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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XL2V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00365

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245315**
2.STATE VENDOR OR MEDICAID NO.
(L2) **541743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRIMONT HEALTH CARE CENTER**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

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 **06/22/2015** (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)
09/30

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(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 06/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/22/2015 (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
06/01/1986
(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
06/19/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245315

June 22, 2015

Ms. Lorna Craig-Paulson, Administrator
Trimont Health Care Center
303 Broadway Avenue South
Trimont, Minnesota 56176

Dear Ms. Craig-Paulson:

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 June 12, 2015 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds..

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 22, 2015

Ms. Lorna Craig-Paulson, Administrator
Trimont Health Care Center
303 Broadway Avenue South
Trimont, Minnesota 56176

RE: Project Number S5315024

Dear Ms. Craig-Paulson:

On May 29, 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 14, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 17, 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 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 14, 2015, effective June 12, 2015 and therefore remedies outlined in our letter to you dated May 29, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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
245315	A. Building B. Wing	6/22/2015

Name of Facility	Street Address, City, State, Zip Code
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **06/07/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/07/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/07/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/07/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	06/22/2015	03048	06/22/2015
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
5/14/2015			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245315	01 - MAIN BUILDING 01	6/17/2015

Name of Facility	Street Address, City, State, Zip Code
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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 K0033	06/12/2015	ID Prefix Reg. # NFPA 101 LSC K0050	06/08/2015	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	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	06/22/2015	35482	06/17/2015
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
5/12/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: XL2V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00365

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245315**
2.STATE VENDOR OR MEDICAID NO.
(L2) **541743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRIMONT HEALTH CARE CENTER**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

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 **05/14/2015** (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)
09/30

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(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 :
Wendy Buckholz, HFE NE II 06/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/18/2015 (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
06/01/1986
(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)

Posted 06/19/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2015

Ms. Lorna Craig-Paulson, Administrator
Trimont Health Care Center
303 Broadway Avenue South
Trimont, Minnesota 56176

RE: Project Number S5315024

Dear Ms. Craig-Paulson:

On May 14, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

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 June 23, 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 14, 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 14, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure call lights were available for 1 of 1 residents (R47) interviewed who did not have a call light available. Findings include: During interview and observation on 5/11/15, at 7:15 p.m. R47 indicated she did not have an available call light. R47 indicated she was	F 246	It is the Facility's intent to ensure that call lights are available to all residents. Facility failed to ensure that call light was within reach for 1 or 1 residents (R47). All residents may be affected by this practice. Staff have been educated on the importance of ensuring call lights are within reach of the resident while in their	6/7/15

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

Electronically Signed | 06/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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 246	Continued From page 1 unaware of the appearance of the call light nor it's location. No call light was accessible to R47 in the room at the time of the interview. Upon further inspection of the room, two call light cords were noted to be attached to the wall and were located behind bed-A, with the ends clipped together. Both of the cords were located on the floor and were not within view. R47 utilized the bed designated as bed-B. R47 further indicated she did not know how to summon staff assistance other than to go out of her room to ask for assistance. R47 confirmed she was unaware whether a call light was available for her to use since admitted (5/5/15). The most recent assessment dated 5/12/15, indicated R47 had a Brief Interview of Mental Status (BIMS) score of 10/15, indicating moderate cognitive impairment. During an interview on 5/11/15, at 8:06 p.m. nursing assistant (NA)-A verified all residents were supposed to have a call light within reach located in each room. NA-A further stated she was unaware that R47 did not have a call light available within her reach. When interviewed on 5/11/15, at 8:07 p.m. licensed practical nurse (LPN)-D verified that all residents should have a call light within reach at all times. When LPN-D immediately accompanied the surveyor to R47's room and searched for the call light, it was noted the call lights for both residents residing in bed-A and bed-B were located behind bed-A. The call light was not accessible, visible nor located within reach for R47. LPN-D then questioned R47 whether she was aware of the additional call light located in the bathroom. R47 responded she was not aware of the call light located in the bathroom.	F 246	room. All staff that enter resident's room will check for call light placement before leaving the room. Charge nurse on each shift will audit one time during shift for call light placement and document on medication sheets. Administrator/DON/designate will monitor practice for 3 months with follow up through QA process to ensure substantial compliance with applicable regulations and Facility policy has been achieved. Date of Correction: June 7, 2015	

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F 246	Continued From page 2 When interviewed on 5/12/15, at 9:42 a.m. the director of nursing (DON) verified the expectation was that all residents have a call light located which is easily accessible. The DON further stated that all residents, including those able to function independently, should have a call light within reach.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and monitor a skin condition located on the forehead for 1 of 3 residents (R23) reviewed with skin issues. Findings include: During an observation on 5/11/14, at 3:49 p.m. it was noted that R23 had a nickel sized raised brownish-tan scaly area located on the right side of the forehead. Review of the quarterly minimum data set (MDS) assessment dated 2/3/15, included a Brief Interview of Mental Status (BIMS) with a score of "1", indicating severe cognitive impairment.	F 309	It is the Facility's intent that all skin conditions are identified and monitored. Facility failed to identify and monitor a skin condition for 1 of 3 residents (R23). All residents have a potential to be affected by this practice. Resident (R23) scaly area was evaluated on 5/20/2015 by his primary physician. No changes were made to current medications or treatments. Resident desires no further interventions such as surgery to area. Weekly charting has been revised to document each week on whether or not	6/7/15

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F 309	Continued From page 3 Review of the care plan dated 2/11/15 indicated R23 had a history of squamous cell CA (cancer) of left forehead, excised on 8/8/12. Review of the weekly bath/skin observation sheets dated 1/7/15 thru 5/13/15, did not identify the raised, scaly area noted on R23's right forehead. When interviewed on 5/14/15, at 11:05 a.m. the director of nursing (DON) indicated she was unaware of the raised, scaly area noted on the right side of R23's forehead. The DON stated R23 was last examined by the primary physician on 2/18/15, with no changes noted. When R23's chart was reviewed with the DON, documentation was not available which indicated the physician had ever assessed the raised area noted on the forehead. When the DON questioned licensed practical nurse (LPN)-B about the raised and scaly area on the forehead, LPN-B stated the skin condition had initially been small in size, smooth and had gradually increased in size/appearance to the current condition. After the discussion, LPN-B observed R23's forehead while he was seated in the wheelchair in the dayroom. LPN-B stated the noted area resembled the size and appearance of the previous mole-like area that had been removed by the physician (8/8/12). LPN-B indicated, after the observation, that she thought the physician would more than likely suggest to do the same with this area. LPN-B stated a recommendation that the primary physician examine the raised area on the forehead during the scheduled physician visit next week would be initiated. When interviewed on 5/14/15, at 11:47 a.m. the DON confirmed staff had not identified in the	F 309	there are any skin issues including; scaly/bruised/other skin issues and chart in nurse¿s notes. Nursing staff were educated on 6/3/15, 6/4/15, and 6/5/15; reviewed policy and procedure on skin status documentation. See attachment A The Director of Nursing and/or designee will perform monthly audits for three months to evaluate practice. Results of these audits will be reviewed at quarterly QA process to ensure substantial compliance with applicable regulations and Facility policy has been achieved. Date of Correction: June 7, 2015	

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F 309	Continued From page 4 record nor had they monitored the raised, scaly area located on R23's right forehead. The DON confirmed she would have expected staff to identify and monitor the area. When interviewed by phone on 5/14/15, at 1:46 p.m. family member/power of attorney (FM)-A stated being unaware of the raised, scaly area on the right side of R23's forehead but stated the resident had a history of raised brown scaly areas located on his body which had been removed in the past. FM-A was unaware whether these areas were cancerous or not. FM-A further stated she had not been advised by the physician nor nursing home staff of any areas of concern related to skin condition/issues. When interviewed by phone on 5/14/15, at 2:34 p.m. R23's primary physician stated he had no recollection whether he had observed the raised scaly area on R23's forehead but had not documented in his progress notes anything related to this issue. The primary physician stated the area of concern would be examined at the time of his next scheduled visit, the following week. Measurements provided by the DON on 5/14/15, at 3:15 p.m. indicated the raised, scaly located on R23's right side of the forehead measured as noted: 1 centimeter (cm) wide by 1.7 cm long.	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		6/7/15

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F 371	Continued From page 5 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain dairy products served to residents that were within the expiration date as indicated on the half gallon chocolate milk containers for 4 of 4 residents (R4, R5, R17, R45) who were served outdated chocolate milk. This practice had the potential to affect any other resident who requested chocolate milk. Finding include: During the initial kitchen tour with the certified dietary manager (CDM) on 5/11/15, at 1:33 p.m. the milk cooler located in the kitchen food service area was noted to contain chocolate milk products which were past the expiration date listed on the container. The milk products were currently used by dietary staff to serve residents. This cooler was noted to contain a half empty container of 1/2 (one-half) gallon of chocolate milk and five full 1/2 gallons of chocolate milk; all containers had an expiration date of 5/4/15 (7 days prior). When interviewed at the time of the observation on 5/11/15, at 1:33 p.m. the CDM verified the chocolate milk had an expiration date of 7 days prior and indicated the chocolate milk served earlier during the noon meal (5/11/15) would have been served from these opened milk containers.	F 371	It is the Facility's intent to ensure that food is procured, stored, prepared and served in a sanitary condition. Facility failed to maintain dairy products served to residents that were within the expiration date as indicated on the half-gallon chocolate milk containers for 4 of 4 residents (R4, R5, R17, and R45). All residents that receive chocolate milk with their meals have a potential to be affected by this practice. The half-gallon containers of chocolate milk were discarded. Dietary staff will check the dates on food and beverages daily and discard any outdated items. Staff were educated on checking dates of all food and beverages during staff meeting held on 5/28/2015.See attachment B The Dietary Director and/or designee will perform monthly audits for three months to evaluate practice. Results of these audits will be reviewed at quarterly QA process to ensure substantial compliance with applicable regulations and Facility policy has been achieved.	

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F 371	Continued From page 6 The CDM removed the five milk containers from the refrigerator and instructed dietary aid (DA)-B to dispose of them. During interview on 5/11/15, at 6:09 p.m. R17 confirmed drinking chocolate milk served at the noon meal. During interview on 5/11/15, at 6:33 p.m. R5 confirmed drinking chocolate milk served at the noon meal today. When interviewed on 5/12/15, at 3:46 p.m. the CDM verified four residents (R4, R5, R17, R45) received chocolate milk at meals. During interview on 5/13/15, at 7:53 a.m. the CDM stated all staff were suppose to check the dates on food and beverages and they all are responsible to discard any outdated items. The CDM confirmed that staff had failed to properly implement this procedure.	F 371	Date of Correction: June 7, 2015	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		6/7/15

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F 431	Continued From page 7 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure Novolog insulin was not available for use after the 28 day expiration date for 1 of 3 residents (R4) observed during insulin administration. Findings include: During observation on 5/11/15, at 5:42 p.m. licensed practical nurse (LPN)-D prepared to administer R4's physician ordered insulin dose of Novolog 70/30 16 units subcutaneous (SQ) every (Q) AM and 10 units SQ QPM. LPN-D retrieved the opened vial of insulin from the medication refrigerator. The Novolog 70/30 insulin vial was observed to have been dated 4/9/15, when	F 431	It is the Facility's intent to ensure that insulin is not utilized after the 28 day expiration date. Facility failed to ensure that insulin was not utilized after the 28 day expiration date for 1 of 3 residents (R4). Resident (R4) insulin was ordered and delivered same day. Primary Physician notified of delay in administration of insulin with no concerns noted. All residents that receive insulin may be affected by practice. Policy and Procedure on insulin outdates etc. revised and updated. Dates of	

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F 431	Continued From page 8 opened. The label indicated the insulin could be used for 28 days following the day it was opened and therefore the 28th day was 5/7/15 (4 days prior). LPN-D verified the vial of Novolog 70/30 insulin was outdated according to the documented recommendation and no additional vials of insulin were available for administration. LPN-D further verified the morning dose of Novolog 70/30 insulin had to have been administered from the identified vial as no additional vials of 70/30 Novolog insulin were available for R4. During interview with the director of nursing (DON) on 5/11/15, at 5:49 p.m. it was confirmed that no additional vials of 70/30 Novolog were available for R4 and this vial of insulin had likely been used for the previous seven doses of ordered Novolog 70/30 insulin, which were beyond the 28th day. The DON verified a new vial of insulin should have been replaced on 5/7/15. The DON telephoned Sterling Drug and spoke with the pharmacist who confirmed that Novolog 70/30 insulin expired 28 days after accessing the vial (opening) and was outdated as of 5/7/15, according to the date on the vial. During observation of medications located in the refrigerator in the medication storage room on 5/12/15, at 10:02 a.m. LPN-B confirmed that one (1) vial of Tuberculin Purified Protein was noted to be opened without a date on either the box or the vial, indicating when it was accessed. LPN-B verified the vial had been accessed, doses had been removed and administered without a date documented on the vial to monitor the expiration date. LPN-B confirmed that facility policy required multi-dose vials to be documented with the date it is opened/accessed.	F 431	expiration for insulin vials etc. to be added by nurse that opens and dates vial to a treatment card that is placed on top of insulin box with open and expiration dates. Additionally, the night nurse will review all vials on a weekly basis to check expiration dates and will notify other staff of dates. Check expiration dates added to night shift responsibilities. Nursing staff were educated on 6/3/15, 6/4/15, and 6/5/15 on the above information. The nursing team has reviewed the Facility's policy and protocol for skin concerns. See attachment C The Director of Nursing or designee will perform monthly audits for three months to evaluate practice. Results of these audits will be reviewed at quarterly QA process to ensure substantial compliance with applicable regulations and Facility policy has been achieved. Date of Correction: June 7, 2015	

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F 431	Continued From page 9 During an interview with the consultant pharmacist (CP) on 5/13/15, at 1:30 p.m. related to the expiration date of Novolog 70/30, the CP confirmed that Novolog 70/30 insulin is considered expired 28 days after the day it is opened/accessed. It was verified the Novolog 70/30 insulin with an opened date of 4/9/15 should have been expired on 5/7/15. In a subsequent interview with the DON on 5/14/15, at 12:30 p.m. it was confirmed that multi-dose vials of medication are to be dated at the time they are opened and the expiration date is to be checked prior to administration of that medication. Review of the policy titled, Medication Administration with a review date of 8/18/08, did not reference dating of multi-dose vials nor checking for dates of expiration prior to administration. Review of the policy titled, Insulin Mixing & Administration dated 8/15/08, identified the following procedure: Check the insulin for it's manufacturer's outdate and check for the date on the bottle indicating it was opened by staff (The insulin bottles should be dated when opened and are good for 2 months, after which it needs to be destroyed (flush down the sink in the Med Room)). The procedure had not been updated to include the appropriate expiration according to the type of insulin. The DON verified the policies submitted for review did not contain the necessary information and should have been reviewed and updated according to current practice and standards.	F 431		

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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 May 12, 2015. At the time of this survey, Trimont Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 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 Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/08/2015

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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto: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. Trimont Healthcare Center was constructed as follows: The original building was constructed in 1963, is one-story, has a partial basement, is fully sprinklered and was determined to be of Type II(222) construction; The 1992 Chapel Addition is one-story, has no basement, is fully sprinklered 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. All Resident Rooms are equipped with single-station, battery-operated smoke alarms. The facility has a capacity of 36 beds and had a census of 25 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 On 05-12-2015, between the hours of 9:30 AM and 1:00 PM, facility inspection revealed that the SW Stairwell door from the basement to the first floor needs to close completely when the magnetic hold open release and the door needs to positive latch device into the frame. Deficiency observed on tour while the Maintenance Director (ME).	K 033	It is the Facility's intent to comply with Life Safety Code standards. Maintenance will install an automatic flush bolt on the basement double door to the stairwell. This has been ordered, (enclosed invoice) and will be installed upon arrival on Monday June 8, 2015. See attachment A Date of Correction: June 12, 2015	6/12/15
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		6/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 3 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. Findings include: On facility tour between 0930 AM and 1:00 PM on 05/12/2015, the review of the fire drill documentation for the past 12 months (March 2014 to April 2015) revealed that the following was found: 1. The following fire drills were missed: a. 2014 - 2nd quarter - Day shift b. 2014- 3rd quarter - Night shift 2. The drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted: Day - 1346 & 1352 hours Night - 0400, 0400 & 0400 hours These deficient practices were confirmed by	K 050	It is the Facility's intent to comply with Life Safety Code standards. Maintenance will use the form enclosed to monitor dates, times, and location of fire drills to make sure they are staggered. There will be a designated time for drill on 11-7 shift effective June 1, 2015. See attachment B Date of Correction: June 8, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 4 Director of Facility Maintenance (ME) at the time of discovery.	K 050		

ATTACHMENT A

Order Details

Your Order Number: 1236632841
Your PO Number: MARK ELLANSON
Your Order is Being Prepared For:
TRIMONT HEALTH CARE CTR
303 BROADWAY AVE S
TRIMONT MN 56176-9702

Shipping Address
WW GRAINGER
BLOOMINGTON BRANCH
TRIMONT HEALTH CARE CTR
303 BROADWAY AVE S
TRIMONT MN 56176-9702

Order Summary

Product		Price	Qty	Status	Total
	Automatic Flushbolt, Metal Door Item no: 5VRE6 Sign up for Auto-Reorder	$210.50 each	1	Preparing to Ship *Expected to arrive Monday, June 08 2015*	$210.50

Subtotal	$210.50
Tax	$0.00
Freight	$11.26
Total Cost*	$221.76

Additional Order Information

Customer Information
TRIMONT HEALTH CARE CTR
303 BROADWAY AVE S
TRIMONT, MN 56176-9702

Billing Information
TRIMONT HEALTH CARE CTR
303 BROADWAY AVE S
TRIMONT, MN 56176-9702
US

Shipping Information
Deliver To
TRIMONT HEALTH CARE CTR
303 BROADWAY AVE S
TRIMONT MN 56176-9702

Additional Information
Order Date: 06/04/2015
Grainger EIN No: 36-1150280
PO: MARK ELLANSON
Customer Account number ending in: 1099
Caller: MARK ELLANSON
Telephone: 507-639-2381

We will deliver according to the following terms and conditions:
Incoterms© 2015: FOB
Freight Terms: PPA
Payment Terms: Net 30 Days after invoice date

Top Products

ATTACHMENT B

2015 Fire Drills

	Date	Time	Location
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			