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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: X00M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00778

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245244**

2.STATE VENDOR OR MEDICAID NO.
(L2) **278525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM - LONG PRAIRIE**
(L4) **20 NINTH STREET SOUTHEAST**
(L5) **LONG PRAIRIE, MN** (L6) **56347**

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 **07/01/2015** (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 **70** (L18)

13.Total Certified Beds **70** (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
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, HFE NE II — 07/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/07/2015 (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
11/01/1981
(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: **00** (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/23/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245244
July 7, 2015

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, Minnesota 56347

Dear Mr. Swenson:

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 06/10/2015, the above facility is certified for or recommended for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds .

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 1, 2015

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, Minnesota 56347

RE: Project Number S5244024

Dear Mr. Swenson:

On June 1, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 21, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 12, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 21, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 21, 2015, effective June 10, 2015 and therefore remedies outlined in our letter to you dated June 1, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
245244	A. Building B. Wing	7/1/2015

Name of Facility	Street Address, City, State, Zip Code
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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 F0166 Reg. # 483.10(f)(2) LSC	06/10/2015	ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	06/10/2015	ID Prefix F0467 Reg. # 483.70(h)(2) LSC	06/10/2015
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	07/01/2015	29249	07/01/2015
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
5/21/2015	

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
245244	A. Building B. Wing **01 - MAIN BUILDING 01**	6/12/2015

Name of Facility	Street Address, City, State, Zip Code
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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 K0067	**05/29/2015**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	07/01/2015	27200	06/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/21/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: X00M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00778

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(L2) **278525100**

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(L3) **CENTRACARE HEALTH SYSTEM - LONG PRAIRIE**
(L4) **20 NINTH STREET SOUTHEAST**
(L5) **LONG PRAIRIE, MN** (L6) **56347**

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 **05/21/2015** (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 **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Carol Bode, HFE NE II — 06/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/23/2015 (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
11/01/1981
(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
Posted 06/23/2015 Co.

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

Electronically delivered
June 1, 2015

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, Minnesota 56347

RE: Project Number S5244024

Dear Mr. Swenson:

On May 21, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 21, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 21, 2015 (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 November 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to respond to a grievance for 1 of 1 residents (R18), who expressed a grievance to the facility. Findings include: R18's quarterly Minimum Data Set (MDS) dated 4/14/15, identified the resident had no cognitive impairment, was independent with activities of daily living (ADL)s and locomotion, and had diagnosis including end stage chronic obstructive pulmonary disease (COPD), asthma, and	F 166	F-166: The intent/goal is that the facility actively seeks a resolution and keeps the resident appropriate apprised of its progress toward resolution. A. Address how corrective action will be accomplished for resident found to have deficient practice. 1. Family confrence with daughter, son, social worker, director of nursing, administrator and resident #18 was set for June 4, 2015. Obudsmen was invited and was not able to attend. Family was	6/10/15

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

Electronically Signed | 06/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

(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 166	Continued From page 1 anxiety. During interview on 05/18/2015, at 6:21 p.m. R18 stated the beauty shop was around the corner from his room, and when they do finger nails and perms, the smell bothers him and makes it difficult to breathe. R18 stated the exhaust system in his bathroom does not work to get rid of the smells, and when he closes the room door, it gets too hot in his room. R18 stated he had complained about this to several staff; including a nurse and the administrator. R18 stated no one in the facility had come to talk to him about this concern, and after he went to the administrator and expressed his concerns, he was told by the administrator that he would, "Check on it," however, he has heard nothing about it. R18 stated he spoke to the maintance department about his concerns, and was told his bathroom fan doesn't work to help with the smells, however, nothing had been done to repair it. An undated, untitled, hand written document written by R18 to the facility indicated, "Can you please do fingernails and perms in a room with an exhaust fan/system. It bothers (the smell) some of the residents. Thanks!" The facility investigation and action dated 1/23/15, indicated, "There is Exhaust Fan System in Beauty shop. There are 2 Grilles located above chairs and is operational. It was brought to my attention that they are doing nails in the Lounge area and that's what is bothering residents. Perms and nails should be done in beauty shop room and may have to close door when doing." R18's Care plan dated 4/16/15, indicated R18 had alteration in respiratory status, self care deficit, and depression related to diagnosis of end	F 166	notified of conference date and time. Daughter called and could not come, 1 son was having truck trouble and the other son did not come. Resident #18 attended and we discussed all of the issues presented below. 2. Facts about the complaint were presented as well as what has been done and what will be done in regards to the complaint. 3. Due to resident #18 medical condition the facility is unable to 100% eliminate the odors in the facility, but has worked towards decreasing the odors in the facility. 4. Options were given to resident #18 that included to(1) remain in his present room knowing that due to the age of the building and where the beauty shop is located in adjacent to his room that the smells will not be totally removed and he will need to close his door to his room, turn on his air in his room, open his window in his room, go to a room on the west side of the nursing home if the smells bother him (room will be made available to him at his request. (2) Offer a room change to the west side of the nursing home down the south wing. Residents do not smell any perm smells on the south wing when perms are being given. (3) Find a different nursing home that can meet his needs better than we are able to do with our existing building. Social Worker will help facilitate move to a new nursing home. 5. 6/8/15 resident #18 chooses option #1. He wants to stay in his present room and does not want to move. Reminded him	

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F 166	Continued From page 2 stage COPD and oxygen use. The care plan did not address R18's concerns of smells bothering him. During observation on 05/20/2015, at 7:27 a.m. R18 was independently walking in his room and was using oxygen via nasal cannula. R18's room was on the east wing of the facility, which was approximately 25 feet from the beauty shop. During interview on 05/19/2015, at 11:18 a.m. staff assistant (SA)-M stated R18 often complains about the smell of the nail polish and perms coming from the beauty shop. During interview on 5/19/15, at 11:21 a.m. registered nurse (RN)-A stated R18 complains about strong smells everyday the beauty shop does someone's hair or if the facility does residents finger nails. RN-A stated R18 is so sensitive to smells, staff had to take the hand sanitizer out of his room. RN-A stated staff had offered to move R18 to the other side of the nursing home, however, the resident didn't want to move because all of his friends are on the current wing he lives on, and the kitchen is on that side of the building and the smell coming from the kitchen bothers him. RN-A stated she was unsure if R18 was offered to move down the other wing (the facility has 3 separate wings), and it has been difficult because R18 likes to have his door open to people watch and because it can get hot in his room with the door closed. During interview on 05/19/2015, at 2:04 p.m. social services (SS)-A stated she heard from staff R18 was bothered by the smells of perms and nail polish coming from the beauty shop which made it more difficult for R18 to breathe. SS-A	F 166	that there are times when staff does not know when a perm is being given, so he will need to put on his call light and ask them to shut the door to his room. He agreed to this. 6. Care planned the grievance and quarterly will be reviewed with resident #18 and family at his care conference. B. How will the facility identify other residents having the potential for the same dificient practice to occur? 1. Residents who voice or write a concern have the potential for the same deficient practice to occur. C. Address what measures will be put into place or process changes made to ensure that deficient practice will not recur. 1. Grievance policy updated and added to keep resident appropriately apprised of its progress toward resolution at each quarterly care conference by social service department. 2. Written grievance cards(comment cards) will be brought to care conference by Social Worker and will give to families and/or residents to complete if concerns voiced. Monthly at resident council comments cards will be brought to the meeting by Activity Manager and given to residents who have complaints and encouraged to fill out. If they choose not to fill out the concern, the concern will be followed through with the present process. 3. Educaton to all staff in the nursing home on the grievance process. D. Indicate how the facility plans to	

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F 166	Continued From page 3 stated the facility had offered to move R18 down a different hallway that was located by the kitchen which R18 did not want, however, she stated she did not think about offering the resident a room down the other hall which was not located by the beauty shop or the kitchen. SS-A stated she believed the facility solution was to ensure the beauty shop door was closed when they were doing nails or a perm. SS-A stated she was not sure who informed the beautician to ensure the door was closed, and she was not sure if this was being done, but expected staff would ensure this was being completed. During interview on 5/19/15, at 2:10 p.m. director of nursing (DON) stated she believed the activity staff spoke with the beautician and informed her to close the door to the beauty shop when doing a perm or nails to decrease the smell. During interview on 5/19/15, at 2:00 p.m. activities staff (AS)-A said the beauty shop door was supposed to remain closed and she informed the beautician and support staff of this. During interview on 05/19/2015, at 2:39 p.m. beautician (B)-B stated she worked on Tuesday afternoons. B-B stated she had not been informed by the facility to close the door to the beauty shop, and actually the facility had told her to make sure the door was left open because the cats litter box is kept in the beauty shop. During interview on 05/19/2015, at 2:55 p.m. RN-C stated R18 complains about the smells when there are perms done in the beauty shop or when residents have their nails painted. RN-C stated the beauty shop door is always open, and she knew R18 had expressed this concern for	F 166	monitor its performance to make sure that solutions are sustained. 1. Social Service will monitor concern forms received from staff, resident and family on a weekly basis. She will track if the concern has been resolved or not and care plan the problem if not resolved and keep the resident updated on the progress of the concern at quarterly conferences. 2. Social Service will report at the quality meeting the number of concerns received, number of unresolved concerns and discussion on those concerns that are not resolved for input from the quality council. Roxanne Ostendorf, Director of Nursing	

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F 166	Continued From page 4 several months. During interview on 05/19/2015, at 3:25 p.m. administrator stated R18 spoke with him and told him he had difficulty breathing from the smell from the beauty shop. The administrator stated he knew staff had asked R18 to move rooms, but the resident refused due to the smell from the kitchen. The administrator stated there were no further plans in place to resolve R18's complaints. During interview on 05/20/2015, at 8:37 a.m. maintenance manager (MM)-A stated R18 had been complaining for several months about the smell coming from the beauty shop. MM-A stated it would be possible to put a booster, or a larger motor with a higher RPM (revolutions per minute) on the exhaust system in the beauty shop to help with the smells. MM-A stated he had not been part of the discussion on how to resolve R18's grievance, and the exhaust system was not discussed with him to try to resolve R18's grievance. The facility Grievance procedure dated 11/3/0, indicated, "A grievance will be considered to be 'formal' if it has one or more of the following criteria: *Concern is written by individual or family about a care-related issue [not financial concerns]. *The individual or family contacts the Administration." A policy titled Quality Concern Process and Grievance Resolution revised 2/2015, indicated "Patient/Resident Complaint; A formal or informal, written or verbal grievance that is made to the facility by a client or representative when a client issue cannot be resolved promptly by staff	F 166		

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F 166	Continued From page 5 present; A complaint is also defined as whenever the client or their representative requests a response from the facility."	F 166		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 278	F-278: Facility failed to ensure each	6/10/15

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F 278	Continued From page 6 review, the facility failed to ensure the resident had a dental assessment which accurately reflected the residents current dental condition for 1 of 2 residents, (R57) reviewed for dental status. Findings include: R57's quarterly Minimum Data Set (MDS) dated 2/10/15, indicated the resident had moderate cognitive impairment, had no dental problems including no broken teeth, and was independent with activities of daily living (ADL)s and personal hygiene. During observation on 05/19/2015, at 10:49 a.m. R57 was sitting in a chair watching television. R57 was noted as having multiple missing, broken, and black teeth throughout his mouth. R57's Care plan dated 5/21/15, did not include any information regarding R57 broken, missing, or decayed teeth. During interview on 05/20/2015, at 11:28 a.m. registered nurse (RN)-D stated residents should have a full oral assessment completed upon admission, annually, and if there are any significant changes. RN-D stated she did not assess R57's teeth when she completed the annual MDS assessment, however, she should have to ensure R57 had all of his dental needs met. RN-D was unable to find any oral assessment that had been completed for R57 regarding the condition of his teeth on admission, or ongoing. RN-D was unable to verify if R57 had broken, missing, or decayed teeth upon admission. During an interview on 05/20/2015, at 11:36 a.m.	F 278	resident assessment accurately reflects the resident current dental condition. A. Address how corrective action will be accomplished for this resident found to have been affected by the deficient practice. 1. MDS RN completed oral/dental assessment on client #57 following the guidelines in the RAI manual "Steps for Dental Assessment". B. How will the facility identify other residents having the potential to be affected by the same deficient practices? 1. All residing residents have the potential to be affected by the same deficient practice to occur. C. Address what measures will be put into place or process changes made to ensure the deficient practice will not recur. 1. Reviewed the "Steps for Dental Assessment" in the RAI manual page L-2 with admitting RN's and MDS nurse. Going forward on all comprehensive assessments the dental assessments will be done following the guidelines in the RAI manual. 2. Oral health policy was updated to reflect the changes made and these were reviewed with RN's and MDS RN. 3. Dental assessment in Point Click Care was changed to include requirements from the MDS Dental Assessment guidelines. 4. All residing residents in the facility had an oral/dental assessment completed by the MDS RN to assure current accurate	

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F 278	Continued From page 7 RN-E stated R57 was admitted in 12/2013, however, there was no documentation of an oral assessment upon admission or annually. RN-E stated R57 had not seen a dentist since admission, however, it had been offered and refused. R57's Dietary assessment dated 5/11/15, did not address R57's broken, missing, or decayed teeth. The facility policy titled Oral Health Program dated 05/2010 indicated "Within the first 90 days after admission, the resident will see a dentist for an oral assessment...If the resident or family refuses dental exam their request will be honored, and again the RN will assess the condition of the oral cavity, teeth, and tooth supporting structure."	F 278	dental condition. D. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. 1. Every month for 3 months dental assessments will be audited by quality RN and DON on each resident who has had a comprehensive MDS assessment. 2. After 3 months if no negative trends found will do audit check every quarter on random selection of residents who have had a comprehensive MDS assessment in the quarter. 3. Results of auditing will be shared at the quarterly quality meeting. Roxanne Ostendorf, Director of Nursing	
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain an adequate ventilation system to effectively eliminate smells for 1 of 1 resident, R18, who had complaints of strong chemical smells from the beauty shop which made it difficult to breathe. Findings include: R18's quarterly Minimum Data Set (MDS) dated	F 467	F-467: The facility failed to have outside ventilation by means of windows or mechanical ventilation or a combination of the two. Probes to F-tag 467 are how well is the space ventilated, is there good air movement and are temperature, humidity and odor levels all acceptable?	6/10/15

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F 467	Continued From page 8 4/14/15, identified the resident had no cognitive impairment, was independent with activities of daily living (ADL)s and locomotion, and had diagnosis including end stage chronic obstructive pulmonary disease (COPD), asthma, and anxiety. During interview on 05/18/2015, at 6:21 p.m. R18 stated the beauty shop was around the corner from his room, and when they do finger nails and perms, the smell bothers him and makes it difficult to breathe. R18 stated the exhaust system in his bathroom does not work to get rid of the smells, and did not think the exhaust system in the beauty shop was adequate to ensure the chemical smell did not linger and go out into the hallway and patient rooms. An undated, untitled, hand written document written by R18 to the facility indicated, "Can you please do fingernails and perms in a room with an exhaust fan/system. It bothers (the smell) some of the residents. Thanks!" The facility investigation and action dated 1/23/15, indicated, "There is Exhaust Fan System in Beauty shop. There are 2 Grilles located above chairs and is operational. It was brought to my attention that they are doing nails in the Lounge area and that's what is bothering residents. Perms and nails should be done in beauty shop room and may have to close door when doing." R18's Care plan dated 4/16/15, indicated R18 had alteration in respiratory status, self care deficit, and depression related to diagnosis of end stage COPD and oxygen use. The care plan did not address R18's concerns of smells bothering him.	F 467	A. Address how corrective action will be accomplished for resident #18 to have been affected by the deficient practice. 1. Facility Development Director from CentraCare reviewed the beauty salon at Long Prairie LTC facility the afternoon of June 3, 2015. The review was requested due to being cited a deficiency under the tag F-467 during annual survey with a complaint from a resident about odors from the beauty shop with survey team finding there was insufficient ventilation in this area. 2. The following is what was found by David Danielson, Director of Facilities Maintenance and Facility Development. a. Mechanical ventilation is provided both for exhaust and supply to the beauty salon. b. Currently the supply ventilation is unkown. c. The beauty shop has 2 chairs for clients. d. The beauty shop is approximately 200 square feet. e. Based on current exhasut rates it appears the exhaust rate for the beauty salon in 10 ACH. f. Attempted to verify that the room was negative to the corridor although it was difficult to determine. David Danielson reviewd the report from the inspectors and found that they referenced information from the Minnesota State Rules for NEW CONSTRUCTION. This area was constructed in 1975, thus would not be subject to the new construction rules. The Minnesota State Rules does indicate for	

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F 467	Continued From page 9 During observation on 05/20/2015, at 7:27 a.m. R18 was independently walking in his room and was using oxygen via nasal cannula. R18's room was on the east wing of the facility, which was approximately 25 feet from the beauty shop. During interview on 05/19/2015, at 11:18 a.m. staff assistant (SA)-M stated R18 often complains about the smell of the nail polish and perms coming from the beauty shop. During interview on 5/19/15, at 11:21 a.m. registered nurse (RN)-A stated R18 complains about strong smells everyday the beauty shop does someone's hair or if the facility does residents finger nails. RN-A stated R18 is so sensitive to smells, staff had to take the hand sanitizer out of his room. During interview on 05/19/2015, at 2:04 p.m. social services (SS)-A stated she heard from staff R18 was bothered by the smells of perms and nail polish coming from the beauty shop which made it more difficult for R18 to breathe. SS-A stated the facility had offered to move R18 down a different hallway that was located by the kitchen. SS-A stated she believed the facility solution was to ensure the beauty shop door was closed when they were doing nails or a perm. SS-A verified she was not involved in a conversation with the facility regarding looking at the ventialtion system in place. During interview on 5/19/15, at 2:00 p.m. activities staff (AS)-A said the beauty shop door was supposed to remain closed and she informed the beautician and support staff of this. During interview on 05/19/2015, at 2:39 p.m.	F 467	areas built after June 30, 1988 the building are expected to meet ASHRAE chapter 7 of the 1982 applications handbook. The new construction rules do have the following requirements for barber/beauty shop rooms. 1. All air should be directly exhausted to the exterior (we meet this code). 2. Requires 10 ACH (we meet this code). 3. Requires the room to have a lower pressure than the room surrounding it, or be a a negative pressure to corridor. THE FOLLOWING RECOMMENDATIONS TO HELP RESOLVE THE ODOR COMPLAINTS ARE: 1. Determine the supply and exhaust ventilation utilizing a qualified balancer. 2. Adjust the supply and exhaust ventilation to ensure that the beauty salon is always negative to the surounding rooms and corridor. On June 10, 2015 at 3:00 p.m. a contractor will be coming from Premier Test and Balance to meet with David Danielson from CentraCare and our facility maintenance manager Ron Klinkhammer to check on the recommendations that were recommended by David Danielson. Per Bob Dahler the codes for building in 1975 were sent and both requirements were met. B. How will the facility identify other residents having the potential to be	

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F 467	Continued From page 10 beautician (B)-B stated she had not been informed by the facility to close the door to the beauty shop, and actually the facility had told her to make sure the door was left open because the cats litter box is kept in the beauty shop. During interview on 05/19/2015, at 3:25 p.m. administrator stated R18 spoke with him and told him he had difficulty breathing from the smell from the beauty shop. The administrator stated he knew staff had asked R18 to move rooms, but the resident refused due to the smell from the kitchen. The administrator stated there were no further plans in place to resolve R18's complaints, and the facility had not discussed the current ventilation system in the beauty shop or checked to see if it was strong enough to get rid of the smells. During interview on 05/20/2015, at 8:37 a.m. maintenance manager (MM)-A stated R18 had been complaining for several months about the smell coming from the beauty shop. MM-A stated it would be possible to put a booster, or a larger motor with a higher RPM (revolutions per minute) on the exhaust system in the beauty shop to help with the smells. MM-A stated he had not been part of the discussion on how to resolve R18's grievance, and the exhaust system was not discussed with him to try to resolve R18's grievance. MM-A verified the current exhaust system in the beauty shop should be stronger to eliminate the chemical smells.	F 467	affected by the same deficient practice. 1. Complaints from other residents about odors would have the potential for the same deficient practice. C. Address what measures will be put into place or process changes made to ensure that the deficient practice will not recur. 1. We will never be able to assure 100% of the time that odors will be eliminated. This is an individual sense and is unrealistic to eliminate all types of odors. 2. We will comply with the Minnesota statutes and codes on ventilation. 3. When complaints are voiced or written about ventilation issues we will address the concerns. We may not be able to eliminate the odor but will follow through following the grievance policy. 4. See above for corrective action steps that are being taken to reduce the odors from the beauty shop. D. Indicate how the facility will monitor its performance to make sure that the solutions are sustained. 1. Routine maintenance checks of the ventilation system for meeting Minnesota statutes and codes in the beauty shop will be done by maintenance department on a weekly check. 2. Report will be shared at the quarterly quality LTC meetings by maintenance representative on any negative findings. I Roxanne Ostendorf, Director of Nursing	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey CentraCare Health System Long Prairie NH was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/05/2015

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
	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency CentraCare Health System Long Prairie C & NC was built in 1963 with additions in 1966 and 1976. The 1963 building is 1- story, without a basement and was determined to be Type II (111) construction. In 1966 an addition to the south of the original building was built, is 1-story without a basement and was determined to be of a Type II (111) construction. The 1976 addition to the east of the 1966 addition is 1-story with a partial basement and was determined to be of Type V (000) construction. The building is divided into 6 smoke zones by 1/2 hour fire barriers. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is completely protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the	K 000		

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K 000	Continued From page 2 Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes some corridor smoke detection, with additional detection in all common areas and a doors that are held open. The fire alarm system has been installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The fire alarm has automatic fire department notification. The facility has a capacity of 70 beds and had a census of 67 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the	K 067	A & E Plumbing & Heating Inc. completed the fire and smoke damper inspection at our facility CCH-LP on 5/29/15. Inspection record with results on file. Ron Klinkhammer, Maintenance Manager	5/29/15

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K 067	Continued From page 3 safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 1:00 PM to 4:00 PM on 05/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor, that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient condition was verified by the Maintenance Supervisor.	K 067		