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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WUED

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245594**
2.STATE VENDOR OR MEDICAID NO.
(L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL- MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/06/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 02/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 4/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/25/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5594
On 01/06/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 02/13/14, the Minnesota Department of Public Safety completed a PCR in additon to a Federal Monitoring Survey (FMS) also being completed on 02/13/14 . Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 11/21/13 standard survey, effective EFFECTIVE DATE. Refer to the CMS 2567b for both health and life safety code and the FMS PCR.

Effective November 15, 2011, the facility is certified for 50 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245594

March 20, 2014

Ms. Terrie Frank, Administrator
Gil- Mor Manor
96 Third Street East
Morgan, Minnesota 56266

Dear Ms. Frank:

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

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

Effective January 30, 2014 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 28, 2014

Mr. James Broich, Administrator
Gil- Mor Manor
96 Third Street East
Morgan, Minnesota 56266

RE: Project Number S5594023, F5594023, and H5594012

Dear Mr. Broich:

On December 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department's Office of Health facility Complaints for an abbreviated standard survey, completed on November 15, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 21, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health, Licensing and Certification Program, 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 the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required.

On January 14, 2014 a surveyor from the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) at your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F).

On January 28, 2014 CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicare admissions, effective February 15, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of January 28, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation programs (NATCEP) for two years from February 15, 2014.

On January 6, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 13, 2014 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 an abbreviated standard survey on November 15, 2013, standard survey completed on November 21, 2013 and the Federal monitoring survey (FMS) Completed on November 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 28, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard abbreviated survey, completed on November 15, 2013, standard survey completed on January 6, 2013 and the Federal monitoring survey (FMS) effective February 13, 2014 and therefore remedies outlined in our letter to you dated January 28, 2014, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245594	A. Building B. Wing	1/6/2014

Name of Facility	Street Address, City, State, Zip Code
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**12/28/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/28/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KS/KJ	Date: 1/23/2014	Signature of Surveyor: 03048	Date: 1/6/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/21/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245594	A. Building B. Wing	1/6/2014

Name of Facility	Street Address, City, State, Zip Code
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**12/28/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/28/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** KS/kfd	**Date:** 02/28/2014	**Signature of Surveyor:** 08769	**Date:** 01/06/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 11/21/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245594	01 - MAIN BUILDING 01	2/13/2014

Name of Facility	Street Address, City, State, Zip Code
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0017	12/28/2013	ID Prefix Reg. # NFPA 101 LSC K0052	12/28/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	02/28/2014	03049	02/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/19/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245594	A. Building B. Wing **01 - MAIN BUILDING 01**	2/13/2014

Name of Facility	Street Address, City, State, Zip Code
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **01/24/2014**	ID Prefix	Correction Completed **01/23/2014**	ID Prefix	Correction Completed **01/23/2014**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0052	
ID Prefix	Correction Completed **01/30/2014**	ID Prefix	Correction Completed **01/24/2014**	ID Prefix	Correction Completed **01/24/2014**
Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed **01/20/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0147		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	2/28/2014	03049	02/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/14/2014				

FAX to: Number of Pages: 17

CCN: 245594 (3 mo) DPNA Date: 02/15/2014

Facility Name: Gil-Mor Manor (6 mo) Termination Date: 05/15/2014

City and State: Morgan, MN POC Received Date: 02/06/2014

FMS Survey Date: 01/14/2014

(POC date) Plan Of Correction Federal Surveyor Number: 32897

(TW date)Temporary Waiver Contractor Surveyor Number:

(AW date) Annual Waiver

S/S	K-Tag	
E	K25	POC 1/24/14
E	K27	POC 1/23/14
F	K52	POC 1/23/14
E	K56	POC 1/30/14
E	K62	POC 1/24/14
F	K144	POC 1/24/14
E	K147	POC 1/20/14

Approved: YES By: David Fliess Date: 02/07/2014

Morgan Memorial Foundation, Inc.
d.b.a. Gil-Mor Manor

January 30, 2014

David Fliess, Safety Engineer
Centers for Medicare and Medicaid Services
Division of Survey ad Certification
233 North Michigan Avenue
Suite 600
Chicago, Illinois, 60601-5519

Dear Mr. Fliess,

Enclosed are our plans of correction for the deficiencies which we were cited with from your visit on January 14, 2014. We believe that we have met all the requirements for an acceptable plan of corrections for the cited deficiencies.

I am asking that you process this as soon as possible so that we are within the required three month months of being in compliance, February 15, 2014, so that we do not have the summary of enforcement remedies imposed on Gil-Mor Manor.

If you should have any questions please feel free to contact me 507-227-1677 which is my cell number. I am leaving on vacation on January 31, 2014 for a week trip to Hawaii and I am trying to make sure that everything is taken care of in my absence. I will be returning on February 8, 2014.

Sincerely,

Jim Broich

Jim Broich
Administrator

96 Third Street East
Morgan, MN 56266
507-249-3143 Telephone
Office Fax 507-249-2310
Nurses Station Fax 507-249-2287

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 1/14/14 following a Minnesota Department of Health Survey on 11/19/13. At this Comparative Federal Monitoring Survey, Gil-Mor Manor 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 related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Gil-Mor Manor is a one story slab on grade building with no basement of Type II (000) construction that was built in 1961. The building is fully sprinklered and there is supervised smoke detection located in the corridors and spaces open to the corridors. The facility has 35 certified beds. All 35 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 33. The requirement at 42 CFR, subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	SEE ATTACHED POC	1-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Brock — TITLE: ADMINISTRATOR — (X6) DATE: 1/30/14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 025	Continued From page 1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide properly fire-stopped smoke barriers in accordance with LSC Section 19.3.7.3. This deficient practice could affect 10 of the 33 residents, as well as an undetermined number of staff and visitors. Findings include: On 1/14/14 at 2:30 pm, observation of the smoke barrier above the ceiling tiles by the therapy room revealed a 1/2" annular gap around a 2" sprinkler pipe and a 6" by 8" hole with several data lines passing through. This deficient practice was confirmed by the Administrator and the Maintenance Director at the time of discovery.	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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:	K 027	See Attached POC	1-23-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 2 Based on observation and interview, the facility failed to provide doors in smoke barrier walls that met the requirements of NFPA 101 - 2000 edition, sections 19.3.7.5, 19.3.7.6 and 8.3.4. This deficient practice could affect 20 of the 33 residents, as well as an undetermined number of staff and visitors. Findings include: On 1/14/14 at 2:20 pm, observation revealed that the serving door leading into the kitchen was in a smoke barrier wall and did not have a self closer. This deficient practice was confirmed by the Administrator and the Maintenance Director at the time of discovery.	K 027		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to test and maintain the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4, 9.6 and 9.6.1.4, as well as, NFPA 72 - 1999 edition, Sections 7-3.1,	K 052	See Attached POC	1-23-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 3 7-3.2 and 7-5.2.2. This deficient practice could affect all 33 residents as well as an undetermined number of staff and visitors.. Findings include: On 1/14/14 at 11:00 am, review of the document titled "2013 Fire Alarm Report" revealed that the annual fire alarm system test and inspection report did not include all of the pull stations. The document titled "2012 Fire Alarm Report" revealed that there were 18 pull stations in the facility and the document titled "2013 Fire Alarm Report" only reported testing of 16 pull stations. When the surveyor asked why the numbers had changed, the Maintenance Director stated "I'm not sure why they didn't test all of the pull stations." This deficient practice was confirmed by the Administrator and the Maintenance Director at the time of discovery.	K 052		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	See Attached POC	1-30-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 056	Continued From page 4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7: NFPA 13 - 1999 edition, Sections 5-1.1, 5-4.6.4, and 5-6.5.2.3. This deficient practice could affect 10 of the 33 residents as well as an undetermined number of staff and visitors. Findings include: On 1/14/14 at 3:10 pm, observation revealed in the corridor by the Employee Entrance there were two different types of sprinklers installed. The corridor had standard response sprinklers and quick response sprinklers installed. This deficient practice was confirmed by the Administrator and the Maintenance Director at the time of discovery.	K 056		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2.2.1.1, 2-4.1.4, 9-7, 9-7.1 and Table 2-1. This deficient practice could affect 15 of the 33 residents as well as an undetermined	K 062	See ATTACHED POC	1-24-14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 5 number of staff and visitors. Findings include: 1. On 1/14/14 at 2:35 pm, observation in room 48 revealed a 1" annular gap around a 1.5" sprinkler pipe passing through the ceiling tile adjacent to a sprinkler. 2. On 1/14/14 at 2:45 pm, observation revealed in the east wing janitor closet ceiling three 4" by 2" holes each with several 1/2" electrical conduits passing through that were not properly firestopped. 3. On 1/14/14 at 3:05 pm, observation revealed in the laundry room a 1 foot by 2 feet missing section of ceiling tile directly above the dryer and adjacent to a sprinkler. These deficient practices were confirmed by the Administrator and the Maintenance Director at the time of discovery.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to test the emergency generator in	K 144	See ATTACHED POC	1-24-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

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K 144	Continued From page 6 accordance with the requirements of NFPA 101 - 2000 edition section 19.5.1 and 9.1.3; NFPA 110 - 1999 edition, Sections 6-4 and 6-4.2.2; as well as NFPA 99 - 1999 edition Section 3-4.1.1.2. This deficient practice could affect all 33 residents as well as an undetermined number of staff and visitors. Findings include: On 1/14/14 at 11:40 am, review of the document titled "Emergency Generator - Monthly Test Log" revealed that each monthly tests' load was documented at 10kw for the past year. When asked what load is being applied to the generator when it's being tested, the Maintenance Director stated, "When the electrician was here he calculated 10kw and so I just write in 10kw each month. When asked if the amperage was being recorded during each load test and used to calculate the load, the Maintenance Director stated "No, I've just been writing in 10kw." This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 144		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to install and maintain the electrical system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.5.1 and 9.1.2, as well as, NFPA 70 - 1999 edition. This deficient practice could affect approximately 15 of the 33 residents as well as an undetermined number of	K 147	See Attached POC	1-20-14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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	Continued From page 7 staff and visitors. Findings include: 1. On 1/14/14 at 3:00 pm, observation revealed in the employee break room a refrigerator, coffee pot, and large vending machine plugged into a power strip. 2. On 1/14/14 at 3:20 pm, observation revealed in the boiler room two large fans plugged into a power strip. These deficient practices were confirmed by the Administrator and the Maintenance Director at the time of discovery.	K 147		

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January 29, 2014

Plan of Correction - NFPA 101 Life Safety Code Standard

K25 (SS = E)
The facility failed to provide properly fire-stopped smoke barriers in accordance with Life Safety Code, Section 19.3.7.3. At the time of the survey, it was observed that the smoke barrier above the ceiling tiles next to the therapy room revealed a ½" annular gap around a 2" sprinkler pipe and a 6" by 8" hole with several data lines passing through that were not properly fire-stopped with sealant or foam.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
The facility Maintenance Director ordered a supply of fire sealant spray foam and fire caulking to be used to seal areas within smoke barriers. On 01/24/2014, the Maintenance Director filled gaps using the fire sealant spray foam and fire caulking around the sprinkler pipe and the 6" by 8" hole with data lines passing through it.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
A thorough building walk through was performed by our Maintenance Director on 01/20/2014 to identify and seal any additional smoke barrier problem areas to ensure compliance with this Life Safety Code regulation.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
Moving forward, the Maintenance Director will incorporate an audit checklist when reconditioning rooms, resident areas and offices while performing maintenance tasks or building repairs that involve ceilings, walls, doors, smoke barriers, or sprinkler system in order to prevent this deficient practice from occurring in the future.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;
Quarterly, the Administrator and the Maintenance Director will conduct a facility inspection/walk-through in order to monitor continued compliance with this Life Safety Code.

The date that each deficiency will be corrected. Facility completion date was 01/24/2014.

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K027 (SS = E)
The facility failed to provide doors in smoke barrier walls that met the requirements of NFPA 101 – 2000 Edition sections 19.3.7.5, 19.3.7.6 and 8.3.4. The service door to the kitchen dish room was in a smoke barrier wall and did not have a self-closer.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
On 01/23/2014, our Maintenance Director and Protection Systems installed an auto-closure, a magnetic lock and connected it to our existing system to bring our facility in compliance with NFPA 101 – 2000 Edition.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
By installing the auto-closure, magnetic lock to this door and connecting it to our existing system, this correction will help prevent injury or harm to residents, visitors and staff in the event of fire in the kitchen.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
Moving forward, the Maintenance Director will incorporate an audit checklist when reconditioning rooms, resident areas and offices while performing maintenance tasks or building repairs that involve ceilings, walls, doors, smoke barriers, or sprinkler system in order to prevent this deficient practice from occurring in the future.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;
Quarterly, the Administrator and the Maintenance Director will conduct a facility inspection/walk-through in order to monitor continued compliance with this Life Safety Code.

The date that each deficiency will be corrected. Completion date was on 01-23-14.

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K052 (SS = F)
The facility failed to test and maintain the fire alarm system in accordance with the requirements of NFPA 101 - 2000 Edition, sections 19.3.4, 9.6 and 9.6.1.4 as well as NFPA 72 – 1999 Edition, sections 7-3.1, 7-3.2 and 7-5.2.2. The facility's annual fire inspection results show discrepancies in the number of pull stations from year to year as well as in the number of ion and photo detectors.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
Protection Services arrived at Gil-Mor Manor on 01/23/2014 and conducted a thorough review of all pull stations as well as ion and photo detection devices. As a result of this inspection, it was determined that in previous inspections and testing performed by Protection Systems, they included the clinic in the numbers of manual fire alarm boxes and detectors. The correct number of devices at Gil-Mor Manor are as follows; Manual Fire Alarm Boxes = 13; Ion Detectors = 11; Photo Detectors = 17.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
Each year during our annual fire alarm system test and inspection, the Maintenance Director will accompany the vendor during their entire visit in order to ensure that all aspects of their annual visit is addressed and completed as required and that there are no unexplainable discrepancies.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
Each year during our annual fire alarm system test and inspection, the Maintenance Director will accompany the vendor during their entire visit in order to ensure that all aspects of their annual visit is addressed and completed as required and that there are no unexplainable discrepancies.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;
The Maintenance Director and the Administrator will review and compare the annual fire alarm system test and inspection to previous years in order to identify any discrepancies and ensure that the vendor did a thorough inspection and performed all of the necessary tests.

The date that each deficiency will be corrected. The completion date to bring the facility in compliance was 01/23/2014.

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K56 (SS = E)
The facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 – 2000 Edition, Sections 19.3.5 and 9.7: NFPA 13 – 1999 Edition, section s 5-1.1, 5-4.6.4 and 5-6.5.2.3. During the survey, observation revealed in the corridor by the employee entrance there were two different types of sprinklers installed. The employee's time clock corridor had standard response sprinklers and the area by the cooler and housekeeping closet had quick response sprinklers installed.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
In 1992, Gil-Mor Manor completed an addition to east side of their existing building, beginning from the door by the time clock to the east wing of the building. In order to remedy this deficiency, the facility installed a fire rated (90 minute) smoke door between the two smoke compartments that is equipped with an auto-closure and magnetic lock and is connected to our existing fire alarm system in order to separate the smoke compartments.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
By separating these smoke compartments, this will allow for the use of the different sprinkler types in each separate area so no other residents have the potential to be affected.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
Moving forward, the Maintenance Director will incorporate an audit checklist when reconditioning rooms, performing maintenance tasks or building repairs that involve ceilings, walls, doors, smoke barriers, or sprinkler system in order to prevent this deficient practice from occurring in the future.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
Quarterly, the Administrator and the Maintenance Director will conduct a facility inspection/walk-through in order to monitor continued compliance with this Life Safety Code.

The date that each deficiency will be corrected. On 01-23-2014, Protection Systems installed the magnetic lock and connected it to our existing system and then on 01-30-2014, the Maintenance Director installed a fire rated (90 minute) smoke door between the two areas to bring the facility in compliance.

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K62 (SS = E)
The facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 – 2000 Edition, sections 19.3.5 and 9.7 and NFPA 25 – 1998 Edition, sections 2.2.1.1, 2-4.1.4, 9-7, 9-7.1 and Table 2-1. During the survey, room 48 revealed a 1" annular gap around a 1.5" sprinkler pipe passing through the ceiling tile adjacent to a sprinkler, also in the janitor closet located on the east wing it was observed to have three 4" by 2" holes each with several 1/2" electrical conduits passing through that were not properly fire-stopped, then in the laundry room a 1 foot by 2 foot missing section in the ceiling tile directly above the dryer and adjacent to a sprinkler, all of these areas were not properly fire-stopped with sealant or foam.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
During the survey, room 48 revealed a 1" annular gap around a 1.5" sprinkler pipe passing through the ceiling tile adjacent to a sprinkler, also in the janitor closet located on the east wing it was observed to have three 4" by 2" holes each with several 1/2" electrical conduits passing through that were not properly fire-stopped, then in the laundry room a 1 foot by 2 foot missing section in the ceiling tile directly above the dryer and adjacent to a sprinkler, all of these areas were not properly fire-stopped with sealant or foam. The facility Maintenance Director ordered a supply of fire sealant spray foam and fire caulking to be used to seal areas within smoke barriers. On 01/24/2014, the Maintenance Director filled gaps using the fire sealant spray foam and fire caulking in room 48, the janitor closet and laundry room.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
A thorough building walk through was performed by our Maintenance Director on 01/20/2014 to identify and seal any additional smoke barrier or sprinkler system problem areas to ensure compliance with this Life Safety Code regulation.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
Moving forward, the Maintenance Director will incorporate an audit checklist when reconditioning rooms, performing maintenance tasks or building repairs that involve ceilings, walls, doors, smoke barriers, or sprinkler system in order to prevent this deficient practice from occurring in the future.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;
Quarterly, the Administrator and the Maintenance Director will conduct a facility inspection/walk-through in order to monitor continued compliance with this Life Safety Code.

The date that each deficiency will be corrected. Facility completion date for the laundry room was 01/20/2014, the completion date for room 48 was 01/24/2014 and the completion date for the janitor closet was 01/24/2014.

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K144 (SS = F)

Based on record review and interview, the facility failed to test the emergency generator in accordance with the requirements of NFPA 101 – 2000 Edition, section 19.5.1 and 9.1.3; NFPA 110 – 1999 Edition, sections 6-4 and 6-4.2.2; as well as NFPA 99 – 1999 Edition, section 3-4.1.1.2. Review of facility log revealed that each monthly test load was documented at 10kw for the past year.

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

At the time of the survey, Gil-Mor Manor was not able to provide amperage calculations for each of the generator tests. The Maintenance Technician will perform and document Gil-Mor Manor's weekly inspections and monthly generator load testing, which includes documenting the load being applied to the generator when it is tested and what the amperage was during each load test that was used to calculate the load. A warm-up and cool-down is also conducted during monthly tests that are not part of the 30 minute load test by the Maintenance Technician.

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

By having the Maintenance Director document and track his calculations will help ensure that the facility is properly performing the required monthly load tests so not other residents have the potential to be affected.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;

The Maintenance Director will add a calculation log in order to document the calculations used and the results of each monthly test.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur

Quarterly, the Maintenance Director and the Administrator will review and compare the monthly emergency generator tests to ensure that all components of the test have been performed and documented properly. This will include reviewing the calculations documented and used to arrive at the information documented in the log.

The date that each deficiency will be corrected. The completion date was 01-24-2014.

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K147 (SS = E)
The facility failed to install and maintain the electrical system in accordance with the requirements of NFPA 101 – 2000 Edition, sections 19.5.1 and 9.1.2 as well as NFPA 70 – 1999 Edition. Upon survey, it was discovered that power strips were being used in the boiler room to connect two fans for use with the cooling system and in the break room to connect the refrigerator, vending machine, and coffee machine in the break room.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
Immediately, on 01/14/2014 the power strips were taken out of service and removed from the boiler room cooling system and plugged the fans directly to an existing outlet. Also immediately, items in the break room were unplugged and only plugged in the refrigerator and vending machine. Then on 01/20/2014, the Maintenance Technician reorganized the break room to allow for proper use of the outlets in this location.

How the facility will identify other residents having the potential to be affected by the same deficient practice;
Moving forward, the Maintenance Director will incorporate an audit checklist when reconditioning rooms, performing maintenance tasks or building repairs that involve ceilings, walls, doors, smoke barriers, or sprinkler system in order to identify and prevent this deficient practice from occurring in the future.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
Moving forward, the Maintenance Director will incorporate an audit checklist when reconditioning rooms, performing maintenance tasks or building repairs that involve ceilings, walls, doors, smoke barriers, or sprinkler system in order to identify and prevent this deficient practice from occurring in the future.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;
Quarterly, the Administrator and the Maintenance Director will conduct a facility inspection/walk-through in order to monitor continued compliance with this Life Safety Code.

The date that each deficiency will be corrected. The completion date for this deficiency was 01/20/2014.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WUED

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245594**

2.STATE VENDOR OR MEDICAID NO.
(L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL- MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

4. TYPE OF ACTION: **2** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/21/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited; 1 TJC; 2 AOA; 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
X 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
	35			
(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):

At the time of the standard survey completed November 21, 2013, and the abbreviated standard survey completed November 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) whereby corrections were required as evidenced by the attached CMS-2567(s). The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Joseph Garvey, HFE NE II — 12/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3728

December 12, 2013

Mr. James Broich, Administrator
Gil- Mor Manor
96 Third Street East
Morgan, Minnesota 56266

RE: Project Number S5594024, H5594012

Dear Mr. Broich:

On November 21, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health, Licensing and Certification Program, and Public Safety. In addition, on November 15, 2013, an abbreviated standard survey was completed by the Office of Health Facility Complaints 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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;

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 all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag **for the standard survey completed November 21, 2013**), i.e., the plan of correction should be directed to:

Kathyrn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529

Telephone: (507) 537-7158
Fax: (507) 344-2723

Questions regarding all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag **for the abbreviated standard survey completed November 15, 2013**), i.e., the plan of correction should be directed to:

Kris Lohrke, Assistant Director
Office of Health Facility
Complaints Minnesota
Department of Health
O. Box 64970
St. Paul, Minnesota 55164-0970

Telephone: (651) 201-4215
Fax: (651) 281-9796

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 December 31, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 31, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

– Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff, Office of Health Facility Complaints staff, and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require

the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 15, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5594s14L&C_OHFC.tr.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	See Attached Plan of Correction approved KMS 12/26/13 RECEIVED DEC 23 2013 Minnesota Department of Health Marshall	12/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Brock — TITLE: Administrator — (X6) DATE: 12/20/13

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

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	245594	A. BUILDING _____ B. WING _____	11/21/2013

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F 279	Continued From page 1 by: Based on observation, interview and document review the facility failed to develop a plan of care to include the coordination of hospice services for 1 of 1 resident (R9) who was reviewed for hospice care. Findings include: R9 was admitted on 3/18/09, with diagnosis that included congestive heart failure (CHF), coronary artery disease (CAD) and cerebral vascular accident (CVA). Review of the nurses' notes identified the resident had experienced a decline in his health status since 8/20/13, and that R9 had been admitted to hospice services on 11/4/13. Review of R9's plan of care did not include end of life care provided by facility staff or the hospice care givers. Interview with registered nurse (RN)- B on 11/20/13 at 9:00 a.m., confirmed R9 was receiving care from hospice services. RN-B also confirmed that a plan of care had not been developed to include the resident's end of life care. Further interview with RN-B, indicated she was not aware of when the hospice nurses conducted their visits, because they did not provide the facility with a schedule. She stated she would have to call the hospice service provider to obtain R9's plan of care. Interview with RN-A on 11/20/13 at 9:25 a.m., confirmed the plan of care did not identify any interventions related to R9's current hospice services and/or end of life care. RN-A also was unsure of when the hospice nurses conducted	F 279		

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	245594	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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F 279	Continued From page 2 their visits at the facility, because a schedule had not been provided to the facility. She further indicated that occasionally the hospice nurse would call and inform the facility staff if they were coming that day. RN-A stated the communication between the facility and hospice staff could improve. Attempts were made to contact the hospice nurse for interview, without success.	F 279		
F 329 SS=D	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 drugs.	F 329	See ATTACHED PLAN of CORRECTION	12/28/13

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	245594	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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F 329	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide parameters for the use of as needed (PRN) Tylenol and Vicodin for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4 had physician orders for PRN pain medications, Tylenol and Vicodin, without identified parameters for when to use which medication. R4 was admitted with diagnoses that included: degenerative disc disease, osteoarthrosis, and chronic pain. Review of the current physician orders dated 10/31/13, included Tylenol Extra Strength 500 milligrams (mg) 1-2 tablets by mouth p.o. (per oral) every six hours as needed and Vicodin 5-500 mg 1-2 tablets p.o. every six hours as needed for pain. There were no parameters for use identified in the order nor on the medication administration record to determine which pain medication (Tylenol vs. Vicodin) should be used to treat R4's pain. No parameters were identified to determine whether to administer 1 or 2 tablets of either medication. When interviewed on 11/21/13 at 10:20 a.m., RN-C confirmed there had been no parameters defined to differentiate when to administer PRN Vicodin versus PRN Tylenol, nor when to use 1 or 2 500 mg tablet. When interviewed on 11/12/13 at 11:10 a.m., RN-B stated that R4 that pain would be assessed	F 329		

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F 329	Continued From page 4 by how R4 exhibited symptoms, such as grunting, arching her back and/or appeared uncomfortable. She confirmed that no parameters had been identified for the use of either medication.	F 329		

Morgan Memorial Foundation, Incorporated
d.b.a. Gil-Mor Manor and Gil-Mor Haven
96 Third Street East
Morgan, MN 56266
Telephone 507-249-3143
Fax 507-249-2310

Plan of Correction

F279 (SS=D) 483.20(d), 483.20(k)(1) Develop Comprehensive Care plans

Resident 9 was admitted to hospice on 11/04/2013, the facility failed to obtain a copy of the care plan from the hospice provider in order to develop a comprehensive care plan with measurable objectives and timetables that meets this residents medical, nursing, mental and psychosocial needs, in addition, no hospice contact information or hospice staffing schedule was found in this medical record. The hospice provider was contacted to provide the missing information and stated they were not aware that they are required to provide an individualized care plan to the facility. Hospice providers contact information and staffing schedule was received and placed in the resident medical record. On 12/10/2013, the facility received a copy of the hospice care plan and placed in the resident's medical record. The Hospice care plan will be utilized to create a comprehensive care plan for the hospice resident.

The facility will utilize a hospice admission checklist to ensure that all components necessary to provide adequate care for each resident admitted to hospice. This way we will be able to track items such as the hospice providers care plan, contact numbers and staffing schedule, etc. for each resident admitted on hospice. Education will be provided to ensure that all licensed nursing staff and social worker understand the process and why we need to complete this checklist for all new hospice admissions. The facility implemented the use of the hospice admission checklists on 12/16/2013.

The DON will conduct monthly audits, for six months, of all hospice residents' records to ensure that the hospice admission checklist is in place and that we have the hospice plan of care in the resident's medical record. Results of these audits will be reviewed at the quarterly Quality Assurance meetings.

The charge nurse will review all resident records to determine if other residents are on a hospice stay. If the resident is on hospice the charge nurse will obtain the necessary documentation that we need from the hospice provider using the hospice admission checklist. The hospice care plan will be utilized to develop a comprehensive care plan for the hospice resident.

This deficiency and plan of correction will be discussed at the next Quality Assurance meeting on 12/23/2013.

The DON or her designee will be responsible to perform the audits to ensure continued compliance. Completion date is 12/28/2013.

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Hospice Provider Checklist

Resident Name: _____

DOB: _____

Hospice Admission Date: _____

Physician: _____

Hospice Diagnosis: _____

Name of Hospice Provider	Address	Telephone/Fax

Resident Emergency Contact Information

Contact #1	**Contact #2**	**Contact #3**
Name: Address:	Name: Address:	Name: Address:
Home: Cell: Work:	Home: Cell: Work:	Home: Cell: Work:

Hospice Election Form: ☐ Date: _____ Initials _____

Hospice Care Plan: ☐ Date: _____ Initials _____

Hospice Schedule for Services: ☐ Date: _____ Initials _____

Medicare Secondary Payer Form: ☐ Date: _____ Initials _____

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Plan of Correction

F329 (SS=D) 483.25(l) Drug regimen is free from unnecessary drugs

Resident 4 was found not to have an adequate diagnosis for her Seroquel 50mg to be given orally, twice daily. The facility contacted her physician to obtain an appropriate diagnosis or rationale as to why this medication was prescribed. Her physician responded stating that this medication is given to control this resident psychosis related to major depression with anxiety.

Resident 4 was found to be prescribed both Tylenol 500 mg, 1 to 2 tablets every six hours as needed for pain, and Vicodin 5-500mg, 1 to 2 tablets every six hours as needed for pain. According to the medical record, there were no parameters set according to the pain scale to determine which medication to administer. The facility contacted the resident's physician to obtain parameters and the following order was received on 11/22/2013 and gave the following parameters for medication administration every six hours,

Tylenol 500 mg, 1 tablet if pain is rated 1 to 2;

Tylenol 500 mg, 2 tablets if pain is rated 3 to 4;

Vicodin 5-500 mg, 1 tablet if pain is rated 5 to 7

Vicodin 5-500mg, 2 tablets if pain is rated 8 to 10

The charge nurse will review all resident records to review pain medications, if two or more pain medications are ordered and the diagnosis warrants the use of the two pain medications, the charge nurse will contact the physician. The results will be discussed at the Quality Assurance meeting on 12/23/2013.

In the event that a physician prescribes two or more pain medications for a resident, the facility will send for a clarification to his or her physician. This clarification will include the physicians prescribed parameters for each pain medication to be given according to the facility's pain scale by using verbal and non-verbal pain rating. Verbal being rated from "1" meaning the least amount of pain level and "10" meaning the worst pain level and non-verbal methods of determining pain, vocal complaints of pain, facial expressions, body actions and/or behavioral indicators.

All licensed nurses and trained medication aides will receive education and training on reviewing pain medications when two or more pain medications are ordered by the physician. Licensed nursing staff will obtain clarification from physician giving specific medication parameters to identify when and how much pain medication should be administered based on pain levels. Individualized education and training will be completed by 12/27/2013.

In order to prevent this in the future, quarterly audits will be completed by the Director of Nursing to review resident's use of antipsychotic medications and to ensure that adequate

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diagnoses are given. Audit will include, monitoring for side effects, effectiveness, continued need for medication or possible reduction of medication, and proper diagnosis. The audit findings of antipsychotic medications will be reviewed at our quarterly Quality Assurance meetings.

This deficiency and Plan of Correction will be reviewed at our quarterly Quality Assurance meeting on 12/23/2013.

The Director of Nursing or her designee will be responsible to perform the audits to maintain compliance. Completion date is 12/28/2013.

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Antipsychotic Medication Monitoring

Resident Name: _____

DOB: _____

Physician: _____

Medication Name/Dosage: _____

MedicationStart Date: _____

Diagnosis: _____

Last reduction date	
Side effects of medication	
Ongoing monitoring of the resident to evaluate effectiveness in achieving the therapy goal	
An appropriate indication for use of medication	
Specific and documented goal of medication	
Behaviors warranted for use of medication?	
Is the use of medication for the duration needed and at the lowest effective dose	
If no reduction, is there documentation from MD to justify need to continue medication?	
Has family signed consent for use of medication and aware of risks and benefits?	

Anxiety is not an appropriate diagnosis for the use of an antipsychotic medication.

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

F5594022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 19, 2013. At the time of this survey, Gil Mor Manor was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 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 55101-5145, or	K 000	POC ok TB 12-23-13 RECEIVED DEC 23 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-31-13

EXIT: 11-21-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Brorck	Administrator	12/20/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Gil-Mor Manor was constructed as follows: The original building was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1989 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a complete automatic fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 32 at time of survey. 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	K 017	See Attached Plan of Correction	12/28/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 017	Continued From page 2 Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend 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 the 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, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation, the facility had a use area which was not separated from the corridor in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. In a fire emergency, this deficient practice could adversely affect 12 of 35 residents. FINDINGS INCLUDE: On 11/19/2013 at 11:40 AM, observation revealed The Restorative Room on the Central Wing corridor was a space open to the corridor system, and was not equipped with electrically supervised automatic smoke detection. This arrangement did not meet the Exception(s) at NFPA 101 (2000), Chapter 19, Section 19.3.6.1.	K 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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K 017	Continued From page 3 This finding was confirmed with the chief building engineer at the time of discovery.	K 017		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4. and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 35 of 35 residents. FINDINGS INCLUDE: On 11/19/2013 at 12:20 PM, during a review of the facility's annual Fire Alarm Test Report dated 09/03/2013, sixteen (16) Manual Fire Alarm Boxes were noted on the fire alarm system, however, no documentation was provided identifying the locations, serial numbers, and outcomes for both visual and functional test	K 052	See ATTACHED PLAN of CORRECTION	12/28/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL- MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

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K 052	Continued From page 4 results for each of these Alarm Initiating Devices. As such, it could not be verified that visual and functional testing of each device on the fire alarm system had been properly conducted. This finding was confirmed with the chief building engineer.	K 052		

Morgan Memorial Foundation, Incorporated
d.b.a. Gil-Mor Manor and Gil-Mor Haven
96 Third Street East
Morgan, MN 56266
Telephone 507-249-3143
Fax 507-249-2310

Plan of Correction

K017 (SS=D) NFPA 101 Life Safety Code Standard

The facility's Restorative room located on the central wing was not equipped with electrically supervised automatic smoke detection unit. Protection Systems will be at the facility on 12-27-2013 to install and connect the hard wired, electrically supervised automatic smoke detector in the restorative room located on the central wing to our current system. The Chief Building Engineer is responsible to ensure that the deficiency is corrected and monitoring to ensure that the deficiency does not reoccur. The completion date to bring the facility in compliance is 12/28/2013

K052 (SS=F) NFPA 101 Life Safety Code Standard

The facility's annual fire alarm test report dated 09/03/2013, did not include the locations, serial numbers and outcomes for both the visual and functional test results of the 16 manual fire alarm initiating devices. Protection Systems will be at the facility on 12/27/2013 to test and document the visual and functional test results for the 16 manual fire alarm initiating devices. The results report will be placed in the facility's maintenance monitoring and audit book for review by the Administrator and Fire Marshall. The Chief Building Engineer is responsible for the correction and monitoring to prevent the deficiency from reoccurring. The completion date to bring the facility in compliance is 12/28/2013.