p.m. the DM verified R79 had not previously been receiving the diet as ordered by the physician, and the dietician had noticed this error in diet in August. The DM stated the diet change had not been communicated to the DM. On 9/14/17, at 3:12 p.m. the dietician verified R79's order was missed, and stated the order was originally changed to low potassium diet in June, and then was again ordered in July. The dietician stated she caught the error during a review in August. The dietician stated nursing was responsible to communicate the change in diet to the dietary department. The dietician verified R79 had received the wrong diet for some time. On 9/14/17, at 3:14 p.m. the director of nursing (DON) stated when nursing receives physician's orders, the orders are entered in the electronic	F 325		

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F 325	Continued From page 20 medical record (EMR). The order is discussed in an interdisciplinary meeting with dietary personal present. The DON stated the DM should check the EMR for new orders daily. The DON stated she would expect nursing to communicate new orders with the dietary department, and physician orders should be followed.	F 325		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the	F 329		10/10/17

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F 329	Continued From page 21 medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic 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 observation, interview, and document review, the facility failed to ensure psychotropic medications were comprehensively assessed for side effects for 3 of 5 residents (R20, R124, R138) reviewed for unnecessary medications. In addition, the facility failed to develop a care plan for monitoring of target behaviors related to antipsychotic medications for 1 of 5 residents (R124), and identify an appropriate diagnosis and obtain consent for use of an antipsychotic medication for 2 of 5 residents (R124, R138) reviewed for unnecessary medications. Findings include: R20's Admission Record printed 9/14/17, indicated R20 was admitted to the facility on 2/28/17. R20's Diagnosis Report printed 9/14/17, indicated R20's diagnoses included unspecified tremor, and abnormalities of gait and mobility. R20's quarterly Minimum Data Set (MDS) dated 7/27/17, indicated R20 had severely impaired cognitive skills for decision-making and signs of delirium with inattention. R20's MDS indicated R20 had no signs or symptoms of psychosis,	F 329	R#20, R#124, R#138 had psychotropic assessments, target behaviors and consents completed on 9/29/17. Action as it applies to others: The Psychopharmacological Policy remains current. All residents receiving a psychopharmacological medication will be reviewed to assure all pieces required to be initiated including consent, DGR, Assessment and Target Behaviors are in place. All licensed nurses, nurse managers and social services will be educated on the Psychopharmacological Policy which includes Assessment, GDR, Target Behaviors, and consents for use. Recurrence will be prevented by: Audits will be completed on 3 residents receiving psychopharmacological medications 3x weekly on all units x 90 days to assure consents, Target Behaviors, GDR, and assessments are in place. The results of these audits will be	

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F 329	Continued From page 22 rejected care 4-6 days out of the week, had physical behaviors 1-3 days, and verbal behaviors 1-3 days. The MDS also indicated R20 received an antipsychotic medication every day. R20's Physician Appointment Note dated 6/7/17, included orders for Seroquel (antipsychotic medication) 25 milligrams (mg) twice daily. R20's After Visit Summary dated 6/7/17, indicated Seroquel was ordered for behavior and sleep. R20's signed Physician Orders dated 7/17/17, included orders for Seroquel 25 mg by mouth twice daily for dementia behaviors, and indicated R20 initially began the orders on 6/7/17. R20's consultant pharmacist Medication Regimen Review dated 8/16/17, recommended a reduction of the Seroquel, with the goal of discontinuation of the medication. The consultant pharmacist's recommendation further indicated the physician complete an assessment of risk versus benefit for use of the Seroquel, indicating the medication was a valid therapeutic intervention for R20, and recommended monitoring of potential adverse consequences. R20's signed Physician Orders dated 8/21/17, directed the Seroquel to be decreased to 12.5 mg twice daily. A Psychopharmacological Drug Assessment (PDA) dated 8/22/17, indicated R20 was started on Seroquel due to behaviors noted when he was seeing his physician, but behaviors were currently stable, and the Seroquel was decreased. The PDA indicated the diagnosis for the Seroquel was dementia with behaviors, and that an AIMS or DISCUS (tools to measure neuroleptic symptoms	F 329	shared with the facility QAPI Committee monthly for input on the need to increase decrease, or discontinue the audits. The correction will be monitored by: DON/Social Services	

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F 329	Continued From page 23 of tardive dyskinesia or involuntary movements caused by antipsychotic medications) had been completed. R20's target behaviors included self transferring and becoming angry when staff were assisting him, striking out and yelling/swearing at staff and pushing away from them or at them. On 9/13/17, at 10:26 a.m. R20 stood up from the wheelchair in the dining room and began to walk around the table. Staff were notified and he was assisted to sit in a stationary chair two tables over, on the other side of the dining room. At 11:56 a.m. R20 was eating his lunch independently, using a regular spoon. R20 had a noticeable tremor of his hands. On 9/14/17, at 10:58 a.m. licensed practical nurse (LPN)-B stated R20 had impulsive and unpredictable behaviors. LPN-B stated the Seroquel was ordered by the primary physician when R20 had behaviors in the MD's office. LPN-B stated R20's side effects were monitored, and the facility has done a reduction. LPN-B verified Seroquel is not an appropriate medication for dementia with behaviors, and stated the facility did not want the Seroquel, but R20's behaviors have stabilized on the Seroquel. LPN-B verified an AIMS or DISCUS was not done for R20, and stated it should have been done upon starting the antipsychotic medication, and every 6 months. LPN-B stated she did not see side effect monitoring of Seroquel for R20. LPN-B stated Seroquel was not given to sedate R20 and verified it would add to his risk of falls. On 9/14/17, at 2:17 p.m. the director of nursing (DON) stated she would expect a baseline DISCUS and pharmacological assessment to be done for antipsychotic medications.	F 329		

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F 329	Continued From page 24	F 329		

R124's Admission Record printed 9/13/17, indicated R124 was admitted to the facility on 8/4/17.

R124's Diagnosis Report dated 9/13/17, indicated diagnoses that included anoxic brain damage (damage to the brain due to lack of oxygen), anxiety, and encephalopathy (a general term that means brain disease, damage, or malfunction).

R124's Order Summary Report dated 8/9/17, included medication orders for Haldol (an antipsychotic medication) 5 milligrams(mg) every six hours as needed (PRN) for agitation. The orders also included Ativan (an antianxiety medication) 2 mg every 6 hours PRN for anxiety. The orders directed to give the PRN Ativan prior to Haldol, and directed to administer Benadryl (antihistamine) with the Haldol. The orders lacked a physician order for use of the Benadryl.

R124's care plan dated 8/29/17, indicated R124 had a behavior problem, but lacked goals for medication use, and non-pharmacological interventions for staff to attempt prior to initiating the PRN Haldol and Ativan.

R124's admission Minimum Data Set (MDS) dated 8/11/17, indicated R124 had received antipsychotic medication for 7 of the 7 days in the

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F 329	Continued From page 25 lookback period. R124's Care Area Assessment (CAA) dated 8/21/17, indicated R124 needed an CAA assessment due to falls, and use of psychotropic medication use. The facility failed to complete the CAA identified by the MDS for the CAA of Psychotropic Medication Use. R124's medical record lacked a side effect movement disorder assessment, a psychopharmacological drug assessment, and indication that R124's representative had been notified of the Haldol. R138's Admission Record dated 9/14/17, indicated R138 was admitted to the facility on 9/9/17. R138's Diagnosis Report dated 9/14/17, indicated R138 diagnoses included anxiety. R138's electronic Medication Administration Record (eMAR) for 9/17, indicated R138 received Zyprexa (antipsychotic medication) at 2.5 mg at bedtime for a diagnosis of health management. R138's medical record lacked a side effect movement disorder assessment, an appropriate diagnosis for the use of the Zyprexa, and indication that R124's representative had been notified of the Zyprexa. On 9/13/17, at 12:30 assistant director of nursing (ADON) stated that assessments, consents, diagnosis, and care planning occurs when these medications were newly ordered and upon admission. The ADON verified R138's	F 329		

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F 329	Continued From page 26 representative had not been notified for the use of Zyprexa. On 9/13/17, at 1:17 p.m. the director of nursing (DON) stated she would expect a baseline side effect movement disorder assessment, and pharmacological assessment be done for antipsychotic medications. The DON verified that R138's diagnosis of health management for Zyprexa use was not appropriate. The facility's policy Psychopharmacological Medication Assessment and Review revised on 4/16, directed staff to conduct an initial assessment prior to a medication being initiated and at admission. Additionally, it directed staff to complete a DISCUS or a AIMS assessment regardless of reason for medication use to assure all psychotropic medications are reviewed and assessed for effectiveness, minimal dosage, and potential side effects. The facility's Informed Consent for Anti-psychotic Medication Use policy directed staff to explain all information included in the consent form and to obtain consent prior to administering medication. Potential side effects, what to report to doctor or nurse, questions and acknowledgment of risk and benefit of medication use were all included in the information to be explained to each resident or representative prior to consenting to use.	F 329		

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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 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/06/2017

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 **01 - MAIN BUILDING 01** B. WING _____	**09/13/2017**

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
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: 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 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 Type II (111) construction and separated with	K 000		

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K 000	Continued From page 2 2-hour fire barriers. The building is divided into 8 smoke zones by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected and has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 70 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting maintained and operational in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect the 30 of 70 residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, observation revealed that the battery	K 291	The battery operated light in the Chapel was replaced on 9/15/17. The Fireside electrical/mechanical room light was replaced on 9/18/17 and verified to be working. Date of completion: 9/18/17 The facility QAPI Committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	10/18/17

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K 291	Continued From page 3 operated emergency light found in the chapel and the fireside electrical/mechanical room were inoperative when tested at the time of the inspection. This deficient condition was verified by the Maintenance Supervisor.	K 291		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on documentation review and staff	K 324	The Kitchen Hood ventilation and fire	10/23/17

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K 324	Continued From page 4 interview, it was determined that the facility has failed to ensure that the semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 (11), 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 the residents as well as an undetermined number of staff, and visitors to the facility. Findings Include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility failed to provide 2 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient condition was verified by the Maintenance Supervisor.	K 324	suppression system has been professionally inspected per requirements. Inspection dates were: 9/28/15, 9/15/16, 8/23/17. Documents were not available at the time of the inspection. Copies of inspections will be maintained in a binder. Date of completion: 10/23/17 The facility QAPI Committee will review compliance monthly. The correction and monitoring responsibility will be by the: Maintenance Director	
K 355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by:	K 355		9/18/17

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K 355	Continued From page 5 Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) Section 19.3.5.5. This deficient practice could affect the 14 of 70 residents, as well as an undetermined number of staff, and visitors in the event of an emergency Findings include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, observations revealed the following deficient conditions: 1. The fire extinguisher inspections located across the corridor from resident room 208 did not have an annual test/inspection completed since January 2016. 2. The fire extinguisher that is located in the outside liquid oxygen storage and transfill shed was found on the ground and not mounted to prevent damage to the fire extinguisher. This deficient condition was verified by the Maintenance Supervisor.	K 355	Fire extinguisher outside room 208 tag will be tested/inspected by Summit Company by 10/23/17. The Fire extinguisher by the outside liquid oxygen storage transfill shed was mounted on 09/18/17. Date of completion was: The facility QAPI Committee will review compliance monthly. The correction monitoring and responsiblity will be the Maintenance Director.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		10/19/17

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K 521	Continued From page 6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90A(12) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 70 of 70 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years. This deficient condition was verified by a Maintenance Supervisor.	K 521	The fire/smoke damper system is scheduled for inspection on 10/19/17. Date of Completion: 10/19/17 The facility QAPI Committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures	K 712		9/20/17

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K 712	Continued From page 7 and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 7 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 70 of 70 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not transmit a fire alarm signal to the alarm monitoring company for 7 of 12 fire drills This deficient condition was verified by a Maintenance Supervisor.	K 712	Education done with Maintenance Staff on completion of documentation requirements was done on 9/20/17. Policy for Fire Safety/Drills is current. Date of Completion: 9/20/17. The facility QAPI Committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99.	K 901		10/2/17

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K 901	Continued From page 8 Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 70 of 70 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide any risk assessment documenting or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901	Risk Assessment completed on 10/2/17. Date of Completion: 10/02/17. The facility QAPI Committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	
K 914 SS=F	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		10/23/17

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K 914	Continued From page 9 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 70 of 70 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility.	K 914	Annual Electrical outlet inspection and testing will be done by 10/23/17. Date of Completion: 10/23/17. The facility QAPI Committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	

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K 914	Continued From page 10 This deficient condition was verified by a Maintenance Supervisor.	K 914		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 923		9/21/17

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K 923	Continued From page 11 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 section 5.1.3.. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:00 a.m. to 2:00 p.m. on 09/13/2017, observations revealed that the liquid oxygen storage shed that is located outside of the facility did not have any labeling identifying the shed as an oxygen/medical gas storage location. The Outside Liquid storage shed also did not provide any precautionary statements regarding open flame or ignition sources in proximity of the storage location. This deficient condition was verified by a Maintenance Supervisor.	K 923	The liquid oxygen shed has bee labeled as a Transfilling Station as well as a precautionary sign for "No Smoking" on 9/21/17. Date of Completion: 9/21/17. The facility QAPI Committee will review compliance monthly. The correction monitoring and responsibility will be by: Maintenance Director	