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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UVMU
Facility ID: 00474

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245402**

2. STATE VENDOR OR MEDICAID NO. (L2) **938342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENWOOD VILLAGE CARE CENTER**
(L4) **719 SOUTHEAST 2ND STREET**
(L5) **GLENWOOD, MN** (L6) **56334**

4. TYPE OF ACTION: 7
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 **1/17/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **64** (L18)

13. Total Certified Beds **64** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(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 :
Sarah Grebenc, Unit Supervisor 1/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 3/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 3/31/2014 ML

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **02/12/2014** (L33)

DETERMINATION APPROVAL

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

Page 2
Provider Number: 24-5402
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page. Effective January 7, 2014, the facility is certified for 64 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245402

March 14, 2014

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

Dear Ms. Krueger:

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

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

Effective January 7, 2014, the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

February 10, 2014

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

RE: Project Number s542024

Dear Ms. Krueger:

On December 18, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2013, effective January 17, 2014 and therefore remedies outlined in our letter to you dated December 18, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K0067 at the time of the December 5, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 320-223-7365 Fax: 320-223-7348

Enclosure
cc: Licensing and Certification File

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
245402	A. Building B. Wing	1/17/2014

Name of Facility	Street Address, City, State, Zip Code
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

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 F0156 Reg. # 483.10(b)(5) - (10), 483.10(t LSC	01/17/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	01/17/2014	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	01/17/2014
ID Prefix F0356 Reg. # 483.30(e) LSC	01/17/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	01/17/2014	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 10562	Date: 2/10/14	Signature of Surveyor: 10562	Date: 2/10/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
12/5/2013

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

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

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Facility ID: 00474

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2. STATE VENDOR OR MEDICAID NO. (L2) **938342500**

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(L3) **GLENWOOD VILLAGE CARE CENTER**
(L4) **719 SOUTHEAST 2ND STREET**
(L5) **GLENWOOD, MN** (L6) **56334**

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 **12/05/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **64** (L18)

13. Total Certified Beds **64** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(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 :
Christine Bodick-Nord, HFE NE II 01/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/03/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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
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07-Provider Status Change
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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

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

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

CCN-245402

At the time of the standard survey completed December 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval.
Documentation supporting the waiver request is attached.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7109

December 18, 2013

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, Minnesota 56334

RE: Project Number S5402024

Dear Ms. Krueger:

On December 5, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7365
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 14, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 14, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 5, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

RECEIVED DEC 3 1 2013 MN Dept of Health St. Cloud

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING ______ B. WING ______	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE 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 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	**F: 156** It is the policy of the Glenwood Village Care Center to inform residents both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay at the facility. It is also the policy of the Glenwood Village Care Center to provide the resident with the proper liability required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services informing them of their rights to appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services.	OK 1/6/14 SG

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary J. Kruecker
TITLE: Administrator
(X6) DATE: 12-31-13

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING ____ B. WING ____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(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 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a	F 156	Policy will be updated to include guidance as to the timing of the denial letter being issued and to include a denial letter be issued when a resident is discharged to home. Education will be provided to the MDS coordinator and RN clinical managers on updated policy by 1/7/14. Audits will be done on all denial letters issued x 2 months. Audits will be brought to the quality assurance for compliance and review. Responsible Person: Director of Nursing Completion Date: 1/7/2014	

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R15, R27, R21, R31) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their rights to an appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services. Finding include: R15 did not receive the required 48 hour notice prior to the end of skilled services. R15 was admitted to the facility on a skilled stay on 10/31/13, for rehabilitation procedures.	F 156		

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F 156	Continued From page 3 R15 was issued a CMS Form 10123 for skilled services occupational therapy (OT) and physical therapy (PT) wound care ending 11/21/13. The notice was signed by the resident on 11/20/13, 24 hours before the end of skilled services. The resident discharged to home on 11/22/13, per the facility nursing progress notes. R27 was not provided with 48 hours notice prior to the end of skilled services. R27's CMS Form 10123 indicated a date of skilled coverage ending 11/15/13. R27 signed the notice on 11/16/13, after the ending of skilled coverage. R27 discharged from the facility on 11/16/13, per the nursing progress notes. When interviewed on 12/4/13, at 1:15 p.m. registered nurse (RN)-A stated she gives at least a two day notice when Medicare services are ending. When asked about the specific incidences with R27 and R15, she indicated the two residents were, "Isolated incidents," in which there was not a two-day notice provided, as she had found out late that therapies were going to end. RN-A confirmed the denial letters were not issued 48 hours prior to the end of skilled services. RN-A further stated the denial letters would go to the nursing secretary (NS)-M in the front office. R21 did not receive an CMS Form 10123 48 hours prior to discontinuation of skilled services. R21 was admitted to the facility on a skilled stay beginning 7/24/13. R21 discharged from the facility on 10/07/13.	F 156		

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F 156	Continued From page 4 R31 was not issued an CMS form 10123 48 hours prior to discontinuation of skilled services. R31 was admitted to the facility on a skilled stay beginning 10/17/13. R31 discharged from the facility on 10/25/13. When interviewed on 12/4/13, at 1:30 p.m. NS-M stated a CMS Form 10123 had not been provided to R21 or R31 at all, because they had discharged directly to home. When interviewed on 12/5/13, at 11:19 a.m. RN-A stated she thought the residents did not need the letter if they were going home. RN-A stated she goes by a spreadsheet with the facility policy for when to issue the denial letters. She thought R31 and R21 discharged to home as they had stabilized with their therapy services. An undated facility policy entitled BNI [Beneficiary Notices Initiative] Non-Coverage Notices for SNF [skilled nursing facility] Residents, included residents going home after the end of Medicare skilled services should be issued the generic notice, Centers for Medicare and Medicaid Services (CMS) Form 10123. The policy lacked guidance as to the timing of the denial letter being issued and if the facility needed to provide the notice if a resident discharged to home.	F 156		
F 282 SS=E	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.	F 282		

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F 282	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure restorative nursing programs were being provided as directed by the care plan for 4 of 4 residents (R17, R66, R12, and R35), reviewed for restorative nursing programs. Findings include: R17 did not receive range of motion services in frequency, or of each body area as the care plan directed. R17's care plan, dated 10/9/13, indicated to see the restorative plan for the restorative program. When interviewed on 12/4/13, at 11:00 a.m. registered nurse (RN)-B stated the restorative care plan is the Restorative Nursing Assistant Intervention, in the electronic record. The aides access this to do their documentation on the computer, and the directions for each resident are included. R17's Restorative Nursing Assistant Intervention, in the electronic record, for the months of October, November, and December 2013, directed staff to apply hot backs to neck and shoulders for 15 minutes prior to ROM, and PROM to both upper and lower extremities, shoulder flexion and abduction to 90 degrees, six times a week. No directions were given for number of repetitions or specific joints for ROM. During observation on 12/4/13, at 9:35 a.m. R17	F 282	**F:282** It is the policy of the Glenwood Village Care Center that services provided or arranged must be provided by qualified persons in accordance with each resident's written plan of care. R17 Referral was made to PT and OT to assess ROM in all extremities, trunk and neck for further recommendations. Recommendations from PT and OT will be followed. R66 referral was made to PT and OT for recommendations for ROM to all extremities. Recommendations from PT and OT will be followed. R12 referral was made to PT and OT for recommendations for ROM to all extremities. Recommendations from PT and OT will be followed.	

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F 282	Continued From page 6 was in the therapy room. She was seated in a rock-n-go wheel chair, leaning to the left, had wedge pillows on the left side of the chair, and her head and shoulders were forward. Nursing assistant (NA)-B had applied a warm blanket to R17's neck. This was left in place for 15 minutes. Then NA-B attempted PROM to R17's neck, R17's neck only moved slightly, NA-B stated she was stiff. NA-B then lifted R17's arms up, at the shoulder, less than 45 degrees and repeated this 10 times. No further ROM, PROM, or AAROM (active assist ROM) had been performed. When interviewed on 12/4/13, at 9:55 a.m. NA-B stated this is how she normally assists R17 with ROM. She had never performed ROM on R17's elbows, wrists, hands, fingers, or lower extremities. A physical therapy aide had shown her how to perform ROM for R17 when she started recently. NA-B was not aware the directions on the electronic record instructed to assist with ROM on R17's lower extremities, or what all joints to perform ROM on. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative nursing programs. R17 should have received ROM as directed in the electronic record. The physical therapy aide (PTA) educates new staff on how to perform ROM for each resident. RN-B knew they were having difficulty, and had directed each unit manager to ensure restorative programs were being accomplished. She had not taken further action to ensure each residents program was being provided as ordered. R66 did not receive the restorative nursing program directed by the care plan.	F 282	R35 referral was made to PT and OT for recommendation for restorative program. Recommendations from PT and OT will be followed. All other residents who are currently receiving a nursing restorative program will be reassessed by RN clinical manager and referred to PT and OT as needed. Restorative nursing program policy was reviewed and updated. Audits will be conducted weekly x 3 weeks on all residents who receive a ROM program that ROM has been completed as planned. Audits will be brought to the quality assurance for compliance and review. Responsible Person: Director of Nursing Completion Date: 1/7/2014	

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F 282	Continued From page 7	F 282		

R66's care plan dated 7/3/13, indicated the restorative care plan was on the restorative plan of care.

R66's electronic Restorative Nursing Care plan for October, November, and December 2013, directed staff: Seated exercises, gentle AAPROM to knees 10 and ankles 10 times as tolerated. Gentle stretching to both heel chords and hamstrings, hold 30 seconds, repeat twice. Staff was directed to do this six times a week.

R66's restorative nursing program was documented as being completed only four times in October 2013, 11 times in November 2013, and had not been completed in December, as of December 5, 2013.

When interviewed on 12/4/13, at 2:15 p.m. NA-B stated she was not always able to complete R66's restorative nursing program. She will do ROM on upper and lower extremities, but has never done the hamstring or heel cord stretches. The ROM has to be done in bed, and she doesn't always catch R66 in bed in order to do it. She had not been able to do any ROM for R66 this month so far.

When interviewed on 12/5/13, at 10:10 a.m. NA-D stated if the restorative aide has a day off, the bath aide will usually do the restorative nursing program for residents, or the nursing assistants working with the resident that day could do it. She had never assisted either R17 or R66 with their programs.

When interviewed on 12/5/13, at 10:17 a.m. NA-D stated she is a bath aide and sometimes

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F 282	Continued From page 8 will need to do the restorative nursing programs, if there is no restorative aide that day. She had a list of residents who she would assist with their programs, however, R17 and R66 were not on this list. When interviewed on 12/4/13, at 2:00 p.m. RN-B verified the restorative program had not been completed as directed for R66. R66 was recently changed from assist of two to transfer to a full body lift due to a decline in ability to transfer. When interviewed on 12/5/13, at 9:15 a.m. the director of nursing (DON) verified restorative nursing programs were not being completed correctly or in the frequency ordered for R17 and R66. It could be because the restorative nursing assistant is new. She would expect the programs to be completed as directed. If the restorative aide did not know the proper way to do assist with the restorative programs, she should ask the charge nurse. R12 did not receive range of motion services as directed by the care plan. R12's care plan, dated 6/13/13, indicated a restorative plan of care for range of motion services and to refer to the restorative plan. R12's Restorative Care Intervention/Task sheets, for , November and December 2013, instructed staff to perform PROM to the lower extremities to include hip abduction, knee extensions and flexion, heel cord stretches, 10-15 repetitions	F 282		

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F 282	Continued From page 9 (reps) five times per week. PROM to the upper extremities 10 reps to shoulders, elbows, wrists and fingers as tolerated and passive range of motion to the neck, side to side stretches for 10 reps and flexion/extension to neck for 10 reps. R12's Intervention/Task sheet's showed R12 only had restorative nursing twice between 11/23/13 and 11/30/13, and not at all between 12/1/13 and 12/5/13. When interviewed on 12/5/13, at 9:09 a.m. NA-C stated the normal procedure for restorative programs was that there is usually a restorative aide that completed the exercises, however, this was the restorative aide's usual day off and the responsibility was assumed by the aides working on the unit. R12's ROM program was observed with R12 lying in bed, on 12/5/13, at 9:31 a.m. NA-C began range of motion services with the R12's fingers on the left upper extremity, completing five reps each of finger extension, wrist flexion, elbow flexion and extension and shoulder abduction and adduction. NA-C instructed R12 to loosen and relax the joints as she completed the range of motion activities. NA-C proceeded to move to the right upper extremity and completed the same exercises and reps as for the left upper extremity. NA-C then performed range of motion on the lower extremities, completing five reps of right foot flexion downward and upward and five reps of knee flexion and extension. NA-C then performed the same exercises on the left lower extremity, increasing the reps of knee flexion and extension to seven for the left side. NA-C did not perform ROM on R12's neck, and only did five reps each area, rather than the ten as ordered.	F 282		

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F 282	Continued From page 10 No heel cord stretches had been done. When interviewed on 12/5/13, at 9:37 a.m. NA-C stated she was finished with the restorative exercises she would normally do for R12. NA-C was asked about the facility's procedure for restorative nursing programs and how NA-C would determine which joints to exercise. NA-C stated "I usually just do all of them." NA-C did not know where to locate each resident's instructions for their restorative nursing programs. NA-C did not know R12 was suppose to have 10 reps each area, neck ROM, or heel cord stretches. Restorative nursing services were not provided for R35 as directed by the care plan. R35's care plan dated 7/4/13, directed staff to involve R35 in restorative services to maintain current ROM. R35's Restorative Care Intervention/Task sheets for September, October, and November 2013, included: arm bike, pulleys with weights and active ROM, which included 20 repetitions of heel slides, quad sets, ankle pumps and hip abduction and ambulation. This was to occur five times per week. R35 was also to ambulate every day. R35's electronic documentation of the restorative exercise program for September 2013, showed R35 had refused the arm bike and pulleys nine times, and had not been offered six times. The lower body exercises of the heel slides, quad sets, ankle pumps and hip abduction had not	F 282		

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F 282	Continued From page 11 been done at all. R35 had refused to ambulate 18 of the 30 days. R35's electronic documentation of the restorative program for October, 2013, revealed R35 refused 12 of 31 days to do the arm bike and pulleys and on 6 of 31 days, these restorative services were not offered. Lower body exercises were not offered on 10 of 31 days. The resident refused to ambulate 13 of 31 days. R35's electronic documentation of the restorative program for November, 2013, R35 refused the arm bike and pulleys 11 times, and ten times the exercises were not offered. Lower body exercises were refused 7 times, and services were not offered on 13 days. The resident refused to ambulate 5 of 30 days. When interviewed on 12/5/13, at 11:21 a.m. RN-B stated restorative services were not available for October, 2013 as the restorative staff resigned. She indicated that she informed the nurse managers the staff would need to supplement this until a new staff was hired and trained. She also reported she was not aware of the frequency of which the residents were currently being offered restorative services. A facility policy entitled Rehabilitative Restorative Nursing Program, 3/10, included: 1. Nursing personnel are trained in restorative nursing... 3. Restorative nursing is provided daily per resident needs. 4. ...each resident will be evaluated for his /her rehab potential by the attending physician, with assistance by nursing staff... 7. Residents will be seen at least quarterly by Restorative Nurse. 8. Documentation from above rounds or	F 282		

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F 282	Continued From page 12 re-assessments will be on the back of the "Therapy Recommendations". 9. Restorative Nurse will measure degree of ROM on appropriate residents at least quarterly. If decline 10-20 degrees is noted resident will be reassessed by therapy. 12. Maintenance activity of daily living programs will be described on resident care plan... 14. Occupational therapy, physical therapy and restorative therapy will be consulted for recommendation regarding a restorative program.	F 282		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to provide restorative therapy for 4 of 4 residents (R17, R66, R12, and 35) reviewed, who had been assessed as requiring restorative therapy. Findings include: R17 did not receive range of motion services in frequency or of her arms and lower extremities to prevent a decline, or to maintain her range of motion (ROM).	F 318	F 318: It is the policy of the Glenwood Village Care Center based on the comprehensive assessment of a resident; the facility must ensure that a resident with a limited range of motion receives appropriate treatment and series to increase range of motion and/or to prevent further decrease in range of motion.	

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F 318	Continued From page 13 R17's annual Minimum Data Set (MDS) dated 4/16/13, included a diagnosis of Alzheimer's disease, required total staff assistance of one assist for most activities of daily living (ADL's), did not have any functional limits in ROM, did not reject cares, and had received passive range of motion (PROM) three times during the assessment week. R17's quarterly MDS dated 10/3/13, indicated R17 had declined to requiring two staff assist for most ADL's, and had developed functional limits in range of motion of both upper extremities. The MDS indicated R17 did not reject cares, and had received PROM five times in the assessment week. R17's care plan, dated 10/9/13, indicated to see the restorative plan for the restorative program. When interviewed on 12/4/13, registered nurse (RN)-B stated the restorative care plan is the Restorative Nursing Assistant Intervention, in the electronic record. The aides access this to do their documentation on the computer, and the directions are there. R17's Restorative Nursing Assistant Intervention, in the electronic record, for the months of October, November, and December 2013, directed staff to apply hot backs to neck and shoulders for 15 minutes prior to ROM, and PROM to both upper and lower extremities, shoulder flexion and abduction to 90 degrees, six times a week. No directions were given for number of repetitions or specific joints for ROM. R17's Physical Therapy Restorative Care Program dated 12/28/12, directed staff to apply	F 318	R17 Referral was made to PT and OT to assess ROM in all extremities, trunk and neck for further recommendations. Recommendations from PT and OT will be followed. R66 referral was made to PT and OT for recommendations for ROM to all extremities. Recommendations from PT and OT will be followed. R12 referral was made to PT and OT for recommendations for ROM to all extremities. Recommendations from PT and OT will be followed. R35 referral was made to PT and OT for recommendation for restorative program. Recommendations from PT and OT will be followed.	

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F 318	Continued From page 14 hot packs to R17's neck and shoulders for 15 minutes, then assist R17 with active assist range of motion (AAROM) to neck, trunk, upper extremities, and lower extremities six times per week. R17's PT Progress Notes dated 1/2/13, directed staff to assist R17 with hot Packs for 15 minutes, followed by cervical ROM in sitting position. Also trunk ROM, and upper and lower extremities ROM either in supine or sitting position. R17's Occupation Therapy Recommendations to nursing dated 4/5/13, included, "Gentle passive range of motion (PROM), secondary to decreased response and verbalization." This was to occur three times per week to elbows, wrists, fingers, extension primarily, and shoulder flexion and abduction 15-20 repetitions. Staff were to apply a warm blanket prior to ROM and PROM of neck, and gentle head extension turning left and right. During observation on 12/4/13, at 9:35 a.m. R17 was in the therapy room. She was seated in a rock-n-go wheel chair, leaning to the left, had wedge pillows on the left side of the chair, and her head and shoulders were forward. Nursing assistant (NA)-B had applied a warm blanket to R17's neck. This was left in place for 15 minutes. Then NA-B attempted PROM to R17's neck, R17's neck only moved slightly, NA-B stated she was stiff. NA-B then lifted R17's arms up, at the shoulder, less than 45 degrees and repeated this 10 times. No further ROM, PROM, or AAROM had been performed. When interviewed on 12/4/13, at 9:55 a.m. NA-B stated this is how she normally assists R17 with	F 318	All other residents who are currently receiving a nursing restorative program will be reassessed by RN clinical manager and referred to PT and OT as needed. Restorative nursing program policy was reviewed and updated. Audits will be conducted weekly x 3 weeks on all residents who receive a ROM program that ROM has been completed as planned. Audits will be brought to the quality assurance for compliance and review. Responsible Person: Director of Nursing Completion Date: 1/7/2014	

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F 318	Continued From page 15 ROM. She had never performed ROM on R17's elbows, wrists, hands, fingers, or lower extremities. A physical therapy aide had shown her how to perform ROM for R17 when she started recently. NA-B was not aware the directions on the electronic record instructed to assist with ROM on R17's lower extremities, or what all joints to perform ROM on. R17's Restorative Nursing Assistant flow sheets and Electronic Restorative Follow up Reports dated 10/13, 11/13, and 12/13 indicated: October 2013, ROM had been completed a total of three times only, 15 minutes each time. November 2013, ROM had been completed 11 times, 5 minutes each time. December 2013, ROM had only been completed twice between December 1, 2013 and December 4, 2013, each 5 minutes. In November and December 2013, R17 should have received the ROM 24 times each month. When interviewed on 12/4/13, at 2:00 p.m. RN-B stated she was in charge of the restorative nursing programs. R17 should have received ROM as directed in the electronic record. The physical therapy aide (PTA) educates new staff on how to perform ROM for each resident. RN-B knew they were having difficulty, and had directed each unit manager to ensure restorative programs were being accomplished. She had not taken further action to ensure each residents program was being provided as ordered. When interviewed on 12/4/13, at 12:00 p.m. the physical therapist (PT)-A stated it would be difficult to determine if R17 had decreased ROM of joints related to advanced Alzheimer's disease. PT-A stated the ROM assessment dated 11/27/12, goal was to maintain the ability to sit in	F 318		

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F 318	Continued From page 16 a wheel chair with cervical spine positioned within five degree for neutral, side bent for five minutes and would have the ability to lie supine with cervical spine positioned within five degree of neutral for five minutes. There had been no assessment of R17's actual ability of ROM at the time. PT-A stated he felt R17 had maintained in her goal area. PT-a then attempted to perform PROM on R17's neck and could move it about five degrees, and shoulders he could move 25-45 degrees. R66 did not receive the restorative nursing program as had been assessed as needed. R66's quarterly MDS dated 9/17/13, included a diagnosis of Alzheimer's disease, severe cognitive impairment, required extensive assistance from staff for all ADL's, did not reject cares, had a functional limitation in ROM of upper extremities on one side, and received PROM once during the assessment week. R66's care plan dated 7/3/13, indicated the restorative care plan was on the restorative plan of care. R66's PT assessment dated 7/3/13, indicated the goal was to tolerate lower extremities ROM and stretching 4 to 5 days a week, to increase flexibility, and to transfer with assist of two staff. The PT progress notes dated 7/17/13, indicated restorative nursing training had been completed to nursing staff. R66's Restorative Nursing Assistant Intervention for October, November, and December 2013, directed staff: Seated exercises, gentle AAPROM	F 318		

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F 318	Continued From page 17 to knees 10 and ankles 10 times as tolerated. Gentle stretching to both heel chords and hamstrings, hold 30 seconds, repeat twice. Staff was directed to do this six times a week. R66's restorative nursing program was documented as being completed only four times in October 2013, 11 times in November 2013, and had not been completed in December, as of December 5, 2013. When interviewed on 12/4/13, at 2:15 p.m. NA-B stated she was not always able to complete R66's restorative nursing program. She will do ROM on upper and lower extremities, but has never done the hamstring or heel cord stretches. The ROM has to be done in bed and she doesn't always catch R66 in bed in order to do it. She had not been able to do any ROM for R66 this month so far. When interviewed on 12/5/13, at 10:10 a.m. NA-D stated if the restorative aide has a day off, the bath aide will usually do the restorative nursing program for residents, or the nursing assistants working with the resident that day could do it. She had never assisted either R17 or R66 with their programs. When interviewed on 12/5/13, at 10:17 a.m. NA-D stated she is a bath aide and sometimes will need to the restorative nursing programs if there is no restorative aide that day. She has a list of residents who she would have to assist with their programs, however, R17 and R66 were not on this list. When interviewed on 12/4/13, at 2:00 p.m. RN-B verified the restorative program had not been	F 318		

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F 318	Continued From page 18 completed as directed for R66. R66 was recently changed from assist of two to transfer to a full body lift due to a decline in ability to transfer. When interviewed on 12/5/13, at 9:15 a.m. the director of nursing (DON) verified restorative nursing programs were not being completed correctly or in the frequency ordered for R17 and R66. It could be because the restorative nursing assistant is new. She would expect the programs to be completed as directed. If the restorative aide did not know the proper way to do assist with the restorative programs, she should ask the charge nurse. R12 did not receive range of motion services to prevent further decline in range of motion. R12's diagnoses per the Diagnosis Listing, dated 12/5/13, included torticollis (a condition of abnormal head or neck position), Alzheimer's disease and abnormal posture. R12's quarterly MDS dated 11/19/13, included a functional loss of ROM both upper extremities, required extensive assistance with all ADL's, and did not receive a restorative nursing program. R12's care plan, dated 6/13/13, indicated a restorative plan of care for range of motion services and to refer to the restorative plan. R12's Restorative Nursing Assistant Intervention for November and December 2013, instructed staff to perform PROM to the lower extremities to	F 318		

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F 318	Continued From page 19	F 318		

include hip abduction, knee extensions and flexion, heel cord stretches, 10-15 repetitions (reps) five times per week. PROM to the upper extremities 10 reps to shoulders, elbows, wrists and fingers as tolerated and passive range of motion to the neck, side to side stretches for 10 reps and flexion/extension to neck for 10 reps.

R12's Intervention/Task sheet's showed R12 only had restorative nursing twice between 11/23/13 and 11/30/13, and not at all between 12/1/13 and 12/5/13.

R12 was observed on 12/2/13, at 7:41 p.m. with her hands and fingers in a curled position.

R12 was observed on 12/5/13, at 8:35 a.m. with the fingers and hands on both sides resting in her lap in a curled and closed position.

When interviewed on 12/5/13, at 8:31 a.m. NA-C stated R12 was able to straighten all fingers when she wanted to. NA-C stated R12 typically held herself in a fetal position.

When interviewed on 12/5/13, at 9:09 a.m. NA-C stated the normal procedure for restorative programs was that there is usually a restorative aide that completed the exercises, however this was the restorative aide's usual day off and the responsibility was assumed by the aides working on the unit.

On 12/5/13, at 9:31 a.m., NA-C performed R12's range of motion program while R12 was lying in bed. NA-C began range of motion services with the R12's fingers on the left upper extremity, completing five reps each of finger extension, wrist flexion, elbow flexion and extension and

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F 318	Continued From page 20 shoulder abduction and adduction. NA-C instructed R12 to loosen and relax the joints as she completed the range of motion activities. NA-C proceeded to move to the right upper extremity and completed the same exercises and reps as for the left upper extremity. NA-C then performed range of motion on the lower extremities, completing five reps of right foot flexion downward and upward and five reps of knee flexion and extension. NA-C then performed the same exercises on the left lower extremity, increasing the reps of knee flexion and extension to seven for the left side. NA-C did not perform ROM on R12's neck, and only did five reps each area, rather than the ten as ordered. No heel cord stretches had been done. On 12/5/13, at 9:37 a.m., NA-C stated she was finished with the restorative exercises she would normally do for R12. NA-C further stated she would be back to do more later, "If she looks like she is tightening up." NA-C was asked about the facility's procedure for restorative nursing programs and how NA-C would determine which joints to exercise. NA-C stated "I usually just do all of them." NA-C was unable to verbalize where the restorative nursing instructions for each resident were located at the time of the interview. NA-C did not know R12 was suppose to have 10 reps each area, neck ROM, or heel cord stretches. When interviewed on 12/5/13, at 10:58 a.m. the DON stated that her expectation with regard to restorative nursing programs would be for the aide to ask the charge nurse for help if they were unsure of a restorative program for a resident. Restorative nursing services were not provided	F 318		

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F 318	Continued From page 21 for R35 as had been assessed as needed. R35's quarterly MDS dated 6/18/13, included a diagnosis of heart and lung failure, he was cognitively intact, did not reject cares, required extensive assistance for most ADL's, did not have any functional ROM problems, and was receiving OT (occupational therapy) and PT (physical therapy) services. R35's quarterly MDS dated 9/17/13, showed R35 continued to require extensive assistance with ADL's, but had declined to having bilateral upper impaired functional ROM. The MDS indicated R35 was again receiving PT and OT services. R35's care plan dated 7/4/13, directed staff to involve R35 in restorative services to maintain current ROM. R35's Physical Therapy Progress Notes dated 9/13/13, instructed staff for a restorative nursing program. R35 was to ambulate with the use of a four wheeled walker with assistance of two staff, who were to follow the resident with a wheelchair. R35 was to do lower extremity range of motion independently in bed. In addition, restorative was to work with the resident three times per week to maintain or increase his lower extremity strength. The resident was to do knee extensions and hip flexion with five pound weights for 20 repetitions twice and to do hamstring and hip abductions. R35's electronic documentation of the restorative program for September 2013, the resident had 25 opportunities to participate in the arm bike, pulleys with weights and active ROM (which included 20 repetitions of heel slides, quad sets, ankle pumps and hip abduction) R35 refused the arm bike and pulleys with weights nine times	F 318		

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F 318	Continued From page 22 and six times restorative services were not offered. Restorative Nursing services (which included 20 repetitions of heel slides, quad sets, ankle pumps and hip abduction) were not offered to the resident 25 of 25 days. The resident refused to ambulate 18 of 30 days. The electronic documentation of the restorative program for October 2013, revealed R35 refused 12 of 31 days to do the arm bike and pulleys and on 6 of 31 days, these restorative services were not offered. Restorative Nursing services (which included 20 repetitions of heel slides, quad sets, ankle pumps and hip abduction) were not offered on 10 of 31 days. The resident refused to ambulate 13 of 31 days. The electronic documentation of the restorative program for November 2013, R35 had 26 opportunities to participate in the arm bike, pulleys with weights and active ROM (which included 20 repetitions of heel slides, quad sets, ankle pumps and hip abduction) R35 refused the arm bike and pulleys with weights 11 time and ten times restorative services were not offered. Restorative Nursing services (which included 20 repetitions of heel slides, quad sets, ankle pumps and hip abduction) R35 refused 7 opportunities and services were not offered on 13 days. The resident refused to ambulate 5 of 30 days. When interviewed on 12/5/13, at 11:00 a.m. the PT-A physical therapist stated she was not currently working with the resident and had not evaluated his current functional status. She also reported no referral at the present time had been initiated by nursing staff or the resident's physician. Once the resident is discharged from physical therapy, the nursing department oversees their progress. When interviewed on 12/5/13, at 11:21 a.m. RN-B	F 318		

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F 318	Continued From page 23 stated restorative services were not available for October 2013 as the restorative staff resigned. She indicated that she informed the nurse managers the staff would need to supplement this until a new staff was hired and trained. She also reported she was not aware of the frequency of which the residents were currently being offered restorative services. A facility policy entitled Rehabilitative Restorative Nursing Program, 3/10, included: 1. Nursing personnel are trained in restorative nursing... 3. Restorative nursing is provided daily per resident needs. 4. ...each resident will be evaluated for his /her rehab potential by the attending physician, with assistance by nursing staff... 7. Residents will be seen at least quarterly by Restorative Nurse. 8. Documentation from above rounds or re-assessments will be on the back of the "Therapy Recommendations". 9. Restorative Nurse will measure degree of ROM on appropriate residents at least quarterly. If decline 10-20 degrees is noted resident will be reassessed by therapy. 12. Maintenance activity of daily living programs will be described on resident care plan... 14. Occupational therapy, physical therapy and restorative therapy will be consulted for recommendation regarding a restorative program.	F 318		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		

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F 356	Continued From page 24 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nurse staffing information was posted in a timely manner, and included actual hours of work for nursing personnel. This practice had the potential to affect all 58 residents who resided in the facility, and any family members or visits who may choose to view this information.	F 356	F356: It is the policy of Glenwood Village Care Center to post actual daily staffing hours daily at the beginning of each shift. The following information will be posted facility name, current date, and total number of actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: registered nurses; licensed practical nurses; certified nurse aides and resident census. The following information will be posted on a daily basis and at the beginning of each shift. The form will continue to be posted in a visible area for residents, staff, visitors, etc to review.	

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F 356	Continued From page 25 Findings include: On 12/02/13, at 1:30 p.m. the nursing staffing posting was observed in the front vestibule of the facility during the initial tour. It was dated 11/23/13. The form, entitled Glenwood Village Care Center Staff Hours and Resident Census, indicated the total number of scheduled hours for registered nurse (RN), licensed practical nurse (LPN) and nursing assistant (NA) hours for the day. The hours were listed under each shift for nights, days and evenings. Each shift had a general heading for stop and start times, however did not include the stop and start times for short or partial shifts on the document with the corresponding number of staff and total hours. On 12/04/13, at 8:35 a.m., the nursing staffing posting was noted to be from 12/03/13, and was displayed in the main vestibule of the facility, within a plastic sleeve protector. On 12/04/13, at 12:48 p.m. the nursing staff posting from the prior day, 12/03/13 was still up. The staffing hours for 12/4/13 were filed behind the 12/03/13 posting in the plastic sleeve protector, and were not visible to residents or visitors in the facility. When interviewed on 12/04/13, at 12:58 p.m. the director of nursing (DON), stated the nursing scheduler (NS)-N was responsible for posting the notices. The DON stated specific hours of short shifts are not separately indicated on the staff hours and census, only the total nursing hours for each shift would be listed.	F 356	Daily nursing staffing posting policy was reviewed and remains appropriate. New form was created to include start and stop times of each shift Audits will be conducted weekly x4 to make sure form is filled out correctly. Audits will be brought to the quality assurance for compliance and review. Licensed staff and nursing scheduler will be educated on the policy by January 7, 2014. Responsible Person: Director of Nursing Completion Date: 1/7/2014	

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	245402	A. BUILDING ______ B. WING ______	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 356	Continued From page 26 When interviewed on 12/04/13, at 1:05 p.m. NS-N stated she posts the nursing hours for each day the night before The NS-N indicated each charge nurse on the shift is to update the sheet with changes. She also verified short shifts would not be listed separately under the shift times, only total number of nursing hours would be adjusted. The copies of the weekly nursing schedule spreadsheet, dated 11/28/13 - 12/4/13, revealed the facility staffed short shifts, 400 p.m. or 5:00 p.m. to 9:00 p.m., on afternoons; as well as short shifts of 6:00 a.m. to 11:00 a.m., during the day, during this time frame. Review of the facility nursing staff posting policy, entitled Posting Daily Nursing Staff Schedule, dated 12/10, revealed that within two hours of the beginning of each shift, the number and category of nursing personnel directly responsible for resident care would be posted in a prominent location, and that the nursing staffing information should include the actual time worked during that shift for each category and type of nursing staff. The previous shift's forms per the facility policy were to be maintained with the current shift for a total of 24 hours, then filed in the DON's office as a permanent record.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 431	Continued From page 27 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to properly ensure each insulin pen was labeled with the date opened, for 3 or 4 residents (R5, R29, R59) who received insulin. Findings include: During an observation of the medication cart on the Memory Care unit on 12/4/13, at 11:55 a.m.	F 431	**F 431:** It is the policy of the Glenwood Village Care Center to date insulin pens when the insulin pen is opened. R 5, R 29, R 59 Insulin pens that were not dated was thrown and new pens were initiated and dated when opened. Policy was reviewed and remains appropriate. Will review policy with licensed staff by January 14, 2014. Audits of insulin pens will be conducted weekly x4 to checked for dates on pen when opened. Audits will be brought to the quality assurance for compliance and review. Responsible Person: Director of Nursing Completion Date: 1/7/2014	

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F 431	Continued From page 28 the following was noted: R5's Humalog KwikPen (dial-a-dose insulin pen) containing Humalog insulin (used to control high blood sugar in adults with diabetes), 100 units/milliliters (ml), dispensed on 8/15/13, was not labeled with the date that it was opened. R5's order, signed 11/15/13, directed staff to give Humalog solution, 4 ml subcutaneously (SQ) every day before supper. R29's NovoLog FlexPen (dial-a-dose insulin pen) containing NovoLog insulin, 100 units/ml, without a date that it was dispensed, was not labeled with the date that it was opened. R29's order, signed 11/15/13, directed staff to inject NovaLog FlexPen solution SQ, per sliding scale, twice daily. During an interview on 12/4/13, at 12:05 p.m. registered nurse (RN)-C stated, "They should be dated." During an observation of the medication cart on Unit 2 of the facility, on 12/4/13, at 12:31 p.m. the following was noted: R59's Humalog KwikPen, dispensed on 8/31/13, was not labeled with the date that it was opened. R59's order, signed 11/27/13, directed staff to inject Humalog solution SQ, per sliding scale, four times daily. A review of R5, R29, and R59's medication administration records (MAR) for November and December 2013, indicated each had received the above insulin as ordered. During an interview on 12/4/13, at 12:32 p.m. licensed practical nurse (LPN)-A verified the	F 431		

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F 431	Continued From page 29	F 431		

insulin pens were not currently labeled with a date, but stated she was sure that it had been labeled when opened and that it may have "rubbed off."

During an interview on 12/5/13, at 8:25 a.m. RN-D indicated when insulin pens are opened, "They should be dated...We just talked about that last week."

During an interview on 12/5/13, at 9:10 a.m. RN-C stated, "My expectation would be that the insulin pen be dated when it is taken from the refrigerator and used for the resident."

During an interview on 12/5/13, at 9:42 a.m. LPN-B stated she doesn't give R5's evening insulin, but if it wasn't labeled with the date that it was opened, she would, "Go by the date that it was filled." LPN-B verified the date that it was filled was 8/15/13. LPN-B stated, "Oh, yes, that should be thrown."

During an interview on 12/5/13, at 10:00 a.m. when asked what she would do if she pulled out an insulin pen that was not labeled with the date it was opened, LPN-C stated, "I would get rid of it. I wouldn't use it."

During an interview on 12/5/13, at 10:57 a.m. director of nursing (DON) verified insulin pens should be labeled with the date that they were opened.

According to the Centers for Disease Control and Prevention, Injection Safety, if a multi-dose vial was opened or accessed (e.g., needle-punctured) the vial was to be dated and discarded within 28 days, unless the manufacturer specified

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F 431	Continued From page 30 differently. During a review of the manufacturer's guidelines for Humalog KwikPen insulin pens, the information included, "Once opened, Humalog vials, prefilled pens, and cartridges should be thrown away after 28 days...In-use Humalog KwikPen...must be used within 28 days or be discarded, even if it still contains Humalog." During a review of the manufacturer's guidelines for NovoLog KwikPen, the information included, "Once a NovoLog KwikPen is punctured, it should be kept at temperatures below 86 degrees Fahrenheit for 28 days, then discarded." A facility policy entitled, Medication Containers, dated 7/11, included under, "6. All vials, pens, etc. will be dated when first entered. If there is not a date of "initial entry" the dispensing date will be used for the "initial entry" date and the medication will be discarded accordingly."	F 431		

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F5402023

PRINTED: 12/18/2013
FORM APPROVED
OMB NO. 0938-0391

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	245402	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/05/2013**

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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 Glenwood Village Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	POC ok w/ AW for K67 TB 1-1-14 RECEIVED DEC 31 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 1-14-14
EXIT: 12-5-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary A Krueger
TITLE: Administrator
(X6) DATE: 12-31-13

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

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K 000	Continued From page 1 Barbara.lundberg@state.mn.us and Marian.Whitney@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. Glenwood Village Care Center was constructed at four different times. The original building was built in the 1962, is 1- story, with a partial basement and was determined to be of a Type II (111) construction. In 1975 an addition was added to the northeast that was determined to be Type II (111) construction. In 1978 an addition was added to the southeast that was determined to be Type II (111) construction. In 1987 an addition was added to the west that was determined to be Type II(111). The building is divided into 5 smoke zones on the main floor. An automatic sprinkler system is installed throughout the building in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces. Also, the facility has battery powered smoke detection	K 000		

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K 000	Continued From page 2 in all resident sleeping rooms. The fire alarm is monitored for automatic fire department notification. Because the original building and the 3 additions are of the same type of construction type allowed for existing buildings, the facility was surveyed as one building. The facility has a capacity of 64 beds and had a census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	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 observations and staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all the residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM and 1:00 PM on 12/05/13, observations revealed that the ventilation system in the West Wing of the facility is utilizing the egress corridor as the return air	K 067	AW See Waiver Request on Attached Sheet	

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K 067	Continued From page 3 plenum for the resident rooms. This finding was verified with the Maintenance Supervisor at the time of discovery. A waiver was requested and approved in previous year. This deficient practice was verified by the Maintenance Supervisor.	K 067		

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Friday, January 03, 2014 3:21 PM
To:	'rochi_lsc@cms.hhs.gov'
Cc:	Anderson, James A (DPS); 'ceo@grvillage.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	Glenwood Village Care Center (245402) K67 Annual Waiver Reqest - Previous Approved - No changes

This is to inform you that Glenwood Village CC is requesting an annual waiver for K67, corridors as a plenum. The exit date was 12-5-13.

Glenwood Village CC's waiver request includes information that this item will be corrected as part of a 3.6 million dollar addition/renovation to be completed in December, 2014.

I am recommending that CMS approve this waiver request.

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

Request for waiver for K067 – Sprinkled Buildings

A waiver has been previously approved for this building and there have been no physical/structural changes since the approval of the last waiver.

A waiver is requested for K067 for the following reasons.

A. There will be no adverse effect on the health and safety of the facility's residents and staff because:
    1. The building is protected throughout by an automatic sprinkler system installed in accordance with NFPA 13.
    2. Facility is within five-minute response time from fire station.
    3. The building fire alarm system is monitored to provide automatic fire department notification.
    4. Resident sleeping rooms are equipped with battery operated single station smoke detectors that are checked monthly.
    5. All air handlers shut down automatically when the fire alarm is activated.
    6. All corridors are fully protected by automatic smoke detection.
    7. Annual service and maintenance contracts exist to service all the facility's fire protection systems. (e.g. fire alarm, sprinkler system, fire dampers and portable extinguishers.)
    8. Fire Drills are conducted quarterly on each shift.
    9. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires
    10. The facility and campus is smoke free and signs to that effect are prominently posted at all major entrances.

Compliance with K067 WILL BE MET upon completion of the $3.6 million dollar addition/renovation of the facility that is currently underway. The anticipated completion of this project is slated for December, 2014.

Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood MN 56334

Mary D. Krueger, Administrator
12/31/13