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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YSLH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00467

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245356**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230080000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MCINTOSH SENIOR LIVING**
(L4) **600 NORTHEAST RIVERSIDE AVENUE**
(L5) **MCINTOSH, MN** (L6) **56556**

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) **09/24/2009**

6. DATE OF SURVEY **03/03/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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 :
Lyla Burkman, HFE NEII — 03/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 03/09/2015 (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
10/01/1986
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/06/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245356

March 9, 2015

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, Minnesota 56556

Dear Ms. Knutson:

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

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

Effective January 28, 2015 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 3, 2015

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, Minnesota 56556

RE: Project Number S5356029

Dear Ms. Knutson:

On January 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 8, 2015 that included an investigation of complaint number . 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 March 3, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 6, 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 extended survey, completed on January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 26, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective January 28, 2015 and therefore remedies outlined in our letter to you dated January 14, 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 related to this eNotice

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697 5356r15

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
245356	A. Building B. Wing	3/3/2015

Name of Facility	Street Address, City, State, Zip Code
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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 **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **01/28/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **01/28/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/28/2015**
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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** LB/mm	**Date:** 03/03/2015	**Signature of Surveyor:** 28035	**Date:** 02/06/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/8/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245356	01 - MAIN BUILDING 01	2/6/2015

Name of Facility	Street Address, City, State, Zip Code
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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 Reg. # **NFPA 101** LSC K0052	Correction Completed **01/26/2015**	ID Prefix Reg. # **NFPA 101** LSC K0056	Correction Completed **01/26/2015**	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	03/03/2015	27200	02/06/2015
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
1/6/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YSLH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00467

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(L1) **245356**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230080000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MCINTOSH SENIOR LIVING**
(L4) **600 NORTHEAST RIVERSIDE AVENUE**
(L5) **MCINTOSH, MN** (L6) **56556**

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) **09/24/2009**

6. DATE OF SURVEY **01/08/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (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
	45			
(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 :
Jana Bromenshenkel, HFE NEII — 01/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 03/05/2015 (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
10/01/1986
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2651

January 14, 2015

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, Minnesota 56556

RE: Project Number S5356029

Dear Ms. Knutson:

On January 8, 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 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
lyla burkman@state.mm.us
Telephone: (218) 308-2104
Fax: (218) 308-2122

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 NO DATA, 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 NO DATA the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 8, 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 July 8, 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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period

allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(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 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current state survey results were posted as required which had the potential for affect all 41 residents residing in the facility, family and visitors.	F 167	On 1-9-2015, the most recent survey results dated 10/25/2013 were place in the designated posted survey binder. All current residents and future residents and families of MSL now have access to the most recent survey results. On 1/12/2015, a policy was implemented to ensure that	1/28/2015 ~~1/23/15~~

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

Electronically Signed | 01/28/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(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 167	Continued From page 1 Findings include: During the initial tour of the facility on 1/5/15, at 1:20 p.m. a laminated sign was observed posted outside the door of the director of nursing (DON)'s office and above a black plastic holder which read "Survey Results Posted Here." The black plastic holder contained a black three ring binder. The survey results in the binder were dated 11/08/2012, which was not the most current survey. A survey had been conducted on 10/25/2013. On 1/6/15, at 2:01 p.m. the DON confirmed the survey results for 10/25/13, were not in the survey binder. On 1/6/15, at 2:10 p.m. the administrator verified the most current survey results were not in the survey binder. On 1/7/15, at 7:12 a.m. observed posted on the wall in the common area by the main nursing station was a framed poster of the Resident Bill of Rights. Item #1 listed on the poster indicated the results of the most recent survey of the facility conducted by the state or federal surveyors would be posted in an accessible location. On 1/7/15, at 12:51 p.m. the DON stated the administrator was responsible for posting the survey results.	F 167	the state and/or federal survey results are posted for resident/family access. The Administrator/Medical Records personnel will audit x1 per week for 2 months to ensure the correction is sustained. The Quality Assurance committee will address at the next QA meeting scheduled for February 2015 and corrective action will be completed by 1-28-15.	

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F 167	Continued From page 2 The Your Rights Under The Combined Federal and Minnesota Resident Bill of Rights information packet dated 7/1/2007, which was provided to each resident, indicated under item #28 Examination of Survey Results - each resident had the right to examine the results of the most recent survey of the facility conducted by federal or state surveyors. No policy related to posting of state and/or federal survey results was provided.	F 167		
F 241 SS=E	. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified, homelike dining experience for 11 of 11 (R1, R2, R5, R8, R19, R26, R29, R33, R35, R37, R42) residents who received their meals on trays in the south dining room (special care unit) for 3 of 3 meal observations.	F 241	On 1/23/2015 an educational not was placed in the nurses station, Kitchen sign in station and Activity room explaining that all current residents and future residents residing on the SCU will have meals delivered to them and placed directly on the table and the trays are to be removed. The Dietary philosophy policy has been updated to ensure compliance. All dietary,	~~1/23/15~~ 01/28/15 LB

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F 241	Continued From page 3 Findings include: On 1/5/15, at 5:35 p.m. the south dining room evening meals were observed to arrive in a dietary cart. The residents were observed seated at the dining room tables. Nursing assistant (NA)-C and the program coordinator (PC) were observed to deliver a meal tray to R1, R2, R5, R8, R26, R29, R35, R37 and R42. Each meal tray included an insulated plate, silverware, as well as cold items and beverages. Each resident was observed to eat their meal from the serving tray. On 1/6/15, at 11:30 a.m. the south dining room lunch meal was observed to arrive in a dietary cart. The residents were observed seated at the dining room tables. The activities assistant (AA) and NA-D were observed to deliver a meal tray to R1, R2, R5, R8, R19, R26, R29, R33, R35, R37 and R42. Each resident was observed to eat their meal from the serving tray. On 1/7/14, at 7:47 a.m. NA-A and NA-B were observed to deliver a breakfast tray to R2, R5, R8, R19, R26, R29, R33, R35 and R37 as the residents were seated at the dining room tables. Each resident in the south dining room was observed to eat their meal from the serving tray. During the aforementioned dining observations, at no time, were residents observed to take	F 241	nursing and activity staff will be educated by 1/28/2015. The RD and/or designated personnel will audit x2 weekly for 2 months to ensure a dignified dining is being followed. The Quality Assurance committee will address at the next QA meeting scheduled for February 2015 and corrective action will be completed by 1/28/2015.	

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F 241	Continued From page 4 anything off of another resident's plate or interfere with each other's meal time. On 1/5/15, at 6:30 p.m. R29 stated he would prefer to have his plate placed directly on the dining room table and not left sitting on the serving tray. On 1/5/15, at 7:27 p.m. NA-C confirmed it was common practice to serve the meals on serving trays in the south dining room. On 1/7/15, at 7:09 a.m. cook (C)-A stated it was her expectation that unless there was a special reason for a resident to need to have their meal served on a tray, it would be better if the tray was removed and the dinnerware placed directly on the dining room table. On 1/7/15, at 12:51 p.m. the director of nursing (DON) stated the meals in the south dining room were served this way based off of a recommendation from the consulting registered dietician (RD) as the trays provided a boundary so the residents wouldn't take things off of each other's plate. The DON confirmed there were probably other ways to set these boundaries and they should be individualized for each resident.	F 241		

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F 241	Continued From page 5 On 1/8/14, at 8:25 a.m. the consulting (RD) confirmed she was aware that in the south dining room the residents were being served and ate their meals on a serving tray which helped set boundaries for these residents so they wouldn't take things off of each other's plate. The RD was unable to identify the resident safety concerns mentioned in the facility's dietary department's philosophy policy dated 12/12/2013. The RD verified there had not been individual resident assessments completed which would have identified the need to provide the resident's their meals in this manner. The RD also confirmed there were probably other more dignified ways to provide place setting boundaries for the residents in the south dining room. The MCINTOSH SENIOR LIVING dietary department philosophy policy dated 12/12/2013, indicated the facility would provide quality dining that enhanced the residents dining experience. In addition, meals provided to the special care unit (south dining room) would be provided on trays due to resident safety issues.	F 241		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility	F 465	On 1/13/2015 maintenance repaired the	~~1/26/15~~ 01/28/15 LB

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F 465	Continued From page 6 failed to maintain the kitchen and dish room in a clean and sanitary condition. This had the potential to affect all 41 residents who resided in the facility. Findings include: During the environmental tour with the dietary manager (DM) on 1/7/15, from 12:45 p.m. until 1:15 p.m. the following was observed in the dishwashing room and kitchen: - The wall behind the dishwasher had 10, quarter inch holes making the areas un-cleanable. The DM verified the finding and stated the holes were caused by a dishwasher that had been removed about a year ago and they would have maintenance repair. - An approximately 10 foot long area under the stainless steel counter top a laminated wall had cracked areas with rust and the edging of the ceramic tiles had a thick buildup of a black / gray greasy matter. The DM stated the laminated sheeting under the stainless steel counter top needed to be replaced and the edging of the ceramic tiles need to have a deep cleaning. - A 5 inch by 5 inch vent above the dishwasher	F 465	holes in the wall behind the dishwasher to ensure proper sanitation of the area. The maintenance will repair the cracked areas with rust under the stainless steel counter in the dish room and will be completed by 1/28/2015. The dietary cleaning schedule will be revised to have the vents in the dish room and the kitchen cleaned x2 per month. The cleaning schedule will also include a deep cleaning of the ceramic tile edging of each wall and door frame in the kitchen and dish room on a quarterly basis starting in January 2015. Paper education of the new cleaning schedule to all dietary staff will be completed by 1/28/2015. The RD/Administrator will audit 1x per week for 3 months the ensure cleaning list is being followed and to ensure compliance of sanitary condition in the kitchen and dish room for all current and future residents residing at MSL. The Quality Assurance committee will address at the next QA meeting scheduled for February 2015 and corrective action will be completed by 1/28/2015.	

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F 465	Continued From page 7 was observed to have a thick coating of gray / back matter. The DM verified the vent needed to be cleaned and stated it was currently on the monthly cleaning schedule, however, thought it should be increased to a two times a month cleaning schedule. - All the ceramic tiles edging each wall in the kitchen were observed to have thick gray / black greasy matter on them. - Both the kitchen and dish room ceramic flooring which edged each door frame was observed to to have thick, greasy, gray / black matter on them. At that time of the tour, the DM verified the findings. The DM stated there was a cleaning schedule for the items to be cleaned but did not include a deep cleaning. Adding, the ceramic tile edging along with all the walls and door frames needed a deep cleaning to remove the greasy gray / black matter build up. The facility policy dated 10/15/2012, indicated the DM would create and monitor all cleaning and sanitation tasks needed for the dietary department.	F 465		

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	245356	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2015**

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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 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. At the time of this survey McIntosh Senior Living was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	EPOC	

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

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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 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 McIntosh Senior Living is a 1-story building without a basement. The building was built in 1983 and was determined to be Type V (111) construction. The facility is separated into 4 smoke compartments by 1-hour fire barriers. The facility is completely sprinkler protected with standard response sprinkler heads, which are installed in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes corridor smoke detection and smoke detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 45 beds and had a	K 000		

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K 000	Continued From page 2 census of 41 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include:	K 052	On 1/16/15 the smoke detector located outside of room 106 on the south wing was removed and a plastic plate was placed over the area. This was an old smoke detector that was not currently connected with the facility fire alarm system. The smoke detectors connected to the system are located on the opposite side of the hallway and are in compliance. The smoke detector located outside of the main nurses station now has a plastic deflector between the smoke detector and the HVAC diffuser installed on 1/16/2015 to ensure compliance and proper	1/26/15

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K 052	Continued From page 3 On facility tour between 12:30 PM on 3:30 PM on 01/09/2015, observations revealed that the smoke detectors located in the corridor outside of the main nurses station and resident room 106 in the south wing were installed within 36 inches of HVAC diffusers. This deficient practice was verified by the Maintenance Supervisor (PR).	K 052	functioning of the fire alarm system and fire safety for all current and future residents at McIntosh Senior Living. To ensure this does not occur again, a spot check of the plastic deflectors will be completed during monthly fire drills. The Quality Assurance committee will address at the next QA meeting scheduled for February 2015 and corrective action will be completed by 1/28/2015.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13	K 056	On 1/20/2015, the wardrobe in resident room 114 on West wing was moved to unblock the sprinkler head to allow proper function of the sprinkler head to ensure fire safety for all current and future residents residing at MSL and future	1/26/15

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K 056	Continued From page 4 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 12:30 PM on 3:30 PM on 01/09/2015, observations have revealed the following deficient conditions that are affecting the facilities fire sprinkler coverage: 1) No sprinkler heads were added to the Activities storage room, 2) the sprinkler head that is located in the resident room 114 in the West Wing was found to be blocked by the resident's wardrobe that is fixed to the wall, 3) it was found that there is a Quick Response sprinkler head that is located outside of the refrigerator that was mixed in with standard type sprinkler heads that are located throughout the kitchen. This deficient practice was verified by the Maintenance Supervisor (PR).	K 056	residents. Maintenance will add to the PM checklist to make sure that all sprinkler heads in the building are free of blockage to ensure the proper fire safety compliance. The Quality Assurance committee will address at the next QA meeting scheduled for February 2015 and corrective action will be completed by 1/28/2015. On 1/26/2015, Dakota Fire was here to add a sprinkler head to the Activity storage room and replaced the Quick Response sprinkler head in the kitchen with a standard type sprinkler head to ensure compliance providing fire protection for all current and future residents residing at MSL along with visitors and staff. The Quality Assurance committee will address at the next QA meeting scheduled for February 2015 and corrective action will be completed by 1/28/2015.	