DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVI	CES	
					AND TRANSMITTAL	ID: WUED	_	
					TE SURVEY AGENCY	Facility ID: 00542	2	
 MEDICARE/MEDICAID PROVIDE (L1) 245594 	R NO.	3. NAME AND AI (L3) GIL- MOR		CILITY		4. TYPE OF ACTION: <u>7 (</u> L8)		
2.STATE VENDOR OR MEDICAID N	0.	(L4) 96 THIRD S	STREET EAST	r		1. Initial 2. Recertification 3. Termination 4. CHOW		
(L2) 220043100		(L5) MORGAN, MN			(L6) 56266	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF C (L9)	. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SU (L9) 01 Hospital			ORY 09 ESRD	<u>02</u> (L7) RD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 01/06/	2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	D 15 ASC		L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	Y IS CERTIFIED	AS:		I		
From (a):		X A. In Complia			And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements ce Based On:		2. Technical Personnel	6. Scope of Services Limit		
12. Total Facility Beds	35 (L18)	1	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	 7. Medical Director IF)8. Patient Room Size 		
			1		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	35 (L17)		npliance with Prog ents and/or Appli		: * Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDOV	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
35								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Kathryn Serie, Unit Supe	rvisor	ſ	2/28/2014		Kamala Fiske-Downing, 1	Enforcement Specialist		
· · ·			02/28/2014	(L19)		4/10/20	14 (L20)	
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILI	TY		IPLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Pa	urticipate	RIGI	HTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	(L21)							
	(121)				1			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	1ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNINC	J DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> <u>00</u>			
11/01/1991					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safet ement 06-Fail to Meet Agreement	У	
(L24)	(L41) 27. ALTERNATI	VESANCTIONS	(L25)		03-Risk of Involuntary Terminatio	m		
25. LTC EXTENSION DATE:		n of Admissions:			04-Other Reason for Withdrawal	07 <u>HER</u> 07-Provider Status Change		
(1.27)	1		(L44)			00-Active		
(L27)	B. Rescind Su	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	30	2. DETERMINATION	N OF APPROVAT	DATE				
		01/25/2014						
	(L32)			(L33)	DETERMINATION APPI	ROVAL		

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

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.



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,

Kumala 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



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))

Gil- Mor Manor February 26, 2014 Page 2

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,

Kumala 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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245594	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)) 🗅	ate
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0279	12/28/2013	ID Prefix	F0329	12/28/2013	ID Prefix _			-
-	483.20(d), 483.20(k)(1)	_	-	483.25(I)		Reg. #			-
LSC		-	LSC						-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix			-
Reg. #			Reg. #			Reg. #			
LSC		-	LSC						-
		0 "			0 "				0 "
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #		_	Reg. #		-				_
LSC		-	LSC						-
		-							-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix _			-
Reg. #		_	Reg. #			Reg. #			_
LSC		-	LSC			LSC _			-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix			-
Reg. #			Reg. #			Reg. #			
LSC		-	LSC						-
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		Da	ate:	
State Agency	,	KS/KJ	1/23/20	14	03048			1/	6/2014
Reviewed By	Reviewed	,	Date:	Signature of Surve			Da	ate:	_,
CMS RO									
Followup to	Survey Completed on:			Check for any	Uncorrected De	eficiencies. Was a	Summary of		
	11/21/2013			Uncorrecte	d Deficiencies (CMS-2567) Sent to	the Facility? Y	/ES	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245594	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/6/2014
Name	e 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	(Y	5) Date	(Y4) Item	(Y5)	Date
ID Prefix	F0279	Correction Completed 12/28/2013	ID Prefix	F0329	Correction Completed 12/28/2013	ID Prefix		Correction Completed
	483.20(d), 483.20(k)(1)	-		483.25(I)		Reg. # LSC		
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Dog #		Correction Completed
Reg. #			Reg. #		Correction Completed	Reg. #		Correction Completed
Reg. #					Correction Completed			Correction Completed
Reg. #			Reg. #			Dog #		
Reviewed I	By Reviewed	l By	Date:	Signature of S	urveyor:		Date:	
State Agen	- 10,104	1 By	02/28/203		08769		Date:	01/06/2014
Reviewed E CMS RO	by <u> </u>	л Бу	Date:	Signature of S	ourveyor:		Date:	
Followup t	o Survey Completed of 11/21/2013	n:		Check for any Unc Uncorrected De		ciencies. Was a S IS-2567) Sent to t		NO

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245594	(Y2) Multiple Construction A. Building B. Wing 01 - MA	(Y3) Date of Revisit 2/13/2014	
Name of Facility		Street Address, City, State, Zip Code	
GIL- MOR MANOR		96 THIRD STREET EAST MORGAN, MN 56266	

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(Y4) Item	(Y5)) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 12/28/2013	ID Prefix		Correction Completed 12/28/2013	ID Prefix		Correction Completed
-	NFPA 101 K0017	-	-	NFPA 101 K0052		Reg. #		
L30	K0017	-	130	K0052				
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		-	Reg. #		-			
		-		_		LSC		
		Correction			Correction			Correction
ID Due fin		Completed	ID Due fin		Completed	ID Dusfin		Completed
ID Prefix		-						
Reg. # LSC		-	Reg. # LSC			LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
		-						
Reg. # LSC		-	Reg. # LSC			Reg. # LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #		-	Reg. #			Reg. #		
		-	130					
Reviewed E	By Reviewed	l Bv	Date:	Signature of Su	wevor:		Date:	
State Agen			02/28/201	Ū	030	49	Dale.	02/13/2014
Reviewed E			Date:				Date:	
CMS RO		-		-	-			
Followup t	o Survey Completed or 11/19/2013	ו:		Check for any Unco Uncorrected Defic				NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245594	(Y2) Multiple Construction A. Building B. Wing 01 - MA	(Y3) Date of Revisit 2/13/2014	
Name of Facility		Street Address, City, State, Zip Code	
GIL- MOR MANOR		96 THIRD STREET EAST MORGAN, MN 56266	

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(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4)	Item		(Y5)	Date
		Correction			Correction					Correction
ID Prefix		Completed 01/24/2014	ID Prefix		Completed 01/23/2014		ID Prefix			Completed 01/23/2014
•	NFPA 101		0	NFPA 101			0	NFPA 101		
LSC	K0025		LSC	K0027			LSC	K0052		_
		Correction			Correction					Correction
ID Prefix		Completed 01/30/2014	ID Prefix		Completed 01/24/2014		ID Prefix			Completed 01/24/2014
Reg. #	NFPA 101		Reg. #	NFPA 101			Reg. #	NFPA 101		
LSC	K0056		LSC	K0062			LSC	K0144		
		Correction			Correction					Correction
ID Prefix		Completed 01/20/2014	ID Prefix		Completed		ID Prefix			Completed
	NFPA 101		Reg. #				Reg. #			
	K0147						LSC			
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #				Reg. #			
LSC			LSC				LSC			
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #				– "			
LSC			LSC				LSC			
Reviewed I	By Re	viewed By	Date:	Signature	of Surveyor:				Date:	
State Agen	cy P	PS/KFD	2/28/201	4	03049				02/13/2014	
Reviewed I CMS RO	By Re	viewed By	Date:	Signature	of Surveyor:				Date:	
Followup	to Survey Compl 1/14/20				y Uncorrected Defined Deficiencies (CM				YES	NO
	1/14/20	Т			•		•	-	i Eð	NU

	FAX to:		Number of Pages: 17	1
	CCN:	245594	(3 mo) DPNA Date:	02/15/2014
Facility Name:		Gil-Mor Manor	(6 mo) Termination Date:	
City a	nd 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:	
S/S	K-Tag	(AW date) Annual Waiver		
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		
				. <u></u>
				·

By: David Fliess



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

January 30, 2014

RECEIVED

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

FEB 0 6 2014

CMS-V-DS&C

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 B<mark>roich</mark> Administrator

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

ENTERS	FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE S). 0938-0391	
ATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMPL		
		245594	B. WING		01/1	01/14/2014	
AME OF PRO	DVIDER OR SUPPLIER MANOR	96 TH	DRESS, CITY, ST IRD STREET GAN, MN 562	EAST			
X4) ID PREFIX (E TAG	ACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATOR ^Y ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMEN	TS	K 000				
	Monitoring Survey for Medicare & Me 1/14/14 following a Health Survey on Federal Monitoring found not in subst requirements for p Medicare/Medicai Life Safety from F Fire Protection As - 2000 edition.	d at 42 CFR subpart 483.70(a), ire, and the related National sociation (NFPA) standard 101 a one story slab on grade					
	building with no b construction that is fully sprinklered detection located open to the corrid The facility has 3 dually certified fo	asement of Type II (000) was built in 1961. The building I and there is supervised smoke in the corridors and spaces	e				
	NOT MET as evi	-		0	∧ /	1-24-1	
SS=E	Smoke barriers a least a one half h accordance with terminate at an a protected by fire- panels and steel separate compa floor. Dampers a penetrations of s heating, ventilati 19.3.7.3, 19.3.7.	SAFETY CODE STANDARD are constructed to provide at nour fire resistance rating in 8.3. Smoke barriers may atrium wall. Windows are rrated glazing or by wired glass frames. A minimum of two rtments are provided on each are not required in duct smoke barriers in fully ducted ng, and air conditioning system 5, 19.1.6.3, 19.1.6.4	s.	SEE ATTACHED PO			
LABOBAT	DRY DIRECTOR'S OR PI	ROVIDER/SUPPLIER REPRESENTATIVE	S SIGNATURE	ADMINISTRAT	TrR	(X6) DATE	

other sateguards provide sufficient protection to the patients. (See instructions.) Exception nursing nomes, the infinings stated above are disclosable so day 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.

DEPARTMI CENTERS	ENT OF HEALTH	AND HUMAN SERVI & MEDICAID SERVI	CES CES				FORM A OMB NO.	0938-0391
STATEMENT C		(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	R/CLIA		E CONSTRUCTION 01 - MAIN BUILDING	G 01	(X3) DATE SUF COMPLET	
		245594		B. WING			01/14/2014	
NAME OF PRO	DVIDER OR SUPPLIER MANOR		96 THIR	RESS, CITY, ST. D STREET AN, MN 562	EAST		The second s	(X5)
(X4) ID PREFIX (E TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K 025	Continued From p	age 1		K 025				
	Based on observa failed to provide pr barriers in accorda This deficient prace residents, as well staff and visitors. Findings include: On 1/14/14 at 2:30 barrier above the revealed a 1/2" ar pipe and a 6" by 8 passing through. This deficient prace Administrator and time of discovery. NFPA 101 LIFE S Door openings in 20-minute fire pro- 1¾-inch thick soli protective plates from the bottom of Horizontal sliding Doors are self-cld accordance with not required to sy latching is not ref 19.3.7.7	tot met as evidenced tion and interview, the operly fire-stopped s ance with LSC Section tice could affect 10 c as an undetermined 0 pm, observation of ceiling tiles by the the mular gap around a 2 " hole with several d the Maintenance Dir AFETY CODE STAN smoke barriers have otection rating or are d bonded wood core that do not exceed 4 of the door are permi doors comply with 7 psing or automatic cli 19.2.2.2.6. Swinging wing with egress and quired. 19.3.7.5, 19 a not met as evidence	e facility moke in 19.3.7.3. of the 33 number of the smoke erapy room 2" sprinkler ata lines by the rector at the NDARD e at least a at least a at least 4. Non-rated 8 inches tted. 2.2.1.14. osing in g doors are positive 9.3.7.6,	K 027	See ATTAC	CHED POO		1-23-14

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ATEMEN	OF DEFICIENCIES	& MEDICAID SERVI (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	R/CLIA	(X2) MULTIPL A. BUILDING		RUCTION BUILDING 01		(X3) DATE SI COMPLE		
		245594		B. WING				01/14/2014		
	ROVIDER OR SUPPLIER R MANOR			NESS, CITY, ST D STREET	EAST	CODE				
(4) ID REFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	(EA)	ROVIDER'S PLAN OF CH CORRECTIVE ACT S-REFERENCED TO T DEFICIENC	TON SHO	ULD BE	(X5) COMPLETION DATE	
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION 01 - MAIN BUILDING 01	COMPL	SURVEY LETED	
		245594	в	3. WING		01/1	01/14/2014	
	ROVIDER OR SUPPLIER R MANOR		STREET ADDRES 96 THIRD MORGAN	STREET	EAST			
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	affect all 33 resider number of staff and Findings include: On 1/14/14 at 11:00 titled "2013 Fire Ala annual fire alarm s report did not inclu document titled "20 revealed that there facility and the door Report" only report When the surveyo changed, the Main not sure why they stations." This deficient prace Administrator and time of discovery. NFPA 101 LIFE S. If there is an autor installed in accord for the Installation provide complete building. The sys accordance with M Inspection, Testin Water-Based Fire supervised. Ther supply for the sys systems are equi switches, which a	This deficient practi- nts as well as an und d visitors 0 am, review of the c arm Report" revealed system test and inspe- de all of the pull station 212 Fire Alarm Repo e were 18 pull station cument titled "2013 F ted testing of 16 pull r asked why the num tenance Director sta didn't test all of the p	etermined locument t that the ection ons. The rt" s in the ire Alarm stations. bers had ted "I'm ull by the ector at the DARD m, it is Standard s, to ions of the tained in or the of . It is fully iate water kler and tamper	K 052	See Attacted 1	Poc	1-30-14	

CENTENS FOR MEDICARE & MEDICARID SERVICES OWEN NO. 08860351 STRUERLICE DEDICENCES (x) PROVERIGUE PREVENCUA DENTIFICATION NUMBER: (x) PROVERIGUE PREVENCUA BUNCT OF PROVIDER OF SUPPEY (x) PROVERION NUMBER: (x) PROVERION	DEPART	NENT OF HEALTH	AND HUMAN SERV					M APPROVED 0. 0938-0391			
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE GL- MOR MANOR STREET ADDRESS, CITY, STATE, ZP CODE 96 THIRD STREET EAST MORGAN, IN 52666 BOWDERS PLAN OF CORRECTION OR LEGUENCY MUST BE PRECEDED BY FULL REGULTORY ON LEGUENTRYING REFORMATORY PREV PREX PREV PROVIDERS PLAN OF CORRECTION CEAN OPERATIVE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMPLETION (EACH OPERATIVE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY K 056 Continued From page 4 K 056 K 056 Continued From page 4 K 056 This Standard is not met as evidenced by: Based on observation and interview, the facility Edited to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 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: 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 administrator and the Maintenance Director at the time of discovery. K 062 Sec. ATTACKED PD C. I-24-1/4 SS=E 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 Sec. ATTACKED PD C. I-24-1/4 This Standard is not met as evidenced by: Based on observation and interev	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	R/CLIA							
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 K 060 Continues risking system in accordance 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. K 062 SS=E 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 K 062 Sections 12.2.1.1, 2-4.1.4, 9.7, 9.7.1 and Table 2-1. This deficient practice could affect 15 	PREFIX	FACH DEFICIENCY MUS	T BE PRECEDED BY FULL	REGULATORY	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE				
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 2000 edition, Sections 19.3.5 and 9.7: NFPA 13, NFPA 25 9.7.5 K 062 NFPA 101 LIFE SAFETY CODE STANDARD SEE K 062 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 K 062 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	K 056	Continued From p	age 4		K 056						
fully 00 manifeste as well as an undetermined	1	Based on observa failed to install the with the requireme Sections 19.3.5 an Sections 5-1.1, 5-4 deficient practice of residents as well a staff and visitors. Findings include: On 1/14/14 at 3:10 the corridor by the two different types corridor had stand quick response sp This deficient prac Administrator and time of discovery. NFPA 101 LIFE S Required automa continuously main condition and are periodically. 19 9.7.5 This Standard is Based on observi failed to maintain accordance with Sections 19.3.5 a edition, Sections Table 2-1. This of	tion and interview, th sprinkler system in a ents of NFPA 101 - 20 ad 9.7: NFPA 13 - 199 4.6.4, and 5-6.5.2.3. could affect 10 of the as an undetermined r 0 pm, observation re e Employee Entrance s of sprinklers installed dard response sprink brinklers installed. ctice was confirmed I the Maintenance Di GAFETY CODE STAN tic sprinkler systems natined in reliable op e inspected and teste 0.7.6, 4.6.12, NFPA 1 s not met as evidence ation and interview, 1 is automatic sprink NFPA 101 - 2000 ed and 9.7 and NFPA 25 2.2.1.1, 2-4.1.4, 9-7 deficient practice cou	e facility accordance 000 edition, 99 edition, This 33 number of vealed in there were ed. The lers and by the rector at the NDARD are erating d 3, NFPA 25, ed by: the facility ler system in lition, 5 - 1998 , 9-7.1 and uld affect 15	K 062	See Attacke	20 PDC	1-24-14			

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DEPARTM CENTERS	ENT OF HEALTH	AND HUMAN SERVI & MEDICAID SERVI	CES CES				APPROVED . 0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245594		B. WING		01/1	4/2014
NAME OF PRO	OVIDER OR SUPPLIER		96 THIR	D STREET			
(X4) ID PREFIX (E TAG	EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ES REGULATORY	iD PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	Continued From p number of staff an Findings include:	-		K 062			
	revealed a 1" annu	:35 pm, observation i Ilar gap around a 1.5 Igh the ceiling tile adj	" sprinkler				
	the east wing janit holes each with se	:45 pm, observation or closet ceiling three everal 1/2" electrical on hat were not properly	e 4" by 2" conduits				
	the laundry room section of ceiling t adjacent to a sprin		sing dryer and				
	Administrator and time of discovery.	hese deficient practices were confirmed by the dministrator and the Maintenance Director at the me of discovery.				POC	1-24-14
K 144 SS=F		AFETY CODE STAN		K 144	See ATTACHED	100	1 02 0 0 1
	under load for 30	nspected weekly and minutes per month in NFPA 99. 3.4.4.1.	exercised 1				
	Based on record	not met as evidence review and interview emergency generato	, the facility				

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER ND PLAN OF CORRECTION IDENTIFICATION NUM					E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
		245594		B. WING		0	1/14/2014
	OVIDER OR SUPPLIER		96 THIR	D STREET			
(X4) ID PREFIX TAG	FACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 144 K 147 SS=E	2000 edition section 1999 edition, Section NFPA 99 - 1999 edition, Section NFPA 99 - 1999 edition, Section NFPA 99 - 1999 edition visitors. Findings include: On 1/14/14 at 11:4 titled "Emergency revealed that each documented at 100 asked what load is when it's being test stated, "When the calculated 10kw a month. When ask recorded during edition stated "No, I've ju This deficient pration Maintenance Direct NFPA 101 LIFE State Electrical wiring a with NFPA 70, No This Standard is Based on observing failed to install arr in accordance with - 2000 edition, So	age 6 age 6 age requirements of NF on 19.5.1 and 9.1.3; N ons 6-4 and 6-4.2.2; a dition Section 3-4.1.1. could affect all 33 resi- mined number of staff 40 am, review of the d Generator - Monthly in monthly tests' load w load for the past year. Is being applied to the sted, the Maintenance e electrician was here and so I just write in 10 red if the amperage w each load test and use , the Maintenance Dir st been writing in 10k ctice was confirmed to ector at the time of dis GAFETY CODE STAN and equipment is in ac ational Electrical Cod not met as evidencer ation and interview, the d maintain the electric th the requirements of ections 19.5.1 and 9.7 99 edition. This defi	IFPA 110 - as well as 2. This dents as if and locument Test Log" was When generator e Director he Okw each as being ed to rector w." DARD coordance e. 9.1.2 d by: he facility ical system of NFPA 101 1.2, as well		See Arrached		1-20-1

DEPARTI CENTER	MENT OF HEALTH	AND HUMAN SERVI & MEDICAID SERVI	CES CES			FORM	01/22/2014 APPROVED 0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	R/CLIA	(X2) MULTIPLI A. BUILDING (E CONSTRUCTION 01 - Main Building 01	(X3) DATE SL COMPLE	
		245594		B. WING		01/14	4/2014
NAME OF P	ROVIDER OR SUPPLIER				ATE, ZIP CODE		
GIL- MO	R MANOR			D STREET			
		ATEMENT OF DEFICIENCIE	-9	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
(X4) ID PREFIX TAG	FACH DEFICIENCY MUS	T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
K 147	Continued From p	200 7		K 147			
K 147	staff and visitors.	age /					
	Findings include:						
	the employee brea	:00 pm, observation r k room a refrigerator ding machine plugge	, coffee				
	2. On 1/14/14 at 3 the boiler room tw	:20 pm, observation o large fans plugged	revealed in into a				
	power strip.						
	Administrator and	actices were confirm the Maintenance Dir	ed by the ector at the				
	time of discovery.						
L						If continuati	on sheet Page 8 of

January 29, 2014

Plan of Correction - NFPA 101 Life Safety Code Standard

<u>K25 (SS = E)</u>

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.

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.

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.

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.

<u>K62 (SS = E)</u>

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, <u>room 48</u> 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 <u>laundry room</u> 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.

<u>K144 (SS = F)</u>

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.

<u>K147 (SS = E)</u>

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 AN	D HUMAN SEF	RVICES			CENTERS FOR MEDICARE & MEDICAID SERVICES					
			ICARE/MEDICAII						: WUED		
		PART	I - TO BE COMPL	ETED BY	THE STATE	SURVEY.	AGENCY	Fa	acility ID: 00542		
. MEDICARE/MEDICAID PROVIDER NO. (L1) 245594 .STATE VENDOR OR MEDICAID NO. (L2) 220043100			3. NAME AND ADDR (L3) GIL- MO (L4) 96 THIRI (L5) MORGAN	R MANO) STREE	DR	(L6) 56266		4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	_2.(L8) 2. Recertification 4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE CH. (L9)	ANGE OF OWNE	RSHIP	7. PROVIDER/SUPPL 01 Hospital	IER CATEGOI 05 HHA	RY 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	8. Full Survey After Cor			
 DATE OF SURVEY ACCREDITATION STA 0 Unaccredited 2 AOA 		/2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	Е	FISCAL YEAR ENDING 1 12/31	DATE: (L35)		
11LTC PERIOD OF CERT From (a):	TIFICATION		10.THE FACILITY IS X A. In Compliance		5:	And/Or An	proved Waivers Of T	he Following Requirements:			
To (b):			Program Requi Compliance Ba	rements		2. 7	Fechnical Personnel 24 Hour RN	6. Scope of Servic 7. Medical Directo			
12. Total Facility Beds		35 (L18)	1. Acce	•			7-Day RN (Rural SNF Life Safety Code	 8. Patient Room Si 9. Beds/Room 	ize		
13. Total Certified Beds		35 ^(L17)	B. Not in CompliaX Requirements			* Code:	B *	(L12)			
14. LTC CERTIFIED BED	BREAKDOWN					15. FACILITY	MEETS				
18 SNF	18/19 SNF 35	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37)	(L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGE	NCY REMARKS	(IF APPLICABLE S	HOW LTC CANCELLAT	ION 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 :	18. STATE SURVEY AGENCY APPROVAL	Date:
Joseph Garvey, HFE	NE II	12/26/2013 (L19)	Kate JohnsTon, Enforceme	ent Specialist 01/23/2014 (L20)
	PART II - TO BE COM	PLETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE AGEN	NCY
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pa 2. Facility is not Eligible	articipate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 1. Statement of Financial Solvency 2. Ownership/Control Interest Disc 3. Both of the Above : 	
22. ORIGINAL DATE 23. LTC AGREEMENT OF PARTICIPATION BEGINNING DATE 11/01/1991 (L41) 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTION (L27) B. Rescind Suspension Date		s: (L44)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29. INTERME 0300 (L28)	EDIARY/CARRIER NO. DI (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32. DETERMI	NATION OF APPROVAL DATE		

(L33)

DETERMINATION APPROVAL

(L32)



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding 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

Gil- Mor Manor December 12, 2013 Page 5

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 Gil- Mor Manor December 12, 2013 Page 6

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

STATEMENT OF DECENCIES PI1 PROVIDENSIPPLEXQUE VOX MULTIFIE CONSTRUCTION VOX MUL	CENTER	AS FOR MEDICARE	<u>& MEDICAID SERVICES</u>			UI	VID INU	. 0938-0391
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mes broch Administrator 12/20/13	ABOBAT	assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including funder §483.10(b)(4 This REQUIREMEN	t describe the services that are ttain or maintain the resident's physical, mental, and reing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment).			RECEIVED DEC 23 201 Manestoa Department of H Marchall	3	(X6) DATE
Any dericiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that	LABORATORY		0	NATURE		AA		(X6) DAI'E
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the relation to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days	La						1.	2/20/13
	Any deficience	cy statement ending with	an asterisk (*) denotes a deficiency wh	ich the ins	stituti	on may be excused from correcting providing	it is dete	rmined that able 90 days

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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

PRINTED: 12/10/2013 FORM APPROVED OMB NO. 0938-0391

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		DNSTRUCTION		(X3) DATE	E SURVEY PLETED
		245594	B. WING				11/2	21/2013
	PROVIDER OR SUPPLIER			96 TH	ET ADDRESS, CITY, STATE, ZIP C IIRD STREET EAST IGAN, MN 56266	ODE		
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F 279	review the facility fa to include the coord	ge 1 ion, interview and document iled to develop a plan of care lination of hospice services for who was reviewed for	F :	279				
	included congestive artery disease (CAI accident (CVA). Re identified the reside in his health status had been admitted 11/4/13.	n 3/18/09, with diagnosis that e heart failure (CHF), coronary D) and cerebral vascular view of the nurses' notes ent had experienced a decline since 8/20/13, and that R9 to hospice services on						
	life care provided b care givers. Interview with regis 11/20/13 at 9:00 a.r receiving care from confirmed that a pla developed to includ care. Further interv was not aware of w conducted their visi provide the facility w she would have to o provider to obtain F	y facility staff or the hospice tered nurse (RN)- B on n., confirmed R9 was hospice services. RN-B also an of care had not been e the resident's end of life iew with RN-B, indicated she hen the hospice nurses ts, because they did not with a schedule. She stated call the hospice service 19's plan of care.			· · · · · · · · · · · · · · · · · · ·			
EOBM CMS-22	confirmed the plan interventions relate services and/or end	on 11/20/13 at 9:25 a.m., of care did not identify any d to R9's current hospice d of life care. RN-A also was hospice nurses conducted	11	Facility	 D: 00542 I	f continue	tion shee	t Page 2 of 5

RECEIVED DEC 23 2013

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

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		245594	B. WIN	G		11/:	21/2013
	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 96 THIRD STREET EAST MORGAN, MN 56266		
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F 279 F 329 SS=D	not been provided indicated that occa: would call and infor coming that day. Ri between the facility improve. Attempts were mad for interview, without 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	cility, because a schedule to the facility. She further sionally the hospice nurse im the facility staff if they w N-A stated the communicate and hospice staff could de to contact the hospice n at success. EGIMEN IS FREE FROM ORUGS or for excessive dose (including or for excessive duration; nonitoring; or without adeq se; or in the presence of noces which indicate the dos or discontinued; or any	had vere ation urse F om any or uate se se ss ot	329		F	13 يولرو
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:	WUED11	Fa	cility ID: 00542 If continu	ation shee	et Page 3 of 5
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RECEIVED DEC 2 3 2013 Mianestoa Department of Health Marchall

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

CENTER	<u>AS FOR MEDICARE</u>	& MEDICAID SERVICES	T		<u>JMR NO. 08</u>	938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		245594	B. WING		11/21/	/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 96 THIRD STREET EAST MORGAN, MN 56266		
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F 329	Continued From pa	uge 3	F 32	9		
	by: Based on interview facility failed to prov as needed (PRN) T	NT is not met as evidenced v and document review the vide parameters for the use of Tylenol and Vicodin for 1 of 5 ewed for unnecessary				
	Findings include:					
		rders for PRN pain ol and Vicodin, without ors for when to use which				
	degenerative disc of chronic pain. Revie orders dated 10/31. Strength 500 milligu mouth p.o. (per oral and Vicodin 5-500 hours as needed for parameters for use the medication adm which pain medicat should be used to t parameters were ic	ith diagnoses that included: disease, osteoarthrosis, and ew of the current physician /13, included Tylenol Extra rams (mg) 1-2 tablets by II) every six hours as needed mg 1-2 tablets p.o. every six or pain. There were no identified in the order nor on hinistration record to determine tion (Tylenol vs. Vicodin) treat R4's pain. No dentified to determine whether 2 tablets of either medication.				
	RN-C confirmed the defined to different	on 11/21/13 at 10:20 a.m., ere had been no parameters iate when to administer PRN N Tylenol, nor when to use 1 or	-			
	RN-B stated that R	on 11/12/13 at 11:10 a.m., 4 that pain would be assessed				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: WUED	11 F	Facility ID: 00542 If contin	uation sheet F	Page 4 of 5

Manestoa Department of Health Marchall

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICESOMB NO.							0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245594	B. WING			11/2	21/2013
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F 329	grunting, arching he uncomfortable. Sh	ed symptoms, such as er back and/or appeared	FS	329			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WUED11 Facility ID: 00542

If continuation sheet Page 5 of 5



Marchall

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:	Name:	Name:
Address:	Address:	Address:
Home:	Home:	Home:
Cell:	Cell:	Cell:
Work:	Work:	Work:

	Hospice Election Form:	Date Date	: Initials	1
	Hospice Care Plan:	Date	: Initials	
	Hospice Schedule for Services:	Date	: Initials	
RECEIVED	Medicare Secondary Payer Form:	Date	: Initials	
DEC 23 2013				1

DEC 23 2013

Manestoa Department of Health Marshall

Plan of Correction

F329 (SS=D) 483.25(I) 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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Manestoa Department of Health Marchail

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.

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.



Marshall

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	FIRE SAFETY					
12-31-13	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		POCok 12-23-13		
Ze :	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.		(X)		
-21-13	Minnesota Departm Fire Marshal Divisio the time of this surv not to be in substan requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),		RECEIVE	-P	
ENIT: 11-21-13	PLEASE RETURN CORRECTION FOR DEFICIENCIES (K-	R THE FIRE SAFETY		DEC 2 3 2013		-
	Health Care Fire Ins State Fire Marshal I 445 Minnesota Stre St. Paul, MN 55101	Division et, Suite 145		MN DEPT. OF PUBLIC SA STATE FIRE MARSHAL DIV	ISION	

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							APPROVED	
							MB NO. 0938-0391	
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		245594	B. WING			11/	19/2013	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GIL- MO	R MANOR				6 THIRD STREET EAST NORGAN, MN 56266			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(25)	
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	Barbara.Lundberg@ Marian.Whitney@s							
	THE PLAN OF CO	RRECTION FOR EACH						
	DEFICIENCY MUS	T INCLUDE ALL OF THE						
	FOLLOWING INFO	RMATION:						
	1. A description of v to correct the deficient	vhat has been, or will be, done ency.						
	2. The actual, or pro	oposed, completion date.						
		title of the person ection and monitoring to nce of the deficiency.						
	The original building one-story in height, sprinkler protected a Type II(111) constru The 1989 building a has no basement, is	constructed as follows: g was constructed in 1963, is has no basement, is fully fire and was determined to be of ction; ddition is one-story in height, s fully fire sprinkler protected to be of Type II(111)						
	system with smoke spaces open to the for automatic fire de	mplete automatic fire alarm detection in the corridors and corridors, which is monitored partment notification. The ty of 35 beds and had a of survey.	101					
K 017 SS=D	NOT MET as evider	42 CFR, Subpart 483.70(a) is need by: ETY CODE STANDARD	K 01	17	See ATTACHES PLAN of CORRECTION	-	12/28/13	

Facility ID: 00542

If continuation sheet Page 2 of 5

PRINTED: 12/12/2013

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/12/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY APLETED
		245594	B. WING	i		11/	19/2013
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GIL- MO	R MANOR				96 THIRD STREET EAST MORGAN, MN 56266		
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K 017	Corridors are separ constructed with at rating. In sprinklerer required to resist the non-sprinklered buil above the ceiling. (at the underside of of permitted by Code. waiting areas, dining may be open to the conditions specified be separated from of walls if the gift shop 19.3.6.1, 19.3.6.2.1, This STANDARD is Based on observati which was not separ accordance with NF Chapter 19, Section emergency, this defi affect 12 of 35 reside FINDINGS INCLUD On 11/19/2013 at 11 The Restorative Roo corridor was a space and was not equippe automatic smoke de	ated from use areas by walls least ½ hour fire resistance of buildings, partitions are only e passage of smoke. In dings, walls properly extend Corridor walls may terminate ceilings where specifically Charting and clerical stations, g rooms, and activity spaces corridor under certain in the Code. Gift shops may corridors by non-fire rated is fully sprinklered.) 19.3.6.5	K	017			

Facility ID: 00542

If continuation sheet Page 3 of 5

		AND HUMAN SERVICES				FORM	: 12/12/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ((X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245594	B. WING	-		11/	19/2013
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GIL- MO	RMANOR				THIRD STREET EAST ORGAN, MN 56266		
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K 017 K 052 SS=F	This finding was co engineer at the time NFPA 101 LIFE SAI A fire alarm system installed, tested, an with NFPA 70 Natio 72. The system has and testing program requirements of NF This STANDARD is Based upon a revise the facility failed to r alarm system in acc Chapter 9, Section 9 19.3.4. and NFPA 7 7-3.2 and 7-5.2.2 ar emergency, this def affect 35 of 35 resid FINDINGS INCLUD On 11/19/2013 at 12 the facility's annual 09/03/2013, sixteen Boxes were noted o however, no docum- identifying the locati	nfirmed with the chief building e of discovery. FETY CODE STANDARD required for life safety is d maintained in accordance nal Electrical Code and NFPA an approved maintenance n complying with applicable PA 70 and 72. 9.6.1.4 s not met as evidenced by: ew of available documentation, maintain the building fire cordance with NFPA 101 (00) 9.6 and Chapter 19, Section 2 (1999 edition) Sections nd Table 7-3.1. In a fire icient practice could adversely ents.	K O	G	See ATTACHED PLAN O	f	12/28/13

Facility ID: 00542

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES					FORM	12/12/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL					SURVEY PLETED
		245594	B. WING	-			11/1	9/2013
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K 052	results for each of t As such, it could no functional testing or system had been p	these Alarm Initiating Devices. ot be verified that visual and f each device on the fire alarm	K	052				
	67(02-99) Previous Versions	Obsolete Event ID: WUED;	21	F	acility ID: 00542	continu	ation shee	t Page 5 of 5

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.