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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V8J1

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00193

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245282**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CHARTER HOUSE**
(L4) **211 NORTHWEST SECOND STREET**
(L5) **ROCHESTER, MN** (L6) **55901**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/07/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| 32 | | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud Brown, Unit Supervisor 02/11/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 02/11/2020 (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
**07/01/1985**
(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
**01/27/2020**
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 11, 2020

CMS Certification Number (CCN): 245282

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

Dear Administrator:

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 program.

Effective January 31, 2020 the above facility is certified for:

32 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 11, 2020

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: December 4, 2019

Dear Administrator:

On February 7, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V8J1

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00193

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(L2)

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(L4) **211 NORTHWEST SECOND STREET**
(L5) **ROCHESTER, MN** (L6) **55901**

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 **12/04/2019** (L34)

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

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FISCAL YEAR ENDING DATE: (L35)
**12/31**

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To (b) :

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| 32 | | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 01/24/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/27/2020 (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
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3. Both of the Above :
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**07/01/1985**
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24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 23, 2019

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: December 4, 2019

Dear Administrator:

On December 4, 2019, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

## 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 4, 2020 (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).

In addition, if substantial compliance with the regulations is not verified by June 4, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

**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.**

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245282 | A. BUILDING _____ B. WING _____ | C 12/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CHARTER HOUSE** | **211 NORTHWEST SECOND STREET ROCHESTER, MN 55901** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/4/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 12-2-19 through 12-4-19, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be unsubstantiated:<br><br>H5282008C<br>H5282009C<br><br>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.<br><br>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 761 | Label/Store Drugs and Biologicals | F 761 | | 1/31/20 |

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

Electronically Signed | 01/01/2020

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245282 | A. BUILDING _____ B. WING _____ | C 12/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHARTER HOUSE | 211 NORTHWEST SECOND STREET ROCHESTER, MN 55901 |

| (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 761 SS=E | Continued From page 1<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) 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.<br><br>§483.45(h)(2) 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure one multi-use Aplisol solutions (solution to test for tuberculosis) had been dated when opened. This had the potential to affect 5 of 5 recently admitted residents (R115, R375, R366, R358 and R352) who were administered the Aplisol solution, and any other new admissions or newly hired staff. | F 761 | Revise Storage of Medications to include expirations of multi-use medications (updated 12/27/2019).<br>Labeling of Medication Containers New procedure created 12/27/2019.)<br>-Re-educate nurse staff to write date opened on all multi-use vials and verify medications are not expired prior to use<br>-Audit: House Supervisor to monitor | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245282 | A. BUILDING _____ B. WING _____ | C 12/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 761 | Continued From page 2<br>Findings include:<br><br>On 12/2/19 at 5:28 p.m., a tour was completed of the facility medication room with registered nurse (RN)-A. A white refrigerator was inspected which contained one open vial Aplisol (Tuberculin derivative). The box identified Lot # 329401 contained enough product for "10 Tests," and the opened vial had visible solution remaining inside. A pharmacy label was affixed to the boxes, which identified the solution name, along with a 'fill' date on the label printed as 10/21/19. However, neither the box nor the vial of the opened solution had been dated to demonstrate when the vial had been opened. RN-A verified the vial had no open date.<br><br>This surveyor asked for a list of residents who had received Aplisol solution from the above mentioned vial. The following residents had received the Aplisol beyond the 30 days of the above fill date:<br><br>R115 had received on 11/25/19.<br>R375 had received on 11/22/19.<br>R366 had received on 11/23/19.<br>R358 had received on 11/12/19 and 11/28/19.<br>R352 had received on 11/27/19.<br><br>During interview on 12/2/19, at 6:04 p.m., RN-B stated staff were not aware the Aplisol vial needed to have a date open. RN-B stated the should have had a date open written when the vial had been opened to be used and the Aplisol was good for only 30 days after being opened.<br><br>The Pharmaceutical APLISOL manufacturer insert dated 3/16, indicated the solution was used | F 761 | expiration dates on opened vials weekly and report non-compliance to Nurse Manager<br><br>All elements to be implemented by January 31, 2020. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245282 | A. BUILDING _____ B. WING _____ | C 12/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CHARTER HOUSE** | **211 NORTHWEST SECOND STREET ROCHESTER, MN 55901** |

| (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 761 | Continued From page 3<br>for intradermal injection(s) to help determine the presence of tuberculosis (an infectious agent). The insert provided storage instructions for the medication including bold lettering describing, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."<br><br>A policy for dating medications was requested. The facility provided Tuberculin skin testing, revised 8/16/19, which included check the expiration date on the vial. If the vial has been open for more than 30 days or the expiration date has passed, discard the vial and obtain a new vial. | F 761 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the | F 880 | | 1/10/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHARTER HOUSE | 211 NORTHWEST SECOND STREET ROCHESTER, MN 55901 |

| (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 |
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| F 880 | Continued From page 4<br>facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens. | F 880 | | |

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| | 245282 | A. BUILDING _____ B. WING _____ | C 12/04/2019 |

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| F 880 | Continued From page 5<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>During observation, interview and document review the facility failed to ensure standard precautions for the use of gloves during cleansing of a multiuse glucometer for 1 of 1 residents (R64), observed to have a blood sugar checked.<br><br>Findings include:<br><br>During observation on 12/3/19, at 11:17 a.m., registered nurse (RN)-C checked R64 blood sugar using a multiuse glucometer. After checking R64's blood sugar RN-C removed gloves and washed hands. RN-C carried the glucometer in a white basket to the nurses station. RN-C with no gloves on used a Super-sani wipe to clean the glucometer.<br><br>During interview on 12/3/19, at 11:26 a.m., RN-C verified she had no gloves on when cleansing the glucometer.<br><br>During interview on 12/4/19, at 1:52 p.m., the director of nursing stated it seems universal precautions should be implemented when cleansing the glucometer.<br><br>The facility policy Glucose Point of Care Testing, review date 2/18, indicated Procedure: Glucose | F 880 | Staff education regarding all equipment that has any potential for blood or body fluid exposure, including need to wear gloves when cleaning glucometers.<br><br>Education through email with follow up at staff meetings, and included in mandatory annual infection control education.<br><br>Audit: Nurse manager or designee will audit staff performing cleaning of glucometers for appropriate use of PPE 1x/week for one month, then 1x/month for 3 month with audit reports to QAPI.<br><br>To be completed by January 10, 2020. | |

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| F 880 | Continued From page 6<br>POC Testing: 19. Wipe meter and supply case with Oxivir wipe after every patient. The meter must remain wet for one minute to assure disinfection. Avoid getting electrodes wet on bottom of meter. The policy did not address the use of gloves when cleansing the meter.<br><br>CDC (Centers for Disease Control) indicates, wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids. | F 880 | | |
| F 881 SS=F | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to develop an antibiotic stewardship program, which included the development of protocols and a system to monitor antibiotic use, to include how the program will be implemented and antibiotic use will be monitored. This deficient practice had the potential to affect all 14 residents who resided in the facility.<br><br>Findings include:<br><br>A review of the facility's infection control surveillance program was conducted on 12/3/19, | F 881 | Implement an Antibiotic Stewardship policy which includes roles and surveillance.<br><br>Educate staff regarding facility Antibiotic Stewardship policy and process.<br><br>Share new policy and process at January QAPI meeting.<br><br>Steps will include monitoring and documentation in an electronic tool to be reviewed by nurse manager or designee | 1/31/20 |

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| F 881 | Continued From page 7<br>at 2:01 p.m., with registered nurse (RN)-B. The facility lacked development of protocols for a facility-wide system to monitor the use of antibiotics which includes (but not limited to) appropriate prescribing of antibiotics, criteria before antibiotic use and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified.<br><br>During interview on 12/3/19, at 2:01 p.m., RN-B stated we (facility) do not have an antibiotic stewardship policy.<br><br>During interview on 12/3/19, at 2:53 p.m., the director of nursing (DON) stated the facility had not developed antibiotic stewardship policy. The DON stated, "It is in the works". | F 881 | with weekly IDT review and pharmacist and MD follow up as appropriate. Monthly data presentation to QAPI committee beginning in February 2020 showing January data.<br><br>To be completed by January 31, 2019. | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and | F 883 | | 1/31/20 |

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| F 883 | Continued From page 8<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced | F 883 | | |

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| F 883 | Continued From page 9<br>by:<br>Based on interview and record review the facility failed to offer the pneumococcal 23 (PPSV23), for 1 of 5 residents (R2) and the influenza vaccine for 1 of 5 residents (R7) reviewed for immunization protocol.<br><br>Findings include:<br><br>R2's record identified R2 had been admitted to the facility on 11/12/19 and included immunization for pneumococcal 13 had been on 11/21/19. R2's record lacked documentation to indicate if R2 had been offered to receive or had received PPSV23.<br><br>During interview on 12/3/19, at 4:08 p.m., registered nurse (RN)-B verified R2's record lacked documentation to indicate if R2 had received or been offered to receive PPSV23.<br><br>R7's record identified R7 had been admitted on 10/22/19 and included immunization for influenza had been on 10/24/18. R7's record lacked documentation to indicate if R7 had been offered to receive the influenza vaccination on admission to the facility for 2019.<br><br>During interview on 12/4/19, at 2:36 p.m., RN-B verified R7's record lacked documentation to indicate if R7 had received or been offered to receive the influenza vaccination for 2019. RN-B stated R7 should have been offered the vaccination on admission to the facility.<br><br>The facility policy Pneumococcal Vaccine Charter House Procedure Rochester, dated 10/10/19, indicated Assessment 1. Prior to or upon | F 883 | Implement admission checklist hand-off binder on the medication carts with paper checklists<br><br>-Binders now include copies of the immunization informed consent forms for resident to sign if receive or decline (also part of admission packets).(Done 12-27-19)<br><br>Educate staff to document induration for TB and document if resident declines administration for pneumovax or influenza immunization.<br>- Staff education via email and January staff meetings including review of Mantoux/Tubersol Order Set in EMR.<br>-Revised Order Set - note added for Nurse to document induration (Example: 0 mm). (Done 12-27-19)<br>-Revised Admission and Admission Order set to have separate step for TB screening and risk assessment. (Done 12-27-19)<br><br>-Audit: RNCC or nurse manager will monitor weekly x 4 and then monthly to assure the influenza and pneumovax immunizations and/or required documentation are completed.<br><br>All to be implemented by January 31, 2020. | |

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| F 883 | Continued From page 10<br>admission, residents will be assessed for eligibility to receive the Pneumovax (pneumococcal vaccine), and when indicated will be offered the vaccination within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.<br><br>The facility policy Influenza and Influenza Vaccination Charter house Procedure Rochester, dated 10/22/18, indicated Procedure 1. Charter House will ensure that residents are offered an influenza vaccination between October 1st and May 1st, annually, unless the vaccination is medically contraindicated or the individual has been vaccinated during this time period. | F 883 | | |

Electronically delivered
December 23, 2019

Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: V8J111

Dear Administrator:

The above facility was surveyed on December 2, 2019 through December 4, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the

statement, "This MN Requirement 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:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 12/2/19, 12/3/19 and 12/4/19, a survey was conducted to determine compliance for state licensure. 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. | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>In addition, a complaint investigations were also completed at the time of the licensing survey.<br><br>The following complaints were found unsubstantiated:<br>H5282008C<br>H5282009C | 2 000 | | |
| 21385 | MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance<br><br>Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.<br><br>This MN Requirement is not met as evidenced by:<br>During observation, interview and document review the facility failed to ensure standard precautions for the use of gloves during cleansing of a multiuse glucometer for 1 of 1 residents (R64), observed to have a blood sugar checked.<br><br>Findings include:<br><br>During observation on 12/3/19, at 11:17 a.m., registered nurse (RN)-C checked R64 blood sugar using a multiuse glucometer. After checking R64's blood sugar RN-C removed gloves and washed hands. RN-C carried the glucometer in a white basket to the nurses station. RN-C with no gloves on used a Super-sani wipe to clean the glucometer. | 21385 | Staff education regarding all equipment that has any potential for blood or body fluid exposure, including need to wear gloves (universal precautions)when cleaning glucometers.<br><br>Education through email and staff meetings, and included in mandatory annual infection control education.<br><br>Nurse manager or designee will perform random audits to ensure appropriate infection control practices are followed when cleaning glucometers.<br><br>To be implemented by January 10, 2020. | 1/1/20 |

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| 21385 | Continued From page 2<br><br>During interview on 12/3/19, at 11:26 a.m., RN-C verified she had no gloves on when cleansing the glucometer.<br><br>During interview on 12/4/19, at 1:52 p.m., the director of nursing stated it seems universal precautions should be implemented when cleansing the glucometer.<br><br>The facility policy Glucose Point of Care Testing, review date 2/18, indicated Procedure: Glucose POC Testing: 19. Wipe meter and supply case with Oxivir wipe after every patient. The meter must remain wet for one minute to assure disinfection. Avoid getting electrodes wet on bottom of meter. The policy did not address the use of gloves when cleansing the meter.<br><br>CDC (Centers for Disease Control) indicates, wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids.<br><br>SUGGESTED METHOD OF CORRECTION: Staff could be re-educated on infection control practices during glucometer cleaning. The director of nursing or designee could perform random audits to ensure staff are following infection control practices when cleaning a glucometer.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21385 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and | 21426 | | 1/1/20 |

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| 21426 | Continued From page 3<br>maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a second step Tuberculin skin test (TST) had been completed for 1 of 5 employees (E-A) and failed to ensure 1 of 5 residents (R1) had the second step TST completed.<br><br>Findings include:<br><br>EMPLOYEE TST:<br>E-A had a hire date of 10/21/19. E-A's first step TST given on 10/15/19, with read results 10/17/19 of 0 millimeters (mm) and negative. E-A employee record lacked documentation of a second step TST having been given. | 21426 | Resident TB monitoring:<br>Educate staff to document induration for TB via email and staff meetings.<br><br>Review Mantoux/Tubersol Order Set in EMR with staff<br>-Revised Order Set - note added for Nurse to document induration (Example: 0 mm) (done 12-27-19.)<br>-Revised Admission and Admission Order set to have separate step for TB screening and risk assessment (done 12-27-19).<br><br>Nurse manager or designee will monitor | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00193 | A. BUILDING: _____ B. WING _____ | C 12/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHARTER HOUSE | 211 NORTHWEST SECOND STREET ROCHESTER, MN 55901 |

| (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) COMPLETE DATE |
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| 21426 | Continued From page 4<br><br>RESIDENT TST:<br>R1 was admitted on 11/15/19. R1 had a TST on 7/30/19, with read results on 8/1/19 of 0 mm and negative, however R1's record lacked documentation of a second step TST having been given.<br><br>During interview on 12/4/19, at 2:36 p.m., registered nurse (RN)-B verified the above.<br><br>The facility policy Tuberculosis (TB) Screening, Residents Charter House Policy Rochester, dated 10/18/18, indicated Policy Notes: 2. All residents admitted must have baseline screening within 72 hours of admission or within three months prior to admission. TB screening should include a TB symptom screen and a two-step tuberculin skin test or TB blood test.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could monitor compliance for screening and TST for employees and residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | weekly x 4 and then monthly to ensure the appropriate mantoux administration and documentation is completed.<br><br>Staff TB Monitoring:<br>Nurse manager reinforcement to follow up on Occupational Health notifications regarding new employee TB surveillance.<br><br>Nurse manager to follow protocol regarding suspension of employees not compliant with TB surveillance.<br><br>Nurse manager or designee will audit employee compliance with TB surveillance on a monthly basis.<br><br>All to be implemented by January 10, 2020. | |

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|---|---|---|---|
| | 245282 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **12/03/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CHARTER HOUSE** | **211 NORTHWEST SECOND STREET ROCHESTER, MN 55901** |

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| K 000 | INITIAL COMMENTS<br><br>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.<br><br>UPON RECEIPT OF AN ACCEPTABLE 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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Charter House) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>fm.hc.Inspections@state.mn.us | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 01/01/2020 |

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

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| K 000 | Continued From page 1<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>The Facility is a 24 story building with a basement. The facility was constructed in 1985 and was determined to be of Type I (332) construction. The healthcare is located on the 3rd floor only.<br><br>The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 32 beds and had a census of 14 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, | K 353 | | 1/1/20 |

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|---|---|---|---|
| | 245282 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **12/03/2019** |

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| K 353 | Continued From page 2<br>Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and staff interview, the facility was operating under protocols associated to outdated Categorical Waviers associated to Fire Sprinkler System Inspection, as such not in compliance with conducting the additional quarterly inspections in accordance with the Life Safety Code NFPA 101 - 2012 edition ( 9.7.5, 9.7.7, 9.7.8, and NFPA 25 )<br><br>This deficient practice could affect 17 residents.<br><br>Findings Include:<br>On facility tour between 08:00 AM and 11:00 AM on 12/03/2019, observation and documentation reviewed revealed the following:<br><br>During documentation review, records confirmed the annual fire sprinkler system testing was conducted in Q2 of 2019 and one quarterly inspection was conducted in Q4 of 2018. No records were available to confirm testing was completed for Q1 or Q3 2019. | K 353 | The procedure for fire sprinkler system testing will be changed to quarterly inspections. This will be updated in the work order system to auto generate the updated procedure of quarterly testing in accordance to NFPA 25.<br><br>The change will be completed by February 28, 2020. | |

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| K 353 | Continued From page 3<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 353 | | |
| K 511 SS=D | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain complinace to no extension cord usage in the facility in accordance with the Life Safety Code NFPA 101 - 2012 edition ( NFPA 70, 19.5.1.1, 9.1.1, 9.1.2 )<br><br>This deficient practice could affect 17 residents.<br><br>Findings Include:<br>On facility tour between 08:00 AM and 11:00 AM on 12/03/2019, observations and staff interview revealed the following:<br><br>During walk-through of the facility observed in CR 3-50B the use of a extension cord to power and electrical appliance | K 511 | Staff will be re-educated through staff meetings and emails.<br><br>Monthly unit rounds will be conducted with supervisor of facilities or designee, supervisor of housekeeping or designee, and nurse manager or designee.<br><br>To be completed and implemented by January 31, 2020. | 1/1/20 |

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|---|---|---|---|---|
| K 511 | Continued From page 4<br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 511 | | |
| K 712 SS=D | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to maintain complinace to maintaining proper time seperation of fire drills in accordance with the Life Safety Code NFPA 101 - 2012 edition ( 19.7.1.4 through 19.7.1.7 )<br><br>This deficient practice could affect 17 residents.<br><br>Findings Include:<br>On facility tour between 08:00 AM and 11:00 AM on 12/03/2019, observation and documentation reviewed revealed the following:<br><br>During documentation review, provided documentation revealed the 3rd Shift fire drills for Q3 / Q4 did not meet the 90 min separation requirement | K 712 | A spreadsheet will be created to ensure adequate intervals between time of drills and day of the week. This will be recorded on the electronic work system. Changes will be completed by January 31, 2020. | 1/1/20 |

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|---|---|---|---|---|
| K 712 | Continued From page 5<br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 712 | | |