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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VKZ6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00588

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245125**
2.STATE VENDOR OR MEDICAID NO.
(L2) **112847700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FITZGERALD NH AND REHAB**
(L4) **227 MCKINLEY AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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) **07/22/2014**

6. DATE OF SURVEY **03/14/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
02/28

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

12.Total Facility Beds **24** (L18)
13.Total Certified Beds **24** (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
	24			
(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
Teresa Ament, HFE NEII
Date : 03/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 04/21/2016 (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
05/15/1967
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/22/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245125

April 21, 2016

Ms. Jessica Raad, Administrator
Fitzgerald Nursing Home and Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

Dear Ms. Raad:

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 March 18, 2016 the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 25, 2016

Ms. Jessica Raad, Administrator
Fitzgerald Nursing Home and Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

RE: Project Number S5125028

Dear Ms. Raad:

On February 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 9, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 14, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2016, effective March 18, 2016 and therefore remedies outlined in our letter to you dated February 24, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245125 Y1	A. Building B. Wing Y2	3/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0329	Correction	ID Prefix F0332	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.25(m)(1)	Completed
LSC	03/03/2016	LSC	03/04/2016	LSC	03/04/2016
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	03/04/2016	LSC	03/04/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	03/25/2016	27200	03/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/9/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245125 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	03/04/2016	LSC K0025	03/04/2016	LSC K0027	03/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0029	03/04/2016	LSC K0047	03/04/2016	LSC K0048	03/11/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	03/04/2016	LSC K0052	03/04/2016	LSC K0062	03/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0067	03/18/2016	LSC K0147	03/04/2016	LSC K0154	03/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0155	03/04/2016	LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	CC/mm	03/25/2016	13922	03/14/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/9/2016

[ ] 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VKZ6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00588

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245125**
2.STATE VENDOR OR MEDICAID NO.
(L2) **112847700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FITZGERALD NH AND REHAB**
(L4) **227 MCKINLEY AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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) **07/22/2014**

6. DATE OF SURVEY **02/09/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
02/28

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

12.Total Facility Beds **24** (L18)
13.Total Certified Beds **24** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(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 :
Teresa Ament, HFE NEII 03/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/22/2016 (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
05/15/1967
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 24, 2016

Ms. Jessica Raad, Administrator
Fitzgerald Nursing Home And Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

RE: Project Number S5125028

Dear Ms. Raad:

On February 9, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: chris.campbell@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 March 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 9, 2016 (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 August 9, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor resident choices for bathing frequency and awakening times for 2 of 3 residents (R16, R8) reviewed for choices. Findings include: R16's quarterly Minimum Data Set (MDS) dated 2/5/16, indicated R16 was cognitively intact, and required extensive assistance of one staff for	F 242	F242 A. It is Facility practice to acknowledge and accommodate all resident choices for activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the	3/3/16

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

Electronically Signed | 03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 bathing. The facility bath schedule indicated R16 was scheduled for a bath/shower on Wednesday p.m. shift. On 2/7/16, at 2:40 p.m. R16 stated she was not able to choose her bathing frequency. R16 stated she received a shower one time a week, but she would like to receive at least two showers a week. On 2/9/16, at 12:07 p.m. the social service designee (SSD)-A stated she asked residents about their choices on admission. SSD-A did not recall if she had asked R16 about her bathing preferences. SSD-A stated she would ask residents at their care conference if they had any concerns, but not specifically if they would like to choose their bathing frequency. On 2/9/16, at 1:39 p.m. the director of nursing (DON) was interviewed and stated the SSD should ask residents about their preferences on admission. The facility was unable to provide a policy on resident choices. R8's Admission Record identified diagnoses that included diabetes mellitus without complications. The quarterly Minimum Data Set (MDS) dated 11/4/15, indicated R8 was cognitively intact. The MDS indicated R8 did not have orders for insulin or receive insulin injections. R8's physician order report dated 2/9/16, indicated a 9/4/15 order for accuchecks at 6:00 a.m. daily. In an interview on 2/7/16, at 10:15 a.m., R8 stated she does not choose when to get up in the morning because staff come in early (6:15 a.m.)	F 242	resident. B. The facility has implemented a new policy to address resident choices. C. All residents will have interviews completed to address resident choices. D. The Administrator, DON and Medical Director have reviewed and approved this policy for facility appropriateness. E. All facility staff members will be educated to the implementation of the new facility policy and the proper chain of communication regarding addressing resident choices on 2/29/16. F. Resident R16 was interviewed and their choice for bathing preferences and frequency has been addressed and modified to accommodate their preference 2/29/16. G. Resident R8 was interviewed and their choice for awakening time has been addressed and modified to accommodate their preference 2/29/16. H. Facility audits for all residents to ensure follow through for resident choices policy will be completed by the Social Service Designee monthly for six months and then continue every other month for an additional six months. I. Continued Facility auditing measures to ensure follow through for the resident choices policy will be completed by the Social Service Designee upon any change in resident preferences, admission, quarterly Resident Care Conferences and annual MDS assessment reviews. J. The Social Service Designee will be responsible for completion. K. Correction Date: March 3, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 2 to prick her finger and she doesn't really fall back asleep. R8 stated she had to do accuchecks at home, but didn't do it that early in the morning. In an interview on 2/9/16, at 7:22 a.m., R8 stated it was 6:00 a.m. when they poked her finger today. R8 stated, "It's early. I'm just not used to that." In an interview on 2/9/16, at 7:58 a.m., registered nurse (RN)-B stated she did not perform R8's accucheck, it was done by the night staff as the order was for 6:00 a.m. RN-B stated she completed morning accuchecks around 7:30 a.m., before breakfast. In an interview on 2/9/16, at 8:29 a.m., the Activity Director (AD) stated that as a part of the admission and annual MDS, she asked residents about naps and bedtimes. The AD stated if someone wanted to sleep in, they or the family would need to say something as it is not something she routinely asks. In an interview on 2/9/16 at 9:28 a.m., the Director of Nursing (DON) stated accuchecks would be given early if a resident was awake and some are also done right before breakfast. The DON stated that she was not aware of residents getting accuchecks while they're still sleeping or if someone was awakened to have an accucheck. The DON said that if a resident didn't want an accucheck early, they could say something, but it's not routine for them to ask a resident.	F 242	Resident Choices Policy POLICY Each resident and/or responsible party are encouraged to disclose the resident□s preferences for activities, interests, bed time, awakening time, bathing time and frequency, plan of care, and medication administration time/times at time of admission, upon preference changes, quarterly resident care conferences, and annual MDS assessment reviews. PURPOSE To allow residents and responsible parties to be involved in voicing preferences where resident choices are concerned and to ensure facility follow-through with these choices where feasible. PROCEDURE 1. All RESIDENT ADMISSION, PREFERENCE CHANGE, and CARE CONFERENCE FORMS (Resident Choices) are to be filled out and filed with the Social Service Designee upon preference changes, admission and quarterly care conferences. 2. RESIDENT ADMISSION, PREFERENCE CHANGE and CARE CONFERENCE FORMS (Resident Choices) will be reviewed at the daily IDT meetings once complete. 3. Residents or responsible parties may present concerns about resident choices to any member of the direct care staff at any time and the IDT committee will review within 48 hours and follow-up as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 3	F 242	necessary. RESIDENT ADMISSION, PREFERENCE CHANGE, CARE CONFERENCE FORM (Resident Choices) Resident Name: _____ ____ Date: _____ Type of Interview: _____ — Resident Interview 1. What time do you get out of bed in the morning? Is this the time you prefer? If not, what time would be better? 2. What time do you go to bed at night? Is this the time you prefer? If not, what time would be better? 3. How many times a week do you prefer to shower/bathe? How many shower/baths would you like? 4. Do you have any concern about your bathing schedule? 5. What time do you take your medications?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 4	F 242	Is this the time you prefer? If not, what time would be better? 6. Do you have any concerns with your roommate? 7. Are you satisfied with the care from your current physician? 8. Do you feel all your needs are met here at Fitzgerald? 2/29/16	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 329	Continued From page 5 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain proper consent for antipsychotic medications for 4 of 5 residents (R19, R11, R9, R2) reviewed for unnecessary medications. Findings include: R19's family representative (FM)-A was not informed of the side effects for an antipsychotic medication, which included the increased risk of death. R19's Face Sheet dated 2/9/16, indicated R19's diagnoses included dementia with Lewy Bodies, episodic mood disorder and epilepsy. The quarterly Minimum Data Set (MDS) dated 1/26/16, indicated R19 was rarely or never understood, had short and long tem memory problems and had severely impaired decision making skills. R19 had signs and symptoms of delirium which consisted of inattention and an altered level of consciousness. R19 received antipsychotic and antidepressant medications. The Physician's Orders dated 2/9/16, included orders for Risperdal (antipsychotic medication) 0.25 milligrams (mg) by mouth (po) at bedtime (HS). R19 started the dose of Risperdal on 11/2/15.	F 329	F329 A. It is the Facility practice to ensure that each resident□s drug regimen is free from unnecessary drugs and to obtain proper informed consent for antipsychotic medications to include the Black Box Warning of increased risk of death. B. The facility□s Consent for use of Psychotropic Medication form has been reviewed and revised to include the Black Box warning of increased risk of death. C. The facility□s policy and procedure for Administration of Antipsychotic Medications has been reviewed and revised to include direction for review of potential side effects to include boxed warnings prior to administering antipsychotic or psychotropic medications. D. All RN and Licensed staff will be educated to the consent form revision and the policy and procedure revision on 2/29/2016. E. Residents R19, R2, and R9 and/or responsible party have been educated to the Black Box Warning and newly revised consent form. The new consent form will be updated in the resident□s medical record by 3/5/16. Resident R11 has had all antipsychotic medications discontinued on 3/1/2016. F. Facility wide audit for all residents with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 329	Continued From page 6 R19's Consent for Use of Psychotropic Medications signed 11/10/15, indicated Risperdal was an antipsychotic. A list of potential side effects was included on the consent form. The consent form and list of side effects lacked information which included the increased risk of death. On 2/9/16, at 11:50 a.m. FM-A stated R19 was on the Risperdal twice a day until about a month ago. The Risperdal was decreased to once a day. FM-A stated he/she was informed of the possibility of death when R19 was discharged from the adult behavioral health facility, however it was not discussed while at this facility. The Package insert and Label Information black box warning for Risperdal, indicated there was an increased risk of mortality in elderly patients with dementia-related psychosis. R11's family representative (FM)-B was not informed of the side effects for an antipsychotic medication, which included the increased risk of death. R11's Face Sheet dated 2/9/16, indicated R11's diagnoses included dementia with behavioral disturbances and anxiety. The admission MDS dated 12/3/15, indicated R11 had moderately impaired cognition. The MDS further indicated R11 did not have delirium, psychosis or behaviors. R11 received antipsychotic and antidepressant medications. The Physician's Orders dated 2/9/16, included orders for Seroquel (antipsychotic medication) 12.5 mg po every day in the morning. R11 started	F 329	consent form for antipsychotic medications has been completed to ensure the inclusion of the Black Box warning of increased risk of death. G. Resident audits of revised antipsychotic medication consent form will be performed monthly by the Director of Nursing. H. Correction Date: February 29, 2016 Policy: Administration of Antipsychotic Medications Purpose: To administer medications correctly and safely. Procedure: ¿ Before an antipsychotic medication is administered, the Charge Nurse or DON must have a written order by the physician clearly stating the medication, dosage, route and frequency of administration. ¿ Informed Consent by the resident/responsible party must be on file and updated as necessary. ¿ Ongoing review of potential side effects, including boxed warnings side effects prior to administering antipsychotic or psychotropic medications will be completed by nursing staff. ¿ The Charge Nurse is responsible for the keys to the medication area at all times. The medication area shall be locked at all times when the Charge Nurse is not in the medication area. ¿ RN or licensed nurse will administer medication. ¿ Conversations or other distractions should be avoided while preparing medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 329	Continued From page 7 the Seroquel on 12/7/15. R11's Consent for Use of Psychotropic Medications signed 11/29/15, indicated Seroquel was an antipsychotic used for R11's dementia with behavioral disturbances. A list of potential side effects was included on the consent form. The consent form and list of side effects lacked information regarding the increased risk of death. On 2/9/16, at 1:37 p.m. FM-B stated the Seroquel had helped R11 as before that R11 was the combative. FM-B stated Seroquel started the end of September. FM-B stated he/she was not informed of the side effects, including the possibility of death. On 2/9/16, at 1:52 p.m. the director of nursing (DON) and the administrator were interviewed. The DON verified the consents did not contain the black box warnings for antipsychotics for R19 and R11. The Package insert and Label Information for Seroquel indicated there was an increased mortality in elderly patients with dementia-related psychosis. R2's face sheet printed 2/9/16, indicated R2's diagnoses included vascular dementia, cerebrovascular disease, and major depressive disorder. The undated form used by the consultant pharmacist for review of medications, indicated R2 had a diagnosis of vascular dementia with delusions. R2's quarterly MDS assessment dated 1/25/16, indicated R2 had a moderate cognitive impairment, no signs and symptoms of delirium, and did not display mood or behaviors problems.	F 329	¿ Administering nurse must remain with the resident until the medication is swallowed. If the resident refuses medication, report it and chart the reason. (You may not leave medications with the residents unless they have an order from their physician stating they may self-administer medications without supervision). ¿ Narcotic medications must also be recorded in the appropriate narcotic book and counted at the end of each shift. ¿ Do not give medication when there is definite change in condition of the resident. ¿ Look up all unknown medications before giving them, a Nursing Drug Book is provided at the nurse□s station. ¿ Do not use one resident□s medication for another resident. ¿ The medicine must be charted as soon as the resident takes it. This responsibility cannot be delegated to anyone else but the Charge Nurse who gives the medication. ¿ Medication is to be set up and given to one resident at a time. ¿ The labels of all medication bottles and cards will be neat and legible. Labels shall include prescription number, name of drug, strength, quantity of drug, expiration date, directions for use, resident□s name, physician□s name, date of refill, and if generic, the name of medication being given for. Updated 2/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 329	Continued From page 8 The MDS indicated R2 received an antidepressant medication and an antipsychotic medication. R2's signed physician orders dated 12/22/15, included Zyprexa 5 mg po at HS, and paroxetine HCl 20 mg po once daily. A nurse practitioner progress note dated 8/29/13, indicated R2 had diagnoses that included a stroke and psychosis. The progress note further explained that the current medications, including psychotropics and antidepressants, would be continued due to past serious self-harm attempts when a dose reduction was attempted. A previous document for Psychotropic Minimum Effective Dose Attempts completed by a registered nurse, dated 11/2/09, indicated a reduction in Zyprexa was not advised due to past attempts had led to an increase in psychosis and suicidal behaviors. The same document dated 4/28/10, indicated the same recommendation by an RN, based on a physician's recommendation. A consent for use of Zyprexa and paroxetine dated 11/10/15, indicated R2's family was notified of the benefits of the medication and potential side effects of the medication. The side effects listed on the consent form lacked the increased risk of death. Monthly side effect review indicated R2 had minimal signs and symptoms of agitation/anxiety, restlessness, and depression from 12/15 to present. During an interview on 2/9/16, at 1:20 p.m. the consultant pharmacist (CP) verified the physician	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 329	Continued From page 9 should review the risk-versus-benefit of antipsychotic medications twice a year the first year and then yearly after that, even if there was no change in the medication. The CP verified the significant warnings for the medication should be included on the consent forms for antipsychotics. The Package insert and Label Information for Zyprexa, indicated there was an increased mortality in elderly patients with dementia-related psychosis. On 2/9/16, at 1:52 p.m. the DON and the administrator were interviewed. The DON verified the consents did not contain the significant warnings for antipsychotics for R2. R9's diagnosis list, dated 2/9/16 indicated diagnoses that included dementia without behavioral disturbance, major depressive disorder, and epilepsy. R9's quarterly MDS, dated 12/26/15, indicated R9 had severe cognitive impairment. The MDS had few symptoms of depression, and no delusions or hallucinations. The MDS indicated signs and symptoms of delirium including disorganized thinking and inattention. The MDS also indicated physical behaviors toward others (hitting, kicking) were exhibited on 1-3 days of the look back period and rejection of care was exhibited often but not daily. The MDS further indicated R9 received antipsychotic and antianxiety medications. R9's physician orders dated 2/9/16, included orders for Seroquel (antipsychotic medication) 25 mg po at HS for dementia. The order indicated a start date of 1/13/15.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 329	Continued From page 10 R9's Consent for use of Psychotropic Medication, signed 2/7/16, identified Seroquel . It was absent of a diagnosis for use. A list of potential side effects was included, but did not include the significant warning for Seroquel, which included the increased risk of death. R9's Care Plan dated 12/14/13, indicated R9 took Seroquel due to a history of physical aggression, wandering, and refusal of cares. In an interview on 2/9/16, at 1:00 p.m., the DON, stated R9 had been on Seroquel since before admission to the facility. The DON stated that R9 has a history of becoming agitated while looking for a lost loved one and aggression during cares. The DON stated that R9's family had attempted to reduce the number of medications R9 took, but felt the Seroquel did help reduce aggression and refusals of care. The DON stated the facility attempted a reduction of the Seroquel in 1/15, but it failed. The Package insert and Label Information for Seroquel, indicated there was an increased mortality in elderly patients with dementia-related psychosis. On 2/9/16, at 1:52 p.m. the DON and the administrator were interviewed. The DON verified the consents did not contain the black box warnings for antipsychotics for R9. The undated facility policy and procedure for Administration of Antipsychotic Medications directed a consent by the resident or responsible party must be on file and updated as necessary. The policy and procedure lacks direction for	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 329	Continued From page 11 review of potential side effects, including boxed warnings prior to administering antipsychotic or psychotropic (mood altering) medications, and the need for physician reviews of risk-versus-benefits for psychotropic medications.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication errors were less than 5% for 2 of 5 residents (R1, R22) observed during medication administration. Findings include: During facility medication administration observation, 3 errors occurred during 25 opportunities resulting in an error rate of 12%. R1's face sheet printed 2/9/16, identified diagnoses that included a gastrostomy (an artificial opening to the stomach). R1's signed physician orders dated 12/22/15, included orders for R1 to receive nothing by mouth, and for a tube feeding. R1's medication orders indicated medications were to be given through the GT and included the following medications: -Konsyl (psyllium) Powder (natural fiber for constipation prevention) 15 milliliters (ml) twice a	F 332	F332 A. It is Facility practice to ensure that it is free of medication error rates of five percent or greater. B. The facility has reviewed and revised the medication administration policies and procedures for gastrostomy tube medication administration and insulin administration. C. The facility has created and implemented Direct Care Audit forms for G-tube Medications and Insulin Administration 2/29/16. D. Licensed staff have been educated to the proper procedure for gastrostomy tube medication administration for resident R1 to include water flush between medications and to administer each medication individually per consultant pharmacist recommendations. E. Licensed staff have been educated to the proper procedure for Insulin	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 12 day (BID) -metoclopramide HCl Solution 10 mg three times a day (TID) (used for heartburn or to stimulate stomach emptying) -pseudophedrine HCl 60 milligrams (mg) TID -salt 1/4 teaspoon (tsp) daily -zolpidem tablet (to increase cognitive response to external stimuli) 5 mg daily. R1's physician orders included 30 to 50 cubic centimeters (cc) water flush between each medication administration. On 2/7/16, at 12:50 p.m. licensed practical nurse (LPN)-B prepared R1's medications for administration. Each medication (med) was placed in a separate plastic med cup. The medications included natural fiber powder, liquid metoclopramide, salt, and pseudophedrine, which LPN-B crushed before placing it in the med cup. The medication cups, 350 cc of water, swab sticks, 120 cc of prune juice, and a 60 cc syringe were brought to R1's room. At 12:56 p.m. LPN-B connected the syringe into the GT, and appropriately checked the GT for proper placement. LPN-B removed the plunger from the syringe and set it on the tray, leaving the syringe connected to the GT. LPN-B poured the natural fiber and water from the graduate into an 8 ounce plastic cup and stirred it. LPN-B poured approximately 50 cc of water from the graduate into the syringe which drained by gravity. Then the mixture of water and the natural fiber was poured into the syringe, adding more water to the syringe while it drained. LPN-B poured approximately 20 cc of water into the med cup with the crushed pseudophedrine, poured some of the prune juice into the syringe, and while it was draining, added the salt to the med cup with	F 332	Administration to including priming the insulin pen needle prior to administration for resident R22 who has since discharged as of 2/19/2016. F. Charge RN or DON will audit licensed staff medication administrations via gastrostomy tube for resident R1 daily for one week using the Direct Care Audit form for G-tube medications then weekly for one month. The need for ongoing quarterly monitoring of medication administrations via gastrostomy tube for resident R1 will be determined by the Quality Assurance Committee. G. Charge RN or DON will audit licensed staff insulin administrations via insulin pen for all other residents aside from R22 who discharged 2/19/16 daily for one week using the Direct Care Audit for Insulin Administration then weekly for one month. The need for ongoing quarterly monitoring of licensed staff insulin administrations via insulin pen will be determined by the Quality Assurance Committee. H. The Director of Nursing or her designee will be responsible for completion. I. Correction Date: 3/4/2016 Fitzgerald Nursing Home & Rehab Policy: Medication Administration via G-Tube Purpose: To give medication via G-tube. Procedure:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 13 the crushed pseudophedrine and the small amount of water, and swished the water and medications to mix. LPN-B administered more prune juice, poured in the crushed pseudophedrine and salt mixed with water, poured in the liquid medications, and then poured in the remainder of the prune juice, followed by approximately 50 cc of water, then the remainder of the water. LPN-B was not observed to flush with 30-50 cc of water between each medication. During an interview, at the end of the medication administration, LPN-B stated she flushed the GT before administering medications and when she was done administering medications. During this observation, 1 medication occurred due to the lack of water flush between medications. On 2/8/16, at 4:53 p.m. LPN-A set up medications for administration for R1. LPN-A crushed the pseudophedrine and the zolpidem together, and placed them in a med cup. LPN-A measured the appropriate amount of metoclopramide and natural fiber in separate med cups and put them on the tray. LPN-A placed 270 cc of water from the tap into a graduate and put it on the tray. LPN-A appropriately checked the GT for placement and removed the plunger from the syringe, which was attached to the end of R1's GT. LPN-A poured 50 cc of water from the graduate, let it drain and poured in the liquid metoclopramide medication. LPN-A poured in 30 cc water, then added the crushed medications containing approximately 20 cc of water. LPN-A poured in 30 cc water, poured the natural fiber powder in the empty graduate, added water, mixed, and poured it into the syringe. LPN-A poured approximately 30 cc of water into the syringe, let it drain, removed the syringe, and closed the GT. During this	F 332	¿ Gather Supplies ¿ Wash Hands ¿ Crush medications per manufacturer□s recommendations ¿ Keep all medications separate ¿ Dissolve crushed medications in liquid (as needed) ¿ Administer each medication separately ¿ Flush 30-50cc□s of water before medication administration, between each medication, and after medication administration. Updated 2/29/16 Direct Care Audit- G-tube Medications Date: Resident: Licensed Staff: Type of Cares Observed: YES NO Did the staff wash their hands before and after direct contact with the resident? Did the staff explain the task being performed to the resident? Did the staff check placement of G-tube? Did the staff flush the tube with water before medications/food given? Did the staff have crushed medications in separate cups?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 14 observation, 1 medication error occurred due to the lack of water flush between medications. On 2/8/16, at 5:08 p.m. LPN-A stated she put the crushed medications together because they are both crushed. LPN-A verified the physician orders directed to flush with 30-50 cc of water between each medication. LPN-A verified she should have separated the crushed medications and flushed with water between each medication. During an interview on 2/9/16, at 1:20 p.m. the consultant pharmacist verified the GT should be flushed with water between each medication. The undated facility policy and procedure for Medication Administration via G-Tube directed nurses to flush with 30-50 cc's of water before medication administration, between each medication, and after medication administration. R22's Admission Record printed 2/9/16, identified multiple diagnoses including diabetes mellitus Type 2. A physician order dated 1/21/16 identified Humulin 70/30 sub-cutaneous (sub-q) KwikPen 100 units/ml - 10 units in am, 8 units at noon and 10 units in the evening. On 2/7/16, at 12:27 p.m. LPN-B was observed to administer 8 units of Humulin 70/30 sub-q to the right upper arm of R22. LPN-B was observed to not prime the insulin pen prior to use. This resulted in one medication error. Manufacturers recommendation for the Humalog KwikPen identified to prime the needle before each use as it removed air and prevented getting too much or too little insulin.	F 332	Did the staff flush the tube with 30-50cc water between medications? Did the staff flush the tube with water after food/prune juice given? Were physicians orders followed? Did the staff wash their hands after feeding was finished? Was the resident's bed put back to lowest position after feeding? Was the HOB put at 30 degrees before leaving the room? Was charting completed in a timely manner? Comments (if any): If you answered NO for any of the questions, please write a brief explanation on back. If you would like other areas added to the audit, please notify Nicole Nguyen, DON Upon completion, turn in this sheet to Nicole Nguyen, DON Person completing Audit:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 15 On 2/9/16 at 9:41 a.m. the director of nursing (DON) stated insulin pens should be primed as residents may not be receiving a full dose.	F 332	Teaching Provided to Staff or requested by Staff: Teaching Provided to Resident or requested by Resident: INSULIN PEN NEEDLE PREPARATION, USE AND DISPOSAL POLICY POLICY All licensed staff will be made aware of the proper procedure for the insulin pen needle preparation, use and disposal. PURPOSE: To ensure safe and proper insulin pen preparation, use and disposal according to manufacturer□s instructions. PROCEDURE Preparation 1. Check insulin orders and dose against physician orders. 2. Wash hands	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 16	F 332	3. Clean the rubber seal on the pen with an alcohol wipe. 4. Take the peel tab off the pen needle. 5. Holding the outer cover, push and screw the needle onto the pen in a clockwise direction until it meets resistance. 6. Pull ONLY the outer cover straight off. 7. Always check the flow in the pen needle before each injection by priming the device with an airshot, dial 2 units, point the pen up and press the button. 8. A drop or stream of liquid should appear at the needle tip, IF NOT, repeat as recommended by the pen□s instructions. If the pen still does not prime, change the needle and repeat the above priming steps. Use & Disposal 1. After cleaning and priming the insulin pen, dial the physician ordered dose on the pen per manufacturer□s instruction. 2. Put on gloves, prep skin by cleaning with an alcohol wipe. 3. Pinch skin and insert the needle straight into the skin in one continuous motion until the Clear Outer Shield retracts and the White Sleeve is flush with the skin. 4. Maintain constant pressure against the skin and deliver the dose by depressing the button with your thumb. Do Not withdraw the needle from skin until the dose has been completely delivered. 5. Once the entire dose has been given, lift the pen away from the skin. The inner shield will automatically deploy and lock in place. A RED indicator band will appear confirming shield is locked in place and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 17	F 332	the pen needle has been used. 6. Always hold the pen needle by the white sleeve when removing. 7. Unscrew the pen from the pen needle until the two are separated. 8. Pen connection end is protected. Protection is confirmed when orange shield deploys and covers the needle. 9. Do Not place your fingers on the activated shields. 10. Discard the used pen needle into a sharps collector. 2/15/16 Direct Care Audit-Insulin Administration Date: Resident: Licensed Staff: Type of Cares Observed: YES NO Did the staff wash their hands before and after direct contact with the resident? Did the staff explain the task being performed to the resident? Did the staff clean the top of the insulin pen with Alcohol before placing the needle? Did the staff prime the needle with 2 units of insulin before dialing up correct dose? Did the staff wash their hands before donning gloves?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 18	F 332	Was any education provided to the resident? Was any education provided to the staff? If so, explain below Did the staff remove thepen tip with the disposable remover and place in sharp container? Did the staff wash their hands after giving insulin to the resident? Did the staff document in a timely manner after procedure completed? Comments (if any): If you answered NO for any of the questions, please write a brief explanation on back. If you would like other areas added to the audit, please notify Nicole Nguyen, DON Upon completion, turn in this sheet to Nicole Nguyen, DON Person completing Audit: Teaching Provided to Staff or requested by Staff:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 332	Continued From page 19	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their	F 441	Teaching Provided to Resident or requested by Resident:	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 441	Continued From page 20 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the insulin pen needle remover was properly cleaned after each use to prevent cross contamination of blood-borne pathogens. This had the potential to affect 2 of 2 residents (R15, R22) who utilized insulin pens. Findings include: R15's Resident Admission Record printed 2/9/16, identified diagnoses that included diabetes mellitus. R15's signed physician orders dated 12/22/15, included orders for Lantus (long acting insulin) 15 units twice daily, and a sliding scale Novolog (fast-acting insulin) four times a day. R22's Resident Admission Record printed 2/9/16, identified diagnoses that included diabetes mellitus type 2. R22's signed physician orders dated 1/11/16, included orders for Humulin 70/30 KwikPen (combination insulin) 10 units BID at 8:00 a.m.	F 441	F441 A. It is Facility practice to ensure that proper procedure and equipment is utilized with insulin pen needles for removal to prevent cross contamination of blood-borne pathogens. B. The facility discontinued the use of the reusable insulin pen needle remover and replaced the reusable procedure with a disposable insulin pen needle remover for each insulin pen used for every resident on 2/15/2016. C. The facility policy and procedure for proper use of insulin pen needle removers has been reviewed and revised in accordance with the manufacturer's instructions for the new disposable insulin pen needle removers to prevent cross contamination of blood-borne pathogens and to meet the facility Infection Control Program guidelines. D. All licensed staff have been educated to this new disposable insulin pen needle remover policy and procedure on 2/15/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 441	Continued From page 21 and 6:00 p.m., and 8 units once daily at noon. During an observation on 2/7/16, at 12:26 p.m. licensed practical nurse (LPN)-B administered 8 units of Humulin 70/30 with an insulin pen. LPN-B applied an insulin pen tip needle protector/remover over the needle and set it down on the table. LPN-B picked up the eye drops, glucometer case, insulin pen with the needle protector/remover still covering the needle and returned to the medication cart. She set the insulin pen with the needle protector/remover on top of the cart. LPN-B picked up the insulin pen and removed the needle with the needle remover, and disposed of the needle in the sharps container attached to the side of the cart. LPN-B put the insulin pen needle protector/remover into the top drawer of the cart with the lancets. LPN-B did not clean the sharps protector/remover prior to placing it in the drawer. During an interview on 2/8/16, at 12:29 p.m. LPN-B verified she did not clean the insulin pen needle protector/remover following administration of the insulin. LPN-B verified they only had one needle protector/remover and that it was used for all residents who received insulin with an insulin pen. LPN-B stated there was no protocol yet for cleaning the cover and verified there was a potential for cross contamination. The insulin pen needle protector/remover was observed to be placed in the box with the lancets during the interview. During an interview on 2/8/16, at 12:36 p.m. registered nurse (RN)-A stated there was no protocol for cleaning the insulin pen needle protector/remover.	F 441	E. The facility has created and implemented a Direct Care Audit form for Insulin Administration for licensed staff on 2/15 /16. F. Follow-up audits of insulin pen needle removal will be completed daily for one week using the Direct Care Audit form for Insulin Administration then weekly for one month by the charge RN or DON. The need for ongoing quarterly monitoring of insulin pen needle removal and disposal will be determined by the Quality Assurance Committee. G. Resident R22 has since discharged 2/19/2016 and facility staff has successfully begun following the new procedure for disposable insulin pen needle removers for resident R15 on 2/15/2016. H. The Director of Nursing or her designee will be responsible for completion. I. Correction Date: 3/4/2016 INSULIN PEN NEEDLE PREPARATION, USE AND DISPOSAL POLICY POLICY All licensed staff will be made aware of the proper procedure for the insulin pen needle preparation, use and disposal. PURPOSE: To ensure safe and proper insulin pen preparation, use and disposal according to manufacturer's instructions. PROCEDURE Preparation 1. Check insulin orders and dose against physician orders. 2. Wash hands	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 441	Continued From page 22 During an interview on 2/9/16, at 9:41 a.m. the director of nursing stated she was not aware of a procedure for cleaning the insulin pen needle protector/remover. The facility policy and procedure for Insulin Pentip Needle Removers dated 10/15, lacked directives for cleaning of the insulin pen tip needle removers.	F 441	3. Clean the rubber seal on the pen with an alcohol wipe. 4. Take the peel tab off the pen needle. 5. Holding the outer cover, push and screw the needle onto the pen in a clockwise direction until it meets resistance. 6. Pull ONLY the outer cover straight off. 7. Always check the flow in the pen needle before each injection by priming the device with an airshot, dial 2 units, point the pen up and press the button. 8. A drop or stream of liquid should appear at the needle tip, IF NOT, repeat as recommended by the pen's instructions. If the pen still does not prime, change the needle and repeat the above priming steps. Use & Disposal 1. After cleaning and priming the insulin pen, dial the physician ordered dose on the pen per manufacturer's instruction. 2. Put on gloves, prep skin by cleaning with an alcohol wipe. 3. Pinch skin and insert the needle straight into the skin in one continuous motion until the Clear Outer Shield retracts and the White Sleeve is flush with the skin. 4. Maintain constant pressure against the skin and deliver the dose by depressing the button with your thumb. Do Not withdraw the needle from skin until the dose has been completely delivered. 5. Once the entire dose has been given, lift the pen away from the skin. The inner shield will automatically deploy and lock in place. A RED indicator band will appear confirming shield is locked in place and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 441	Continued From page 23	F 441	the pen needle has been used. 6. Always hold the pen needle by the white sleeve when removing. 7. Unscrew the pen from the pen needle until the two are separated. 8. Pen connection end is protected. Protection is confirmed when orange shield deploys and covers the needle. 9. Do Not place your fingers on the activated shields. 10. Discard the used pen needle into a sharps collector. 2/15/16 Direct Care Audit-Insulin Administration Date: Resident: Licensed Staff: Type of Cares Observed: YES NO Did the staff wash their hands before and after direct contact with the resident? Did the staff explain the task being performed to the resident? Did the staff clean the top of the insulin pen with Alcohol before placing the needle? Did the staff prime the needle with 2 units of insulin before dialing up correct dose? Did the staff wash their hands before donning gloves?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 441	Continued From page 24	F 441	Was any education provided to the resident? Was any education provided to the staff? If so, explain below Did the staff remove thepen tip with the disposable remover and place in sharp container? Did the staff wash their hands after giving insulin to the resident? Did the staff document in a timely manner after procedure completed? Comments (if any): If you answered NO for any of the questions, please write a brief explanation on back. If you would like other areas added to the audit, please notify Nicole Nguyen, DON Upon completion, turn in this sheet to Nicole Nguyen, DON Person completing Audit: Teaching Provided to Staff or requested	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 441	Continued From page 25	F 441	by Staff:	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean, homelike and sanitary environment for 6 of 12 residents' rooms (Rooms: 1, 4, 6, 7, 9, 10) reviewed with dusty ceiling vents, burnt out bathroom lights, loose hanging privacy curtains, and uncleanable and/or soiled surfaces. Findings Include: On 2/9/16, at 8:30 a.m. an environmental tour was conducted with the maintenance director (MD) and the following was verified and observed: Room 1, the bathroom ceiling vent had a thick coating of dust. On the room privacy curtain	F 465	Teaching Provided to Resident or requested by Resident: F465 A. It is Facility practice to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. B. The facility has reviewed and revised the General Housekeeping Guidelines policy for appropriateness. C. All facility staff members will be educated to the General Housekeeping Guideline for reporting environmental concerns in resident rooms 3/3/16. D. Room 1: Bathroom ceiling vent has been cleaned and is free of dust and all privacy curtain hooks have been replaced and curtain is hanging properly 3/2/16. E. Room 4: Bathroom ceiling vent has	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 465	Continued From page 26 between the resident's beds all hooks were not attached causing the curtain to hang loose. Room 4, the bathroom ceiling vent had a thick coating of dust. The bathroom was dark. The light over the sink had two lights, one of which one was burnt out. Room 6, the bathroom ceiling vent had a thick coating of dust. On the room privacy curtain between the resident's beds all hooks were not attached causing the curtain to hang loose. Room 7, there was foam pipe insulation approximately three feet long secured with zip ties on the outer side of the bed frame, creating an uncleanable surface. Room 9, the bathroom ceiling vent had a thick coating of dust. The bathroom was dark. The light over the sink had two lights of which one was burnt out. In addition the light above the sink had a clear plastic cover on the bottom that had two white areas that were approximately four inches by two inches and one area that was approximately two inches by one inch. One end of the cover was held in place by two exposed, pointed screws. The cover was soiled with dust and had areas of paint on it. A glass shelf with chrome brackets above the bathroom sink was soiled with a white substance along the edges of the glass and on the chrome brackets. Room 10, the bathroom floor had a dark build up around edges of the floor and toilet. During the environmental tour on 2/9/16, at 8:30 a.m. the MD stated the ceiling vents were cleaned as he saw they needed cleaning. The	F 465	been cleaned and is free of dust and lights over sink have been replaced and are in working order 3/2/16. F. Room 6: Bathroom ceiling vent has been cleaned and is free of dust and all privacy curtain hooks have been replaced and curtain is hanging properly 3/2/16. G. Room 7: Foam pipe insulation has been removed from bed frame to maintain a cleanable surface 2/9/16. H. Room 9: Bathroom ceiling vent has been cleaned and is free of dust and lights over sink have been replaced and are in working order, clear plastic cover over light in bathroom is clean and free of white paint areas and dust, clear plastic cover over light in bathroom has had screws replaced and no points are exposed, and glass shelf with chrome brackets has been cleaned and is free of white paint 3/4/16. I. Room 10: Bathroom floor edges and toilet have been cleaned and are free of dark build-up 3/4/16. J. Facility wide audit of all resident rooms has been completed to ensure all bathroom ceiling fans are clean and free of dust, bathroom lights above the sink have working bulbs, clear light covers have no screw points sticking out, light covers are clean and free of dust and paint, glass shelves are free of white areas and brackets are clean, and bathroom floors and toilets are clean and free of dark build-up around the edges 3/2/16. K. Facility resident room audits for safe, functional, sanitary, and comfortable environment will be completed weekly for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 465	Continued From page 27 MD did not have a schedule for cleaning the vents. Burnt out lights were replaced if he saw them or someone told him. Room 9's shelf and light was missed when the rooms were cleaned after painting. The MD was unaware of the loose hanging privacy curtains or the foam on the bed frame. The bathroom floor in room 10 would need to be cleaned. The MD stated he repaired or cleaned these areas as he saw them. On 2/9/16, at 11:45 a.m. housekeeper-A stated housekeeping use to clean the bathroom vents but now the MD did it. The facility's General Housekeeping Guidelines policy updated in 2014, indicated to report all equipment malfunctions or breakdowns to the supervisor and maintain cleanliness in resident rooms.	F 465	60 days then monthly for 90 days and continue quarterly thereafter. L. The Administrator or her designee will be responsible for completion. M. Correction Date: March 5, 2016 Fitzgerald Nursing Home & Rehab Policy: General Housekeeping Guidelines Purpose: To keep the facility in a neat, clean, safe, and comfortable manner and follow infection control procedures as required by state and federal regulations. • Keeps carts, equipment, and area cleaned and properly stored at the end of the shift. • Performs specific daily housekeeping tasks as assigned. (see housekeeping checklist) • Performs isolation cleaning in accordance with established infection control procedures. • Maintains adequate daily supplies in closets and cleaning carts and notifies supervisor of supply. • Reports all equipment malfunctions or breakdowns to the supervisor and/or maintenance director. • Maintains cleanliness in resident's room. • Maintains work areas in a clean, safe, and sanitary manner. • Keeps carts and equipment in good working condition, report equipment malfunctions and breakdowns via maintenance Repair Requisition form, and properly store all materials at the end of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 465	Continued From page 28	F 465	each work shift • Report any missing property complaints and/or concerns to Charge Nurse, Environmental Services Manager, Social Service Designee, or Administrator. • Follows proper techniques in the use of chemicals and potentially hazardous materials in the workplace and insures that established infection control and universal precaution practices are maintained. • Maintains standards of resident privacy and confidential. • Performs other duties as assigned. Fitzgerald Nursing Home & Rehab Weekly/Monthly/ Quarterly Environmental Audit Date: Comments Are all Ceiling Vents clean? Y or N Are all curtains in rooms on hooks? Y or N Are all light bulbs in working order? Y or N Resident rooms free of paint splatters? Y or N Are there any exposed screws anywhere? Y or N Are all bathroom tiles and toilets clean	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 465	Continued From page 29	F 465	and free of debris or build up? Y or N Person Auditing: _____ _____ Management: _____ _____ Update 2/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	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 Fitzgerald Nursing Home & Rehab 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 445 Minnesota Street, Suite 145 St. Paul, MN 55101 or by email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2016

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
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Fitzgerald Nursing Home & Rehab is a 1-story building with a partial basement. The building was constructed in 1959, with one addition in 1996. The original building and the addition are Type II(111) therefore, the building was inspected as one building. The building also contains a mental health unit operated by others. The mental health portion of this building is not properly separated and was inspected on this date. The ESRD is properly 2 hour fire rated separated. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 24 beds and had a census of 22 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 7 of 22 residents, visitors, and staff members of the facility. Findings include: On facility tour between 10:30 PM to 3:30 PM on 02/09/2016, observations revealed, that there was a 1/2 inch by 4 inch hole in the ceiling tile that is located outside the entry doors to the Wellstone Behavioral Health Unit.	K 017	K017: 1. On February 10, 2016 the ceiling tile with the hole was replaced with a new one. 2. The Maintenance Director is responsible for monitoring this monthly. 3. Correction Date: February 10, 2016.	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor.	K 017		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 11 of 78 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, observation revealed that there was a penetration found around the sprinkler piping that is passing through the 1 hour smoke barrier above the smoke barrier doors outside of resident room #8. This deficient condition was verified by a Maintenance Supervisor.	K 025	K025: 1. On March 1, 2016, the loose sheetrock was secured and all penetration areas from both sides of the wall/firestop were sealed with fire rated caulking. 2. The Maintenance Director is responsible for monitoring this semiannually. 3. Correction Date: March 1, 2016.	3/4/16
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a	K 027		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 4 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. . Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, observation revealed that the smoke barrier doors by resident room #8 had doors with a gap greater than 1/8 of an inch between the meeting edges of the door leaves. This deficient condition was verified by a Maintenance Supervisor.	K 027	K027: 1. On February 10, 2016, an aluminum strip/astragal was put in place to repair the smoke barrier door gap. 2. The Maintenance Director is responsible for monitoring this semiannually. 3. Correction Date: February 10, 2016.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 7 of 22 residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, observation revealed, that the door leading to the old dialysis that was turned into a storage room had a door that was missing door knob. The missing door knob has left a 2 inch hole in the door that is open to the corridor. This deficient condition was verified by a Maintenance Supervisor.	K 029	K029: 1. On February 13, 2016, the door leading to the old dialysis had a doorknob installed. 2. The Maintenance Director is responsible for monitoring this. 3. Correction Date: February 13, 2016.	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 047	K047:	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 047	Continued From page 6 facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect 22 of 22 residents, staff and visitors from the lack of properly identified means of egress in the event of and emergency. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, it was observed that the exit light that is located in the main dining room is not readily visible from all location and does not provide a directional arrow identifying the exit door. This deficient condition was verified by a Maintenance Supervisor.	K 047	1. On February 18, 2016, a new EXIT light sign was installed in a position that is readily visible from all locations and with directional arrows visible to identify the exit. 2. The Maintenance Director is responsible for monitoring this. 3. Correction Date: February 18, 2016.	
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete fire evacuation policy in accordance with in the event of a fire emergency in accordance with NFPA 101 Life Safety Code section 19.7.1.1. This deficient practices could affect 22 of the 22 residents, staff, and visitors in the event of an emergency.. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, during the documentation review the following deficient conditions were found affecting	K 048	K048: 1. On March 1, 2016, the facility's existing fire evacuation policy for the protection of all patients and for their evacuation in the event of an emergency was located. 2. The facility's policy for fire evacuation was revised and updated in accordance with NFPA 101 Life Safety Code section 19.7.1.1. to address all of the requirements of a written health care occupancy fire safety plan 3/3/16. 3. Completion Date: 3/3/16. 4. The facility's floor sketch was	3/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 7 the facility's emergency evacuation plan and policy: 1. the facility's floor sketch was not current nor accurate and did not identify the fire separations or smoke barriers that are located throughout the facility 2. the current policy was incomplete and did not address all of the requirements of a written health care occupancy fire safety plan. This deficient condition was verified by a Maintenance Supervisor.	K 048	reviewed and will be revised and posted to include current and accurate identification of the fire separations or smoke barriers that are located throughout the facility by 3/11/16. 5. Correction Date: 3/11/16. Fitzgerald Nursing Home & Rehab FIRE EMERGENCY PLAN for DRILLS OR ACTUAL FIRE A. IF YOU DISCOVER A FIRE 1. Rescue anyone in immediate danger. 2. Pull or call out for someone to pull the nearest fire alarm box. (List of pull stations in Disaster Plan Book). 3. If alarms do not sound call 911. 4. Charge Nurse is to assign someone to alert other departments as to whereabouts of the fire by stating "STRAWBERRIES" in the dining room, tub room etc. When calling to the basement call the Kitchen at #109 and let them know where the fire is. They will notify others on the lower level. 5. Charge Nurse is to assign someone to call the Administrator, Director of Nursing and Maintenance Director and let them know of the situation. 6. Confine the fire by shutting doors of room with the fire. 7. Fight the fire with extinguishers and other available means, if the fire is small and can be contained. 8. The person in charge of the building/emergency responders will determine if evacuation of the residents and staff is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 8	K 048	9. Do not use the elevator, use the stairs. 10. The person in charge will appoint one person to stay in lobby to direct the fire department to the location of the fire when they arrive. 11. Person in charge will designate someone to make sure all residents are accounted for. 12. Wait for instructions from the person in charge and/or emergency personnel. SPECIAL INSTRUCTIONS FOR DEPARTMENTS during an ACTUAL FIRE A. PERSON IN CHARGE 1. Ensure that all residents are accounted for and that they are removed from the danger area and out of the "smoke corridor" (behind 2 sets of fire doors). 2. Assign staff person to lobby to direct fire department to area of the fire. 3. Assign staff person to remove Emergency MAR binder and current resident list from the building. 4. Call or assign someone to call Wellstone @ 218-471-4327 and Dialysis @ 744-3226 to let them know where the fire is or ask if there is a problem on their units. B. OFFICE PERSONNEL 1. Close doors and windows. 2. Put resident list and other records and cash in safe, if the fire is in a nearby area. 3. Stand by to assist where needed. C. ALL OTHER STAFF 1. Assist in removing all residents from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 9	K 048		

the fire area and out of the smoke corridor. (Behind 2 sets of fire doors).
2. Close all doors and windows in the immediate area of the fire.
3. Shut off any equipment and oxygen that is not essential.
4. Remove medical records such as Emergency MAR binder and current resident list to a safe area as directed by the person in charge; if necessary take them out of the building.
5. Report to the fire area with an extinguisher to aid in putting out the fire.
6. DO NOT O TO AREA OF FIRE IF THE FIRE IS ON THE LOWER LEVEL O BOILER ROOM.
7. Report to person in charge for further instructions.
8. Stand by to assist where needed.

DIETARY
1. One staff person is to stay by the phone until instructed as to the location of the fire. This person is then to;
a. Alert all persons in the basement area of the fire and make sure all staff, visitors and others are guided to the nearest safest exit. DO NOT USE ELEVATOR.
b. Close all doors and windows.
c. Turn off all stoves, ovens and other equipment.
d. Report to person in charge for further instructions.
e. Stand by to assist where needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 10	K 048	FIRE DRILLS 1. Follow the steps used in an actual for in beginning of policy. 2. Person in charge is to notify Maintenance Director when area is all clear. 3. Maintenance Director will then notify other staff that all is clear. 4. Fire drills are to be varied with the times and dates, they need to be done monthly and on all shifts. 5. Fire drills reports need to be completed whenever a drill or actual fire occurs. 6. You must completely fill out the facility form. They are found at the nurse's station and in the Maintenance Dept. The completed form is then given to the Maintenance Director who keeps it on file for review by the state and federal agencies. Remember R.A.C.E. R-RESCUE AND MOVE ANYONE IN DANGER TO SAFE AREA. A-ALERT, SOUND THE ALARM, CALL FIRE DEPARTMENT (911). C-CONFINE, CLOSE ALL DOORS. E-EXTINGUISH, FIGHT THE FIRE IF SAFE or EVACUATE PERSONS TO SAFETY Remember P.A.S.S. P- PULL THE PIN OF THE EXTINGUISHER A-AIM AT THE BASE OF THE FIRE S-SQUEEZE THE HANDLE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 11	K 048	S-SWEEP SIDE TO SIDE IN THE EVENT OF A SOUNDING ALARM- The fire safety company will call and say they have an alarm sounding- we need to tell them if it is a false alarm OR if we do not know why it is sounding. If we know why it is sounding (ex: burnt toast, smoking in the building etc.) Tell them to cancel, we do not need the fore department. IF YOU DO NOT KNOW REASON FOR ALARM- TELL THEM TO SEND THE FIRE DEPARTMENT. They will also ask for a code word-the code word is "WINTER". WHAT TO DO WHEN WE DO NOT KNOW WHY THE ALARM IS SOUNDING. FOLLOW THE FIRE PLAN AND MAKE SURE ALL RESIDNTS ARE SAFE AND ACCOUTNED FOR. WHEN THE FIRE DEPARTMENT ARRIVES THEY NEED TO BE INFORMED OF ANY INFORMATION YOU HAVE GATHERED-ex: a pull station has been activated, there is a lit smoke detector, you smell smoke and where you smell it. WHAT TO DO WHEN WE KNOW WHY THE ALARM IS SOUNDING: TO SILENCE THE ALARM 1. Go to the ELECTRICAL room by the elevator on the lower level. (door opens hard and it is heavy) Light switch is to the right of the door as you enter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 12	K 048		

2. There is a large tan metal box marked Fire Alarm Control.
3. Keys for this box are in the Maintenance Department and on the Charge Nurse key-ring.
4. Unlock box and open the door.
5. There is a small black board on the inside on the bottom of the panel.

Normal City Tie

Disconnect

Alarm Silence

Trouble Silence

Reset

Fuse

6. Slide the Alarm Silence switch-the one with the yellow shading above and arrow pointing to it. This should silence the alarm. DO NOT RESET THE SYSTEM

If the alarm does not stop sounding it means that a pull station has been activated and you will need to search the building to see which station has been pulled. (There is a list of pull station locations in the Disaster Plan Books) Any pull station that has been tampered with will have the door ajar unless it is on the Wellstone side- they have a keyed system and it is impossible to tell which one of them could have been used, they have 5 pull stations on their side. If you cannot find a pull station that has been tampered with- the fire department will investigate and reset the system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 13	K 048		

In case of a false alarm (when we know the reason for the alarm sounding), you will need to call Vince so he can come in and reset the system.

If you have an alarm sounding and you do not know the cause, the fire department will be here, remember they are in charge. Designate someone to call Vince, or another designated person to tell them what has happened. Follow the fire plan.

If no pull stations have been activated- there may be a sprinkler that has been activated and staff will need to look for water spraying from a sprinkler head.

HOW TO CHECK FOR AN ACTIVATED SMOKE DETECTOR
All smoke detectors (the round cream colored devises on the ceiling) have a RED light on them that will be lit when the alarm has detected smoke.
If you see a detector that is lit- be sure to make note of the location to tell the fire department or Vince.

EVACUATION PLAN
A total evacuation of the building should only take place if a major disaster makes the total building uninhabitable.
I. The person in charge is responsible to:
A. Notify the Administrator and the Maintenance Director.
B. Make the decision to evacuate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 14	K 048	building. C. The person in charge assigns staff to: 1. Call Laura Korpi or John Rauzi @ Eveleth Fire Department at 744-4875 or 911 and identify yourself by name, position, name of facility. Tell operator that "we need help in transporting residents for evacuation". 2. Transfer residents, visitors and staff to front parking lot to buses for further evacuation. (be sure to provide blankets etc. in cold weather) 3. Use current facility resident list to insure that all residents have been moved. II. To secure additional manpower, the following procedure is followed: A. The nurse in charge determines the need for additional staff to assist in evacuation. B. If this is determined the charge nurse will assign a person to call in additional staff. Evacuation routes are posted: A. Main level in front lobby B. Basement C. Hallway on upper level D. Nurse's station IF BEDS NEED TO BE REMOVED FROM THE BUIDLING YOU MUST USE THE LIBRARY DOOE FOR THE EXIT. ALL PERSONS IN PLASTIC BEDS WILL NEED TO BE TRANSFERRED TO A WHEELCHAIR OR OTHER MEANS OF TRANSPORTATION, PLASTIC BEDS DO NOT ROLL OR SLIDE WHEN OCCUPIED. Updated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 15	K 048	3/3/16	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of 22 of 22 residents. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had he following deficient conditions affecting the facility's fire drills: 1. the facility could not provide documentation for 1 overnight shift fire drill in the 3rd calendar quarter. 2. the facility did not vary the time of 3 of 4 of the	K 050	K050: 1. On March 3, 2016, the facility fire drill practices were reviewed and the requirement for varying the fire drill times throughout each shift will be corrected during future fire drills by varying the drill times throughout each shift with documentation in the Life Safety Code Book. 2. The overnight fire drill in the 3rd calendar quarter will be performed as scheduled and documented in the Life Safety Code Book. 3. The Maintenance Director is responsible for monitoring this. 4. Correction Date: March 3, 2016	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 16 2nd Shift fire drills, 3 of the 4 fire drills were held in the 2 PM hour. This deficient condition was verified by a Maintenance Supervisor.	K 050		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 22 of 22 residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, observations revealed the following deficient conditions: 1. During the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or	K 052	K052: 1. On February 10, 2016, the fire alarm panels located in the basement boiler room are now secured and locked. The keys for the lockset are now located in the Maintenance Department. 2. On February 9, 2016, the Fire Drill procedure was reviewed and the deficiency of failure to document and/or verify tests of the digital alarm communicator transmitter will be performed quarterly on the 3rd shift as required. 3. The Maintenance Director is responsible for monitoring this quarterly and annually. 4. Correction Date: February 10, 2016	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 17 verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT). 2. During the facility tour it was revealed that the fire alarm panels located in the basement boiler room were not lock or secured from tampering and that the keys to the panels were left in the lockset. This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 22 of 22 residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, a review of documentation and interview with the Maintenance Supervisor revealed that at the time of the inspection the	K 062	K062: 1. On March 3, 2016, the fire sprinkler flow test documentation was reviewed and closer monitoring of the quarterly flow tests will be performed to ensure that one flow test is performed within each calendar quarter. 2. The Maintenance Director is responsible for monitoring this. 3. Correction Date: March 3, 2016.	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 18 facility could not provide any documentation for 1 of 4 quarterly fire sprinkler flow test having been completed. This deficient condition was verified by a Maintenance Supervisor.	K 062		
K 067 SS=D	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 an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect 22 of 22 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and interview with the Maintenance Supervisor, that the facility could not provide any documentation for the smoke and fire damper testing at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 067	K067: 1. On March 3, 2016, the facility's fire and smoke damper test/inspection documentation was reviewed. 2. This deficiency will be corrected by performing a complete examination of all facility fire/smoke dampers in the building to include complete documentation by March 18, 2016. 3. The Maintenance Director is responsible for monitoring this. 4. Correction Date: March 18, 2016.	3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect 22 of 22 residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, observations revealed the following deficient conditions: 1. There is an unapproved multiple plug adaptor was found in the lounge area across from the reception desk by the main entry. 2. The electrical panel that contains the breaker for the fire alarm panel that is located in the basement boiler room was not secured. 3. There was combustibles being stored directly in front of the electrical panels located in the basement boiler room. This deficient condition was verified by a Maintenance Supervisor.	K 147	K147: 1. On February 10, 2016, the unapproved multiple plug adaptor in the lounge area across from the reception desk by the main entry was replaced with an approved 15 amp grounded surge protector power strip. 2. On February 10, 2016, the electrical panel that contains the breaker for the fire alarm panel located in the basement boiler room has been secured and locked. The keys for the lockset are now located in the Maintenance Department. 3. On February 10, 2016, the combustibles stored in front of the electrical panel have been removed from the front of the electrical panel and are now stored in an appropriate location. 4. The Maintenance Director is responsible for monitoring this. 5. Correction Date: February 10, 2016.	3/4/16
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire	K 154		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 20 watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 22 of 22 residents, visitors and staff. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, observations made during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire sprinkler system out of service policy. This deficient condition was verified by a Maintenance Supervisor.	K 154	K154: 1. On February 29, 2016, the facility's existing automatic sprinkler/fire alarm out-of-service policy was located. 2. The facility's automatic sprinkler/fire alarm out of service policy was revised and updated to include correct contact information for the State Fire Marshall. 3. The Maintenance Director is responsible for monitoring this. 4. Correction Date: 3/3/16. Fitzgerald Nursing Home & Rehab SUBJECT FIRE SAFETY IN CASE OF SYSTEM SHUT DOWN POLICY It is the policy of this facility in accordance to the Life Safety Code that in the event that the sprinkler or alarm system is not operable for a period of 4 hours or more the following plans will be put in place. PROCEDURE 1. Maintenance will notify the Administrator and or the person in charge that the system is down and give an estimated time of reactivation. 2. State Fire Marshall (James A. Anderson) at 320-616-2463 will be notified. 3. The facility will assign a staff member	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 21	K 154	(non-essential ex., hskp, laund, or diet, if possible) to be on Fire Watch. This person is to watch all areas with a visual tour for fire and report to the person in charge. 4. All smoking in the building will be banned. 5. Close all corridor doors if smoke or fire is present. (Remember the doors will not automatically work when the system is not operating). 6. Inform all staff that the sprinklers and/or fire system is not operating and remind them of facility policy. 7. Notify local fire department at 744-4875 and inform them our system is not operational at this time and they will be notified by 911 or telephone in case of emergency. 8. All persons previously notified of system shut down will be re-notified when system is up and running again. Updated 3/3/16	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire	K 155	K155: 1. On February 29, 2016, the facility's existing automatic fire alarm/sprinkler out-of-service policy was located.	3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 22 alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 22 of 22 residents, visitors and staff. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/09/2016, observations made during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire alarm system out of service policy. This deficient condition was verified by a Maintenance Supervisor.	K 155	2. The facility's automatic fire alarm/sprinkler out of service policy was revised and updated to include correct contact information for the State Fire Marshall. 3. The Maintenance Director is responsible for monitoring this. 4. Correction Date: 3/3/16. Fitzgerald Nursing Home & Rehab SUBJECT FIRE SAFETY IN CASE OF SYSTEM SHUT DOWN POLICY It is the policy of this facility in accordance to the Life Safety Code that in the event that the sprinkler or alarm system is not operable for a period of 4 hours or more the following plans will be put in place. PROCEDURE 1. Maintenance will notify the Administrator and or the person in charge that the system is down and give an estimated time of reactivation. 2. State Fire Marshall (James A. Anderson) at 320-616-2463 will be notified. 3. The facility will assign a staff member (non-essential ex., hskp, laund, or diet, if possible) to be on "Fire Watch". This person is to watch all areas with a visual tour for fire and report to the person in charge. 4. All smoking in the building will be banned. 5. Close all corridor doors if smoke or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 23	K 155	fire is present. (Remember the doors will not automatically work when the system is not operating). 6. Inform all staff that the sprinklers and/or fire system is not operating and remind them of facility policy. 7. Notify local fire department at 744-4875 and inform them our system is not operational at this time and they will be notified by 911 or telephone in case of emergency. 8. All persons previously notified of system shut down will be re-notified when system is up and running again. Updated 3/3/16	