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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: X7IL
Facility ID: 00725

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245243**

2. STATE VENDOR OR MEDICAID NO. (L2) **375340900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRANITE MANOR**
(L4) **250 JORDAN DRIVE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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 **2/26/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

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

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

12. Total Facility Beds **48** (L18)

13. Total Certified Beds **48** (L17)

10. THE FACILITY IS CERTIFIED AS:
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
	48			
(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 :
Kathryn Serie, Unit Supervisor 04/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/04/2018 (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 **07/06/1981** (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245243

April 4, 2018

Mr. Thomas Kooiman, Administrator
Granite Manor
250 Jordan Drive
Granite Falls, MN 56241

Dear Mr. Kooiman:

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

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

Effective March 30, 2018 the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 4, 2018

Mr. Thomas Kooiman, Administrator
Granite Manor
250 Jordan Drive
Granite Falls, MN 56241

RE: Project Number S5243029

Dear Mr. Kooiman:

On February 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 26, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 30, 2018 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 January 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 30, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 26, 2018, effective March 30, 2018 and therefore remedies outlined in our letter to you dated February 9, 2018, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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(L4) **250 JORDAN DRIVE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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3. Termination 4. CHOW
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7. On-Site Visit 9. Other
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 02/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 03/20/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2018

Mr. Thomas Kooiman, Administrator
Granite Manor
250 Jordan Drive
Granite Falls, MN 56241

RE: Project Number S5243029

Dear Mr. Kooiman:

On January 26, 2018, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<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) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 7, 2018, 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 March 7, 2018 the following remedy will be imposed:

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

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.

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 April 26, 2018 (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 July 26, 2018 (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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
	245243	A. BUILDING ______ B. WING ______	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 01/23/2018 through 01/26/2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 1/23,01/24, 1/25, and 1/26/2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		2/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/16/2018

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
	245243	A. BUILDING ______ B. WING ______	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 812	Continued From page 1 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dish machine temperatures were appropriately monitored and thermometers utilized to measure food temperatures were appropriately cleaned. This deficient practice had the potential to affect 44 of 45 residents who received meals from the facility's kitchen. Findings include: During an initial tour of the kitchen with certified dietary manager (CDM)-A, on 1/23/18 at 12:23 p.m., CDM-A stated the dishwashing machine temperatures were not being recorded in accordance with facility protocol which indicated they should be recorded following every meal. Review of the manufacturers's instructions for use, and observation of the stamped label on the side of the dishwashing machine,to ensure sanitation, temperatures needed to reach a wash temperature of 150 degrees Fahrenheit (F), and a final rinse temperature of 180 degrees F. Review of the facility's printed 1990 Thermal	F 812	On 1/31/18 all Dietary Staff members responsible for the preparation, serving, and storage of food were provided education in regards to the deficient practices sited from the annual state survey inspection from January 23-Janaury 26, 2018. New temperature logs were implemented on 02/01/2018 for the dishwashers in the main kitchen and in each neighborhood. All staff responsible for observing and recording temperatures were educated on when during the dishwasher cycles that the temperatures should be read and recorded. They were also provided education on the process of what to do in the event the temperature is not getting hot enough to adequately sanitize the dishes. The dietary staff who are in charge of food preparation, storage, and serving were also provided education / instructed not to put the thermometers through the foil and on how to properly cleanse the thermometers between uses. The temperature logs for the dishwasher	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRANITE MANOR	**250 JORDAN DRIVE GRANITE FALLS, MN 56241**

(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 812	Continued From page 2 Sanitizing Dish machine Temperature Record form, for the machine used in the main kitchen, indicated for the month of January 2018 the following: One column included an area for each meal: breakfast, noon, and the evening meal service and there were areas for staff to record dish machine heat sanitation log temperature recordings. These recordings were reviewed and indicated: (1) January 1-11, had no recorded temperature logs for the breakfast or noon dish machine sanitation. (2) January 13th and 14th, had no recorded temperature logs for any of the 3 dish machine sanitation cycles. (3) January 16th, had no recorded temperature logs for for the breakfast or noon dish machine sanitation. (4) January 19th, had no no recorded temperature logs for the breakfast or noon dish machine sanitation. (5) January 22 and 23rd, had no recorded sanitizing temperatures at all. It was noted that 52 of the 93 meal services in December 2017, either fell below acceptable manufacturers's levels of heat sanitation and/or had not been recorded as monitored. Eighty one (81) of 93 meal services during November 2017 fell below acceptable manufacturers's levels of heat sanitation or had not been recorded as monitored. There was no indication on the temperature recording form to identify staff responsibilities if the wash cycle temperatures were to fall outside the manufacturer's specifications for sanitization. The form included identification of the appropriate temperatures including: 140 degrees Fahrenheit (F) wash temperature (which conflicted with the	F 812	and the food temperatures will be monitored weekly for 3 months by the dietary manager and/or dietary supervisor. The staff will be monitored weekly for 3 months by the dietary manager and/or the dietary supervisor. Staff will be monitored weekly for compliance: accurately taking food temperatures and cleansing of the thermometers between uses. Auditing will then go to monthly after that if we have maintained compliance with logging the food and dishwasher temperatures accurately and routinely. Plan of Correction was penned by Dawn Huelsman, DON and submitted as authorized by Shelby McNeil RN.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING ______ B. WING ______	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(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 812	Continued From page 3	F 812		

stamped label on the side of the dishwashing machine), and 180 degrees F for rinse temperature. There was no indication on any of the monitoring forms as to what staff were to do if the temperatures fell out of manufacturer's specification for sanitization.

Review of the printed 1990 Review of Thermal Sanitizing Dish machine Temperature Records for 2 of 2 units (B-orange and A-red) indicated temperatures fell below the necessary 150 degree wash temps and 180 degree rinse temperatures, or included no documentation for the following opportunities:
(1) January 2018, a combined 45 times.
(2) December 2017, a combines 80 times.
(3) November 2017, a combined 68 times.

The CDM was interviewed on 1/25/18, at 2:15 p.m. and agreed staff needed to follow the manufacturer's requirements for safe sanitation levels with the facility's process for monitoring those levels. The CDM stated she had not performed competency testing for dietary staff to ensure they had knowledge in the event the heat sanitation fell below the manufacturer's recommended guideline.

During interview and document review on 1/26/18, at 8:58 a.m. with the maintenance supervisor (MS), regarding the dish machines in the kitchen and on the units, the MS stated these were installed by the factory representatives with alarm defaults. However, the machines were not set to audibly alarm by default from the manufacturer. MS indicated he had not been alerted to any concerns with inappropriate sanitization. The MS further stated staff were supposed to alert him when temperatures fell

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	245243	A. BUILDING ______ B. WING ______	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

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F 812	Continued From page 4	F 812		

below the manufacturer's specifications. The MS explained he performed periodic preventative maintenance as outlined by the manufacturer once per year, unless staff alerted him via a work order to improper sanitization from the dish machines. The MS stated he had not been notified of incorrect heat sanitation readings from facility monitoring.

Interview and document review on 1/26/18 at 10:30 a.m. with the director of nursing (DON) and quality coordinator (QC) indicated they were unaware staff had not been performing monitoring of the dish machine's sanitation process as expected in the kitchen or on the units. They further agreed the form staff had used was outdated and likely from an old dish machine. The DON and QC indicated their system for monitoring dish machine temperatures was a system failure. The DON agreed staff needed to have a consistent way to monitor temperatures of the dish machines used in the facility to ensure appropriate sanitation. The DON and QC further agreed the manufacturer's specification for each machine needed to be monitored to ensure appropriate sanitation. The DON's expectation was staff were to ensure all temps were monitored and logged for every meal; if they fell below manufacturer's specifications, staff were to report that information immediately to their supervisor and/or to maintenance.

No policy/procedures related to staff monitoring the temperatures of the dish machines to ensure sanitation were provided during the survey.

Observation and interview on 1/23/18 at 5:35 p.m. with dietary aide (DA)-A indicated the food items for the supper meal service had been

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GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

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F 812	Continued From page 5 brought to the unit (orange B unit) with thermometers piercing through the tinfoil cover into each food item. DA-A stated all food comes that way from the kitchen, placed there by the cook, so unit dietary aides can easily record temperatures. Once recorded, they remove the thermometers from the tinfoil, then remove the tinfoil from the containers and proceed to serve the food. During observation on 1/25/18, at 11:14 a.m. during the noon meal service, several meal items had been brought down to the unit (red A unit) with thermometers inserted into the food through tinfoil. DA-B stated he needed to insert thermometers into those foods and check temperature readings. At that time, DA-B retrieved a thermometer from the unit kitchen, and wiped the thermometer off with a disposable cloth from a bucket of solution and placed it into a container of meatballs. After checking the temperature of the meatballs, DA-B removed the thermometer and wiped it with the disposable cloth from the bucket with a chemical solution in it prior to inserting the thermometer into a pain of hashbrowns. Upon inspection, the chemical in the bucket used to sanitize the thermometer was Diversey J-512 Sanitizer. Manufacturer instructions for use indicated the product must not be used to clean utensils, flatware or dishes. At that time, DA-B acknowledged being unaware the sanitizer was not appropriate to use to clean the thermometers. DA-B stated staff used the bucket of sanitizer water was used to clean tabletops etc. During interview on 1/25/18 at 2:15 p.m., the CDM stated she was unaware the J-512 cleaner wasn't appropriate to use for cleansing the	F 812		

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F 812	Continued From page 6	F 812		

thermometer. The CDM verified staff had no alcohol wipes available to clean thermometers with in the main kitchen.

During interview on with the director of nursing (DON) and quality coordinator (QC) on 1/26/18 at 10:30 a.m., they acknowledged the sanitizer should not have been used to disinfectant the thermometers used to temp food prior to serving.

Review of the facility's 2009 policy, Use of a Food Thermometer, indicated thermometers were inserted into food. However, the policy made no mention of potential physical or chemical contamination.

F5243027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	**250 JORDAN DRIVE** **GRANITE FALLS, MN 56241**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 24, 2018. At the time of this survey, Granite Manor Nursing Home was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/16/2018

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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. Granite Manor Nursing Home was built in 2015, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		1/25/18

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K 345	Continued From page 2 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with the 2012 edition of NFPA 101 (Life Safety Code) section 9.6.5.1 & NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 77 out of 77 residents. Findings include: During documentation review between 10:30 AM and 2:00 PM on 01/24/2018, revealed there were discrepancies in the amount of Photo detectors, Duct detectors, Heat Detectors and Supervisory Switches from the Fire alarm report 2016 to the current 2017. This deficient condition was confirmed by the Environmental Services Supervisor.	K 345	Fire alarm system- Testing ad Maintenance CFR (s): NFPA 101. We contacted the fire alar company to recheck and then issued a corrected report that has been forwarded to Fire Marshall This report does show correct amount and this will be monitored at our annual inspection by Dale Rosenau, Maintenance Director and monthly fire alarm testing is competed by maintenance department. Document was penned by Dale Rosenau, maintenance director and Dawn Huelsman, DON Manor Nursing. This document is submitted by Shelby McNeil, RN per their authority.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel.	K 901		3/23/18

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K 901	Continued From page 3 Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in the 2012 edition of NFPA 99 section 4.1. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 10:30 AM and 2:00 PM on 01/24/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the Environmental Services Supervisor.	K 901	Fundamentals- Building System Categories CFR(s): NFPA 101. Maintenance Department is developing a schedule for inspecting and documenting of building system per NFPA 99 section 4.1. Maintenance Director will be responsible for monitoring. Safety audits are completed quarterly by Care Center maintenance staff. Plan of Correction was created by Dale Rosenau, Maintenance Director and Dawn Huelsman, DON Care Center. Plan of Correction submitted per their authority by Shelby McNeil, RN.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity	K 920		3/30/18

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

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K 920	Continued From page 4 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect an undetermined amount of staff and visitors. Findings include: During the facility tour between 10:30 AM and 2:00 PM on 01/24/2018, observations revealed a nebulizer plugged into an unapproved power strip in room 450. This deficient condition was confirmed by the Environmental Services Supervisor.	K 920	Electrical Equipment- Power Cords and Extension Cords We are placing an order for UL-1363A power strips. These will be installed as soon as possible but no later than 3/30/18. These are the only power strips to be used in the facility and will be checked by Maintenance Director. Maintenance Director will be responsible. All extension cords have been removed 1/25/2018. Safety audits are will be completed quarterly. Plan of Correction was created by Dale Rosenau, Maintenance Director and Dawn Huelsman, DON. POC submitted by Shelby McNeil RN per their authority.	

Electronically delivered
February 9, 2018

Mr. Thomas Kooiman, Administrator
Granite Manor
250 Jordan Drive
Granite Falls, MN 56241

Re: State Nursing Home Licensing Orders - Project Number S5243029

Dear Mr. Kooiman:

The above facility was surveyed on January 23, 2018 through January 26, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at kathryn.serie@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
	00725	A. BUILDING: ______ B. WING ______	01/26/2018

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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	00725	A. BUILDING: ____ B. WING ____	01/26/2018

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 1/23, 1/24, 1/25 and 1/26/2018, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00725	A. BUILDING: ____ B. WING ____	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21132	MN RULE 4658.0670 Subp. 1 Dishwashing; Requirements Requirements. The dishwashing operation must provide separation in the handling of soiled and clean dishes and utensils, and must conform with either part 4658.0675 <http://www.revisor.leg.state.mn.us/arule/4658/0675.html> or 4658.0680 <http://www.revisor.leg.state.mn.us/arule/4658/0680.html> for washing, rinsing, sanitizing, and drying. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dish machine temperatures were appropriately monitored and that thermometers to measure food temperatures were appropriately cleaned. This deficient practice had the potential to affect 44 of 45 residents who received meals from the facility's kitchen. Findings include: During an initial tour of the kitchen with certified dietary manager (CDM)-A, on 1/23/18 at 12:23	21132	Corrected	2/1/18

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21132	Continued From page 3	21132		

Continued From page 3

p.m., CDM-A stated the dishwashing machine temperatures were not being recorded in accordance with facility protocol which indicated they should be recorded following every meal.

Review of the manufacturers's instructions for use, and observation of the stamped label on the side of the dishwashing machine,to ensure sanitation, temperatures needed to reach a wash temperature of 150 degrees Fahrenheit (F), and a final rinse temperature of 180 degrees F.

Review of the facility's printed 1990 Thermal Sanitizing Dish machine Temperature Record form, for the machine used in the main kitchen, indicated for the month of January 2018 the following: One column included an area for each meal: breakfast, noon, and the evening meal service and there were areas for staff to record dish machine heat sanitation log temperature recordings. These recordings were reviewed and indicated:
(1) January 1-11, had no recorded temperature logs for the breakfast or noon dish machine sanitation.
(2) January 13th and 14th, had no recorded temperature logs for any of the 3 dish machine sanitation cycles.
(3) January 16th, had no recorded temperature logs for for the breakfast or noon dish machine sanitation.
(4) January 19th, had no no recorded temperature logs for the breakfast or noon dish machine sanitation.
(5) January 22 and 23rd, had no recorded sanitizing temperatures at all.
It was noted that 52 of the 93 meal services in December 2017, either fell below acceptable manufacturers's levels of heat sanitation and/or had not been recorded as monitored. Eighty one

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21132	Continued From page 4 (81) of 93 meal services during November 2017 fell below acceptable manufacturers's levels of heat sanitation or had not been recorded as monitored. There was no indication on the temperature recording form to identify staff responsibilities if the wash cycle temperatures were to fall outside the manufacturer's specifications for sanitization. The form included identification of the appropriate temperatures including: 140 degrees Fahrenheit (F) wash temperature (which conflicted with the stamped label on the side of the dishwashing machine), and 180 degrees F for rinse temperature. There was no indication on any of the monitoring forms as to what staff were to do if the temperatures fell out of manufacturer's specification for sanitization. Review of the printed 1990 Review of Thermal Sanitizing Dish machine Temperature Records for 2 of 2 units (B-orange and A-red) indicated temperatures fell below the necessary 150 degree wash temps and 180 degree rinse temperatures, or included no documentation for the following opportunities: (1) January 2018, a combined 45 times. (2) December 2017, a combines 80 times. (3) November 2017, a combined 68 times. The CDM was interviewed on 1/25/18, at 2:15 p.m. and agreed staff needed to follow the manufacturer's requirements for safe sanitation levels with the facility's process for monitoring those levels. The CDM stated she had not performed competency testing for dietary staff to ensure they had knowledge in the event the heat sanitation fell below the manufacturer's recommended guideline.	21132		

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21132	Continued From page 5 During interview and document review on 1/26/18, at 8:58 a.m. with the maintenance supervisor (MS), regarding the dish machines in the kitchen and on the units, the MS stated these were installed by the factory representatives with alarm defaults. However, the machines were not set to audibly alarm by default from the manufacturer. MS indicated he had not been alerted to any concerns with inappropriate sanitization. The MS further stated staff were supposed to alert him when temperatures fell below the manufacturer's specifications. The MS explained he performed periodic preventative maintenance as outlined by the manufacturer once per year, unless staff alerted him via a work order to improper sanitization from the dish machines. The MS stated he had not been notified of incorrect heat sanitation readings from facility monitoring. Interview and document review on 1/26/18 at 10:30 a.m. with the director of nursing (DON) and quality coordinator (QC) indicated they were unaware staff had not been performing monitoring of the dish machine's sanitation process as expected in the kitchen or on the units. They further agreed the form staff had used was outdated and likely from an old dish machine. The DON and QC indicated their system for monitoring dish machine temperatures was a system failure. The DON agreed staff needed to have a consistent way to monitor temperatures of the dish machines used in the facility to ensure appropriate sanitation. The DON and QC further agreed the manufacturer's specification for each machine needed to be monitored to ensure appropriate sanitation. The DON's expectation was staff were to ensure all temps were monitored and logged for every meal; if they fell below manufacturer's specifications,	21132		

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21132	Continued From page 6 staff were to report that information immediately to their supervisor and/or to maintenance. No policy/procedures related to staff monitoring the temperatures of the dish machines to ensure sanitation were provided during the survey. SUGGESTED METHOD FOR CORRECTION: The Administrator and the Dietician could review and revise food service policies and procedures to assure that dishwasher temperatures are being monitored and maintained at the appropriate temperature, and to ensure sanitizers being used on food utensils are appropriate. Staff could be trained as necessary. The Certified Dietary Manager could monitor/audit the foods being served on units, to ensure temperatures are being taken in an acceptable manner, utilizing proper sanitation methods. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21132		