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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UGZI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245496**
2.STATE VENDOR OR MEDICAID NO.
(L2) **611042800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEOTA MANOR HEALTH CARE CENTER**
(L4) **700 NORTH MONROE STREET**
(L5) **MINNEOTA, MN** (L6) **56264**

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) **01/01/2014**

6. DATE OF SURVEY **06/18/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **67** (L18)

13.Total Certified Beds **67** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(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):
CCN: 24-5496
Post certification revisit (PCR) of the Health survey was completed on June 18, 2015. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been sent for approval by CMS.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(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
Posted 07/15/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/03/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245496

June 23, 2015

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

Dear Ms. Johnson:

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 29, 2015 the above facility is certified for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 23, 2015

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

RE: Project Number S5496026

Dear Ms. Johnson:

On May 7, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 29, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 22, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 29, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 29, 2015, effective May 29, 2015 and therefore remedies outlined in our letter to you dated May 7, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245496	01 - MAIN BUILDING 01	6/22/2015

Name of Facility	Street Address, City, State, Zip Code
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0011	**05/29/2015**	ID Prefix Reg. # **NFPA 101** LSC K0062	**05/06/2015**	ID Prefix Reg. # **NFPA 101** LSC K0067	**05/29/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 06/23/2015	**Signature of Surveyor:** 35482	**Date:** 06/22/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/29/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245496	A. Building B. Wing	6/18/2015

Name of Facility	Street Address, City, State, Zip Code
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**05/29/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**05/29/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/kfd	06/23/2015	03048	06/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/29/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

June 23, 2015

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

Re: Reinspection Results - Project Number S5496026

Dear Ms. Johnson:

On June 18, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 29, 2015, with orders received by you on May 7, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UGZI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245496**
2.STATE VENDOR OR MEDICAID NO.
(L2) **611042800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEOTA MANOR HEALTH CARE CENTER**
(L4) **700 NORTH MONROE STREET**
(L5) **MINNEOTA, MN** (L6) **56264**

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) **01/01/2014**

6. DATE OF SURVEY **04/29/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **67** (L18)

13.Total Certified Beds **67** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 05/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(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
06/03/2015
(L33)

DETERMINATION APPROVAL

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

CCN-24-5496

At the time of the standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction. Documentation supporting the facility's request for a continuing waiver involving K67 will be forwarded. Approval of the waiver request will be recommended. refer to the CMS 2786R Provision Number K84 Justification page.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 7, 2015

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

RE: Project Number S5496026

Dear Ms. Johnson:

On April 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<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;

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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

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 June 8, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated 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.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 29, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 29, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING _____ B. WING _____	04/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for 1 of 1 (R39) resident reviewed for positioning needs. Findings include: R39's diagnosis list obtained from the electronic record titled Clinical Diagnosis included: dementia with behavioral disturbance, abnormal posture, gastroenteritis, acute pain, reflux, and nutritional deficiency.	F 282	Discussion was held on 4/28/15 morning interdisciplinary meeting and a referral was made to Occupational therapy for positioning r/t difficulty supporting head and with eating. A screen was completed on 4/28/15 by OT and a communication was returned to nursing that therapy was looking into alternate options. Therapy orders were received for R39 on Thursday, April 30th for OT therapy to evaluate and treat for positioning in W/C. Evaluation by OT was completed on	5/29/15

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

Electronically Signed | 05/15/2015

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

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F 282	Continued From page 1 R39's care plan dated 4/3/13, identified R39 as having a problem with activities of daily living (ADLs) and alteration in ADL status-dressing, grooming, bathing, related to behavior, cognitive loss; and disease process. Staff were directed to follow the 12/11/13, Occupational Therapy (OT) recommendations: staff to gently move R39's head back to head rest and then place head strap over forehead prior to feeding. Monitor for red marks and remove strap if noted. R39's most recent Minimum Data Set (MDS) was completed 2/4/15 and indicated a brief interview for mental status (BIMS) score of 99 which indicated the assessment was not able to be completed related to (r/t) severe cognitive impairment. During observation on 4/27/15, at 4:45 p.m. R39 was seated in her upright reclining wheelchair (w/c), positioned at the table for her evening meal. R39's head and upper body were tipped forward and toward her left shoulder with her chin resting against her chest. No strap was observed in use to support her head in an upright position. Nursing assistant (NA)-A was bending forward and almost leaning her head against R39 in an attempt to spoon food into R39's mouth. R39 was taking minimal bites of food as it was offered. On 4/28/15, at 8:00 a.m. R39 was observed being fed breakfast meal by NA-B. No head support was observed during this time. NA-B was attempting to feed R39 as she was seated in an upright position in a reclining w/c with her head and shoulders leaned forward and chin resting on her chest. On 4/28/15, at 12:05 p.m. during observation of	F 282	Monday, May 4, 2015. R39 continues to be working with therapy on positioning treatment. All residents will be reviewed for appropriate use of positioning devices per care plan review and assessment by 5/30/2015. Therapy referals will be made as indicated per review. A policy and procedure written for referral process to therapy and follow up on positioning devices. Education on policy and procedure will be completed at nursing meeting on 5/29/15 at scheduled nursing meeting. All residents with new positioning devices and existing positioning devices will be reviewed for on-going appropriateness and appropriate use and accuracy of the care plan. The assessment will be completed within 1 week of therapy implementation of a new positioning devices and monthly untill their nex quarterly, annual, or significant change. Ongoing reviews will be completed then quarterly therafter by case manager. Audits of positioning device follow up will be completed monthly x 3, then quarterly for 1 year. Audits will be reviewed with the QA team. The DON will assure this is completed.	

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F 282	Continued From page 2	F 282		

noon meal, NA-B was assisting R39 to eat her pureed noon meal. R39 was again seated in an upright position in a reclining w/c with head and shoulders leaned forward and her chin resting toward her chest. No strap or supportive device was observed to be in use for head support. NA-B was attempting to feed resident by leaning forward and turning her head sideways toward R39's chest in an attempt to visualize R39's mouth. NA-B made no attempt to reposition R39's head to allow easier access to the offered spoon.

During morning meal on 4/29/15, at 8:15 a.m. NA-B was again observed assisting R39 with her pureed diet. No head positioning strap was observed to be in place. R39's head and shoulders were leaned forward and to the left and her chin rested against her chest. NA-B was leaned forward and her head was turned to the side in an attempt to visualize R39's mouth as she was offering bites of food.

An interview was conducted on 4/28/15, at 3:06 p.m. with NA-A and NA-B. Both NA's indicated R39 requires total care (unable to participate) with all ADLs and is seated in a reclining w/c with a head rest. Both NA's indicated R39 has a tendency to sit leaning forward with her chin toward her chest and the chair is reclined r/t head positioning. Both NA's confirmed R39 must be fed all foods and fluids. Both NA's indicated R39 has a Velcro strap that is supposed to be applied to R39's forehead and around the head rest of the chair during meals to position her head in an upright position. NA-B indicated she did not like to use this r/t "uncomfortable" but indicated R39 had not expressed discomfort. NA-A indicated agreement with NA-B's information. Both NAs

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F 282	Continued From page 3 confirmed they had not been using the head strap. During interview on 4/28/15, at 3:24 p.m. registered nurse (RN)-A indicated R39 is not responsive to communication or direction, doesn't use her call light and is totally dependent upon staff assistance. RN-A further indicated R39 is seated in a special chair per recommendation of OT. RN-A indicated R39 was declining in physical ability and becoming harder for staff to feed, which resulted in a request for OT to re-evaluate r/t difficulty observed when staff fed R39. RN-A confirmed it was very difficult to position and maintain R39 in an upright position when seated in her chair. The director of nursing (DON) was interviewed on 4/29/15, at 11:35 a.m. and confirmed the head strap for R39, was an intervention identified on the plan of care and should have been utilized during meals for positioning her head in an upright position. The DON further stated she was unaware the positioning strap was not being utilized as care planned .	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		5/29/15

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F 309	Continued From page 4 by: Based on observation, interview and document review the facility failed to provide proper positioning during meal times for 1 of 1 resident (R39) reviewed for positioning. Findings include: R39's diagnosis list obtained from the electronic record titled Clinical Diagnosis included: dementia with behavioral disturbance, abnormal posture, gastroenteritis, acute pain, reflux, and nutritional deficiency. R39's most recent comprehensive assessment, Minimum Data Set (MDS) dated 2/4/15, indicated a Brief Interview for Mental Status (BIMS) score of 99 indicating severe cognitive impairment. During observation on 4/27/15, at 4:45 p.m. R39 was seated in her upright reclining wheelchair (w/c) positioned at the table for her evening meal. R39's head and upper body were tipped forward and toward her left shoulder with her chin resting against her chest. No Velcro strap was observed to be in use for support of R39's head in an upright position. Nursing assistant (NA)-A was bending forward and almost leaning her head against R39's chest in an attempt to spoon food into R39's mouth. On 4/28/15, at 8:00 a.m. R39 was observed being fed breakfast by NA-B. No Velcro head strap was observed to be utilized during this time. NA-B was attempting to feed R39 as she was seated in an upright position in a reclining w/c with R39's head and shoulders leaned forward and chin resting on her chest.	F 309	Discussion was held on 4/28/15 at morning interdisciplinary meeting and a referral was made to OT therapy for positioning r/t difficulty supporting head and with eating. A screen was completed on 4/28/15 by OT therapy and a communication was returned to nursing that therapy was looking for alternate options. Therapy orders were received for R39 on 4/30/15 for OT therapy to evaluate and treat for positioning in W/C. Evaluation by occupational therapy was completed 5/4/15. R39 continues to be working with therapy on positioning treatment. All residents will be reviewed for appropriate use of positioning devices per care plan review and assessment by 5/29/15. Therapy referrals will be made as indicated per review. A policy & procedure has been implemented for a referral process to therapy and follow up on positioning devices. Education on policy and procedure will be completed at nursing meeting on 5/29/15. All residents with new positioning devices and existing positioning devices will be reviewed for on-going appropriateness and appropriate use. The assessment will be completed withing 1 week of therapy implementation of a new positioning device and montly until their next quarterly, annual, or significan change. Ongoing reviews will be completed then	

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F 309	Continued From page 5 During observation on 4/28/15, at 12:05 p.m. NA-B was assisting R39 to eat her noon meal. R39 was again seated in an upright position in a reclining w/c with head and shoulders leaned forward and her chin resting toward her chest. No strap or supportive device was observed to be in use for head support. NA-B was attempting to feed R39 by leaning forward and turning her own head sideways toward R39's chest in an attempt to visualize R39's mouth. NA-B made no attempt to reposition R39's head to allow easier access to the offered spoon. During the morning meal on 4/29/15, at 8:15 a.m. NA-B was again observed assisting R39 with her diet. No head positioning strap was observed. R39's head and shoulders were leaned forward and to the left and her chin was positioned against her chest. NA-B was leaned forward and her head was turned to the side in an attempt to visualize R39's mouth as she was offering bites of food. An interview was conducted on 4/28/15, at 3:06 p.m. with NA-A and NA-B. Both NA's indicated R39 requires total care (unable to participate) with all ADLs and is seated in a reclining w/c with a head rest. Both NA's indicated R39 has a tendency to sit leaning forward with her chin toward her chest and the chair is reclined r/t head positioning. Both NA's confirmed R39 must be fed all foods and fluids. Both NA's indicated R39 has a Velcro strap that is supposed to be applied to R39's forehead and around the head rest of the chair during meals to position her head in an upright position. NA-B indicated she did not like to use this r/t "uncomfortable" but indicated R39 had not expressed discomfort. NA-A indicated agreement with NA-B's information. Both NAs	F 309	quarterly thereafter by case manager. Audits of positioning device follow up assessment will be completed monthly x 3, then quarterly for 1 year. Audits will be reviewed with the QA team. The DON will assure this is completed.	

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F 309	Continued From page 6	F 309		

confirmed they had not been using the head strap.

During interview on 4/28/15, at 3:24 p.m. registered nurse (RN)-A indicated R39 is not responsive to communication or direction, doesn't use her call light and is totally dependent upon staff assistance. RN-A further indicated R39 is seated in a special chair per recommendation of OT. RN-A indicated R39 was declining in physical ability and becoming harder for staff to feed, which resulted in a request for OT to re-evaluate r/t difficulty observed when staff fed R39. RN-A confirmed it was very difficult to position and maintain R39 in an upright position when seated in her chair.

The physician (MD) progress note dated 4/10/15 indicated the following: "Stable conditons of dementia, epilepsy, constipation and hypothyroidism. Therapy has advised a strap to help keep her head in place and she is in a wheelchair so that is more comfortable and it helps her be able to eat better as her head stays up not crouched down on her chest".

R39's care plan dated 4/3/13 identified R39 as having a problem with ADLs and alteration in adl status-dressing, grooming, bathing, related to behavior, cognitive loss; and disease process. Staff were directed to follow the 12/11/13 OT recommendations: staff to gently move R39's head back to head rest and then place head strap over forehead prior to feeding. Monitor for red marks and remove strap if noted.

The director of nursing (DON) was interviewed on 4/29/15, at 11:35 a.m. and confirmed the head strap for R39 was an intervention identified on the

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F 309	Continued From page 7 plan of care and should have been utilized during meals for positioning her head in an upright position. The DON further stated she was unaware the positioning strap was not being utilized as care planned and it had previously been effective during meal assistance .	F 309		

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	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2015**

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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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 29, 2015. At the time of this survey, Minneota Manor Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 St. Paul, MN 55101-5145, or	K 000	EPOC	

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto: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. Minneota Manor Health Care Center was constructed as follows: The original building was constructed in 1972, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1995 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an assisted living facility by 2-hour fire walls, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire-rated door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 67 beds and had a census of 46 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect 46 out of 46 residents. Findings include: On facility tour between 10:00 AM and 2:30 PM on 04/29/2015, observation revealed, that there are open penetrations above the lay-in ceiling in the 2 hour fire separation in the following locations: 1.) East Hallway between Nursing Home and Assisted Living. 2.) West Hallway between Nursing Home and Assisted Living.	K 011	1. The East Hallway between Nursing Home and Assisted Living were caulked with fire rated caulking to seal the open penetrations Completed 5/15/15 2. The West Hallway between the Nursing Home and Assisted Living were cemented and then caulked with fire rated caulking to seal the open penetration. Completed 5/15/15 3. W 313 door tag could not be read or determined of the fire rating. A new fire door that meets the fire rating will be ordered. Contractor measured the door 5/15/15, quote and order on 5/19/15. The door will be installed upon arrival.	5/29/15

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K 011	Continued From page 3 The door W 313 in the fire wall assembly needs to have fire rating verified. Existing door tag is unreadable, This deficient practice was confirmed by the Facility Maintenance Director (RM) at the time of discovery.	K 011	Facility Maintenance Director inpected all areas to ensure there were no further penetrations. 5/15/15 The areas will be inspected by Facility Maitenance Director every 6 months or immediately following any work completed by contractors to ensure any open penetrations are sealed. Contractors will also be educated on the fire code and instructed to make sure any such penetrations are sealed per fire code. Facility Maintenance Director will document the inspections and keep with our fire records and will report at monthly QA meetings.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 9-4.2.1 and 10-2.2. This deficient practice could affect all 46 residents. Findings include:	K 062	Summit Fire Co. compelted the sprinkler testing on 5/6/15. Facility was placed on an annual schedule. Maitenance Director will call to verify date of testing at least 6 weeks in advance of the annual test.	5/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET** **MINNEOTA, MN 56264**

(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 062	Continued From page 4 On facility tour between 10:00 AM and 2:30 PM on 04/29/2015, observation revealed, the review of the last annual sprinkler inspection report from Olympic Fire Protection was dated 01/22/2014. This is not within the one year inspection period of the this inspection conducted on 04-29-2015. This deficient practice was confirmed by the Administrator (RM) at the time of discovery.	K 062		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was determined the facility's general ventilating and air conditioning system (HVAC) was not installed in accordance with NFPA 101 (2000), Chapter 19, Section 19.5.2.1 and Chapter 9 Section 9.2 and NFPA 90A (1999). In a fire emergency, a noncompliant HVAC system could adversely affect 46 of 46 Based on observation and a staff interview, it was determined the facility's general ventilating and air conditioning system (HVAC) was not installed in accordance with NFPA 101 (2000), Chapter 19, Section 19.5.2.1 and Chapter 9 Section 9.2 and NFPA 90A (1999). In a fire emergency, a noncompliant HVAC system could adversely affect 67 of 67 residents.	K 067	Federal Waiver requested	~~5/29/15~~

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, May 21, 2015 10:40 AM
To: rochi_lsc@cms.hhs.gov
Cc: Gannon, Larry; 'kathy@minmanor.Com'; Dehler, Robert; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH)
Subject: Minneota Manor (245496) 2015 K67 Annual Waiver Request - Previously Approved - No Changes

This is to notify you that Minneota Manor is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 4-29-15.

I am again recommending that CMS approve this waiver requests.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility | **2000 CODE**

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building heating, ventilation & air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K067. A. Compliance with this provision will cause an unreasonable/financial hardship because: 1, The most recent cost estimate dated 10/29/2013 for complying ducted HVAC system is $90,000 - $100,000. 2, A ducted system would decrease the corridor headroom to less than required by the LSC. 3. The building electrical system would need to be upgraded to support a new ducted system. 4. The ducted system would need to penetrate load bearing walls, decreasing building structural integrety. 5. Installation of a ducted system would require asbestos abatement which would increase the cost. 6. Existing non-complying HVAC systems can be allowed to continue to be used. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 Edition. 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. This annual/continuing waiver has been approved in the past.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 5-21-15

Bisbee Plumbing & Heating

Complete Commercial Mechanical Contracting and Metal Fabricating

604 North Hwy. 59, P.O. Box 3
Marshall, Minnesota 56258

PHONE: 507-537-0596
FAX: 507-537-1431

October 29, 2013

Mrs. Johnson
Minneota Manor
700 North Monroe St.
Minneota, Minnesota 56264

RE: Return Air Ducting

Mrs. Johnson,

Bisbee Plumbing & Heating did research into the Minneota Manor return air system for the South Wing, North Wing and a couple of rooms in West Wing. Looking at these systems, in order to install return air duct out of every room walls will need to be busted through into hallways and ceilings will have to be taken down in rooms (partially) and all of the hallways ceilings in order for us to install return air duct back to the rooftop air handling units. Also required would be sprinkler contractor to remove some of the sprinkler lines that are above the ceilings and in the way. Because of going from room to hallway there may be fire dampers or fire/smoke damper required for fire protection.

With this being said Bisbee's is estimating that the cost to do this work could be in the range of $ 90,000 to $ 100,000.00 depending on what will be required.

Sincerely,
Bisbee Plumbing & Heating

Jack Mead

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	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 067	Continued From page 5 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:30 PM on 04/29/2015, observation revealed the ventilation system in the 1972 building utilized the egress corridors as a return air plenum for the building HVAC system. Specifically, resident rooms were equipped with supply air diffusers only, and the bathroom exhaust fans were switched, i.e., did not run continuously. Further, the concealed spaces above the drop-ceiling assembly in the egress corridors were used to provide the return air for the building HVAC system. This arrangement was not in conformance with the requirements at NFPA 90A (1999) Chapter 2, Section 2-3.11.1 and CMS Ref: S&C-06-18. This finding was verified with the chief building engineer (RM).	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
May 7, 2015

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5496026

Dear Ms. Johnson:

The above facility was surveyed on April 27, 2015 through April 29, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie, the unit supervisor or me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00887	A. BUILDING: _____ B. WING _____	04/29/2015

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MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 27, 28th and 29th surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for 1 of 1 (R39) resident reviewed for positioning needs. Findings include: R39's diagnosis list obtained from the electronic record titled Clinical Diagnosis included: dementia with behavioral disturbance, abnormal posture, gastroenteritis, acute pain, reflux, and nutritional deficiency. R39's care plan dated 4/3/13, identified R39 as having a problem with activities of daily living (ADLs) and alteration in ADL status-dressing, grooming, bathing, related to behavior, cognitive loss; and disease process. Staff were directed to follow the 12/11/13, Occupational Therapy (OT) recommendations: staff to gently move R39's head back to head rest and then place head strap over forehead prior to feeding. Monitor for red	2 565	corrected	5/29/15

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2 565	Continued From page 3 marks and remove strap if noted. R39's most recent Minimum Data Set (MDS) was completed 2/4/15 and indicated a brief interview for mental status (BIMS) score of 99 which indicated the assessment was not able to be completed related to (r/t) severe cognitive impairment. During observation on 4/27/15, at 4:45 p.m. R39 was seated in her upright reclining wheelchair (w/c), positioned at the table for her evening meal. R39's head and upper body were tipped forward and toward her left shoulder with her chin resting against her chest. No strap was observed in use to support her head in an upright position. Nursing assistant (NA)-A was bending forward and almost leaning her head against R39 in an attempt to spoon food into R39's mouth. R39 was taking minimal bites of food as it was offered. On 4/28/15, at 8:00 a.m. R39 was observed being fed breakfast meal by NA-B. No head support was observed during this time. NA-B was attempting to feed R39 as she was seated in an upright position in a reclining w/c with her head and shoulders leaned forward and chin resting on her chest. On 4/28/15, at 12:05 p.m. during observation of noon meal, NA-B was assisting R39 to eat her pureed noon meal. R39 was again seated in an upright position in a reclining w/c with head and shoulders leaned forward and her chin resting toward her chest. No strap or supportive device was observed to be in use for head support. NA-B was attempting to feed resident by leaning forward and turning her head sideways toward R39's chest in an attempt to visualize R39's mouth. NA-B made no attempt to reposition	2 565		

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2 565	Continued From page 4 R39's head to allow easier access to the offered spoon. During morning meal on 4/29/15, at 8:15 a.m. NA-B was again observed assisting R39 with her pureed diet. No head positioning strap was observed to be in place. R39's head and shoulders were leaned forward and to the left and her chin rested against her chest. NA-B was leaned forward and her head was turned to the side in an attempt to visualize R39's mouth as she was offering bites of food. An interview was conducted on 4/28/15, at 3:06 p.m. with NA-A and NA-B. Both NA's indicated R39 requires total care (unable to participate) with all ADLs and is seated in a reclining w/c with a head rest. Both NA's indicated R39 has a tendency to sit leaning forward with her chin toward her chest and the chair is reclined r/t head positioning. Both NA's confirmed R39 must be fed all foods and fluids. Both NA's indicated R39 has a Velcro strap that is supposed to be applied to R39's forehead and around the head rest of the chair during meals to position her head in an upright position. NA-B indicated she did not like to use this r/t "uncomfortable" but indicated R39 had not expressed discomfort. NA-A indicated agreement with NA-B's information. Both NAs confirmed they had not been using the head strap. During interview on 4/28/15, at 3:24 p.m. registered nurse (RN)-A indicated R39 is not responsive to communication or direction, doesn't use her call light and is totally dependent upon staff assistance. RN-A further indicated R39 is seated in a special chair per recommendation of OT. RN-A indicated R39 was declining in physical ability and becoming harder for staff to	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 5 feed, which resulted in a request for OT to re-evaluate r/t difficulty observed when staff fed R39. RN-A confirmed it was very difficult to position and maintain R39 in an upright position when seated in her chair. The director of nursing (DON) was interviewed on 4/29/15, at 11:35 a.m. and confirmed the head strap for R39, was an intervention identified on the plan of care and should have been utilized during meals for positioning her head in an upright position. The DON further stated she was unaware the positioning strap was not being utilized as care planned . SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		5/29/15

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2 830	Continued From page 6 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide proper positioning during meal times for 1 of 1 resident (R39) reviewed for positioning. Findings include: R39's diagnosis list obtained from the electronic record titled Clinical Diagnosis included: dementia with behavioral disturbance, abnormal posture, gastroenteritis, acute pain, reflux, and nutritional deficiency. R39's most recent comprehensive assessment, Minimum Data Set (MDS) dated 2/4/15, indicated a Brief Interview for Mental Status (BIMS) score of 99 indicating severe cognitive impairment. During observation on 4/27/15, at 4:45 p.m. R39 was seated in her upright reclining wheelchair (w/c) positioned at the table for her evening meal. R39's head and upper body were tipped forward and toward her left shoulder with her chin resting against her chest. No Velcro strap was observed to be in use for support of R39's head in an upright position. Nursing assistant (NA)-A was bending forward and almost leaning her head against R39's chest in an attempt to spoon food into R39's mouth. On 4/28/15, at 8:00 a.m. R39 was observed being	2 830	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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2 830	Continued From page 7 fed breakfast by NA-B. No Velcro head strap was observed to be utilized during this time. NA-B was attempting to feed R39 as she was seated in an upright position in a reclining w/c with R39's head and shoulders leaned forward and chin resting on her chest. During observation on 4/28/15, at 12:05 p.m. NA-B was assisting R39 to eat her noon meal. R39 was again seated in an upright position in a reclining w/c with head and shoulders leaned forward and her chin resting toward her chest. No strap or supportive device was observed to be in use for head support. NA-B was attempting to feed R39 by leaning forward and turning her own head sideways toward R39's chest in an attempt to visualize R39's mouth. NA-B made no attempt to reposition R39's head to allow easier access to the offered spoon. During the morning meal on 4/29/15, at 8:15 a.m. NA-B was again observed assisting R39 with her diet. No head positioning strap was observed. R39's head and shoulders were leaned forward and to the left and her chin was positioned against her chest. NA-B was leaned forward and her head was turned to the side in an attempt to visualize R39's mouth as she was offering bites of food. An interview was conducted on 4/28/15, at 3:06 p.m. with NA-A and NA-B. Both NA's indicated R39 requires total care (unable to participate) with all ADLs and is seated in a reclining w/c with a head rest. Both NA's indicated R39 has a tendency to sit leaning forward with her chin toward her chest and the chair is reclined r/t head positioning. Both NA's confirmed R39 must be fed all foods and fluids. Both NA's indicated R39 has a Velcro strap that is supposed to be applied	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00887	A. BUILDING: _____ B. WING _____	04/29/2015

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2 830	Continued From page 8	2 830		

to R39's forehead and around the head rest of the chair during meals to position her head in an upright position. NA-B indicated she did not like to use this r/t "uncomfortable" but indicated R39 had not expressed discomfort. NA-A indicated agreement with NA-B's information. Both NAs confirmed they had not been using the head strap.

During interview on 4/28/15, at 3:24 p.m. registered nurse (RN)-A indicated R39 is not responsive to communication or direction, doesn't use her call light and is totally dependent upon staff assistance. RN-A further indicated R39 is seated in a special chair per recommendation of OT. RN-A indicated R39 was declining in physical ability and becoming harder for staff to feed, which resulted in a request for OT to re-evaluate r/t difficulty observed when staff fed R39. RN-A confirmed it was very difficult to position and maintain R39 in an upright position when seated in her chair.

The physician (MD) progress note dated 4/10/15 indicated the following: "Stable conditons of dementia, epilepsy, constipation and hypothyroidism. Therapy has advised a strap to help keep her head in place and she is in a wheelchair so that is more comfortable and it helps her be able to eat better as her head stays up not crouched down on her chest".

R39's care plan dated 4/3/13 identified R39 as having a problem with ADLs and alteration in adl status-dressing, grooming, bathing, related to behavior, cognitive loss; and disease process. Staff were directed to follow the 12/11/13 OT recommendations: staff to gently move R39's head back to head rest and then place head strap over forehead prior to feeding. Monitor for red

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2 830	Continued From page 9 marks and remove strap if noted. The director of nursing (DON) was interviewed on 4/29/15, at 11:35 a.m. and confirmed the head strap for R39 was an intervention identified on the plan of care and should have been utilized during meals for positioning her head in an upright position. The DON further stated she was unaware the positioning strap was not being utilized as care planned and it had previously been effective during meal assistance . SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to positioning assessments, monitoring and care and could provide staff education related to the care of resident related to proper positioning and use of recommended devices. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		