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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YZR7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**
2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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 **11/13/2014** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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, Unit Supervisor 11/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/19/2014 (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
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/23/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/07/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245512

November 13, 2014

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

Dear Mr. Dish:

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 October 31, 2014 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Electronically delivered
November 13, 2014

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512024

Dear Mr. Dish:

On September 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 18, 2014. 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 November 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 27, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 18, 2014, effective October 31, 2014 and therefore remedies outlined in our letter to you dated September 29, 2014, will not be imposed.

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

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

Sincerely,

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

5512r14

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
245512	A. Building B. Wing	11/13/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/24/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/24/2014**	ID Prefix **F0369** Reg. # **483.35(g)** LSC	Correction Completed **10/24/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/31/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/24/2014**	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	LB/mm	11/13/2014	28035	11/13/2014
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
9/18/2014			

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
245512	A. Building B. Wing **01 - NURSING HOME**	10/27/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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 K0069	Correction Completed **10/17/2014**	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 11/13/2014	**Signature of Surveyor:** 27200	**Date:** 10/27/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/16/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**		**YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YZR7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**
2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH FOSSTON**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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 **09/18/2014** (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 **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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 10/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 11/07/2014 (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
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 29, 2014

Mr. Kevin Dish, Administrator
Essentia Health Fosston
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512024

Dear Mr. Dish:

On September 18, 2014, 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:

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;

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (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 October 28, 2014, 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 October 28, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 18, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of

payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

(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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the care plan was followed for 3 of 3 residents (R3, R42, R44) in the south dining room who required adaptive eating equipment with their meals. Findings include: R3's care plan directed the use of a lipped plate during meals and the facility failed to provide it. R3's Physician Order Report dated 8/18/2014 - 9/18/2014, identified R3's diagnoses as	F 282	It is the policy of FCLC to follow Care Plan for residents who require adaptive eating equipment with their meals. A. Residents R3, R42, R44 have been reviewed for proper adaptive equipment by therapy and care plans have been updated. B. RN Coordinators or their designee will complete dysphagia screen on admission, if problems are observed, therapy referral will be generated. C. Therapy will reassess for proper adaptive equipment with referrals, on	10/24/14

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

Electronically Signed | 10/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH FOSSTON	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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F 282	Continued From page 1 Alzheimer's disease, dementia, esophageal reflux and nutritional deficiency. R3's care plan dated 7/16/14, indicated R3 was at a nutritional risk and occupational therapy (OT) had recommended built up utensils and a lipped plate for feeding. On 9/15/14, during the evening meal from 4:37 p.m. until 5:30 p.m. R3 was observed seated in her wheelchair at the dining room table in the south dining room. R3's place setting had built up silverware; however her meal was served on a regular plate. Throughout the meal, licensed practical nurse (LPN)-A was observed to assist R3 with eating by encouraging her to eat and helping her get the food items on her silverware. R42's care plan directed the use of built up silverware during meals and the facility failed to provide them. R42's Physician Order Report dated 8/18/2014-9/18/2014, identified R42's diagnoses as Alzheimer's disease, dementia, nutritional deficiency and adult failure to thrive. R42's care plan dated 7/30/14, indicated R42 was at a nutritional risk and R42 was to have built up silverware at meals to promote independent feeding. On 9/15/14, during the evening meal from 4:37 p.m. until 5:30 p.m. R42 was observed seated in her wheelchair at the dining room table in the south dining room. R42 was observed using regular silverware. Nursing assistant (NA)-A was observed assisting R42 with her meal by putting food items on her fork.	F 282	quarterly screening, and with any change of condition. D. Dietary Manager will be responsible to update Dining room information chart as changes occur. E. Dietary Manager or her designee will audit by observation to ensure all residents are provided with required adaptive eating equipment and care plans are followed with meals, weekly x 4 weeks and randomly thereafter and will document audit results. F. All staff attendees educated for compliance with care planning for proper adaptive equipment at Licensed staff meeting October 1, 2014 and NAR/Dietary/Activity/community assist staff meeting on October 2, 2014. G. Staff not attending were provided education on updated Dining room information chart, to be read/understood prior to their next scheduled shift and with all new employee orientation. Completion date 10-24-14. H. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly.	

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F 282	Continued From page 2 R44's care plan directed the use of an inner lip plate during meals and the facility failed to provide it. R44's Physician Order Report dated 8/18/14-9/18/14, indicated R44's diagnoses as liver failure and malnutrition. R44's care plan dated 9/2/14, indicated R44 had a nutritional risk and was to have an inner lip plate and built up utensils at meals. On 9/15/14, during the evening meal from 4:37 p.m. until 5:30 p.m. R44 was observed seated in his wheelchair at the dining room table in the south dining room. R44's place setting had built up silverware; however his meal was served on a regular plate. On 9/15/14, at 5:10 p.m. the dietary manager verified the above identified residents were not provided with adaptive eating utensils as directed by their individual plan of care and stated they should have been. On 9/15/14, at 5:21 p.m. Cook-A who served the food in the south dining room, confirmed the above identified residents were not provided adaptive eating utensils as directed and stated it was forgotten. The CARE PLANNING policy dated 5/2002, directed staff to follow the plan of care of each resident.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		10/24/14

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F 329	Continued From page 3 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clinical justification for the use of and non-pharmacological interventions were attempted prior to the administration of as needed (PRN) antianxiety and / or antipsychotic medication for 2 of 2 residents (R13, R47) whose medication regimes were reviewed. Findings include:	F 329	It is the policy of FCLC to ensure that each resident has clinical justification for the use of and that non-pharmacological interventions are attempted prior to the administration of as needed (PRN) antianxiety and /or antipsychotic medication. A. RN Coordinators completed assessment/audits in charts R13 and R47 for justifications and amount of use of PRN medications, amending care plans	

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F 329	Continued From page 4 R13 received PRN antianxiety and antipsychotic medication without non pharmacological interventions attempted prior to the administration. R13's medical record also lacked documentation of target behaviors which resulted in the administration of the antipsychotic medication. R13's Physician Order Report dated 8/18/2014-9/18/2014, revealed diagnoses including dementia with senile delusions, depression and anxiety. In addition, this Physician Order Report included Risperdal (antipsychotic) 0.25 milligrams (mg) once a day PRN for delusions and clonazepam (anti-anxiety medication) 0.5 mg once a day PRN for anxiety. R13's quarterly Minimum Data Set (MDS) dated 7/29/14, indicated R13 had severe cognitive impairment and nearly every day had feelings of hopelessness, feeling down and depressed. No signs or symptoms of delirium or psychosis were noted in this review period. R13's care plan dated 8/4/14, indicated R13's behaviors and mood problems consisted of hollering, feeling sad, little interest of pleasure doing therapy, feeling down, depressed or hapless, having little energy, trouble falling to sleep, delusions and a history of hallucinations. The goal was for R13 to be comfortable on the lowest effective medication dose. Interventions directed staff to offer R13 1-1 visits, verbal redirection, activities, administer medication as prescribed by the physician, monitor mood/behavior changes and document as needed. R13's Clinical Documentation - Essentia	F 329	with non pharmacological interventions. B. RN Coordinators will review all residents charts who use psychotropic medications on admit, quarterly, and with sig changes for GDR, and report findings to MD if GDR is warranted. C. Special instructions have been added to EMAR reminding staff to chart alternative interventions tried prior to med administration on all residents who have PRN orders for antianxiety or antipsychotic medications. RN Coordinators will add special instructions to all new PRN orders as they occur. D. Care Plans reviewed and updated with individualized interventions for all residents receiving antianxiety and antipsychotics medications and will be reviewed quarterly at care conferences with residents/family. E. RN Coordinators and Social Services Designee will ensure that all care plans for new residents, quarterly reviews, and significant changes will be individualized with interventions to utilize prior to med administration. F. Licensed staff meeting attendees educated October 1, 2014. G. Staff not attending were provided informational packets on justification and non-pharmacological interventions prior to med administration to be read/understood prior to their next shift and included in all new employee orientation information. Completion date 10-24-14. H. RN Coordinators or designee will do medication chart audits for R13 and R47 weekly x 4 weeks and randomly thereafter to ensure alternative interventions were	

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F 329	Continued From page 5 Psychotropic Drug Review dated 7/29/14, indicated the specific behaviors or moods which would warrant the use of medication would be hallucinations and/or delusions. Non pharmacological interventions for staff to attempt included: 1:1 visits, snacks, activities, music or church. R13's Point of Care Behavior Category Report from 8/19/14, through 8/31/14, indicated no behavior data recorded. The Consultant Pharmacist Medication Review form dated 6/17/14, indicated R13 was on Risperdal 0.25 mg BID (twice a day) for delusions. The consulting pharmacist's recommendation to the physician was to trial a decrease of Risperdal to 0.25 mg every evening and every day PRN for delusions to assess current dose or document ongoing need. The physician responded on 8/14/14, "see orders." R13's current Physician Order Report indicated the start date for Risperdal 0.25 mg PRN, once a day was 8/14/14. The PRN Medication Administration History record and R13's progress notes from 8/19/14, through 9/18/14, revealed the following: 1) R13 was administered Risperdal 0.25 mg on 8/19/14, at 4:02 p.m. for behavioral issue of yelling out. The resident progress notes by the activity staff dated 8/19/14, at 3:36 p.m. noted 1-1 activity was conducted with R13 in the lobby. R13 was awake and saying "get me otta here. I'm cold" . The activity staff explained to R13 that she was inside the building and provided R13 with a blanket. The activity staff attempted to	F 329	attempted prior to PRN med administration. I. RN Coordinators or designee will audit 20 random PRN psych med administrations in resident records each month to make sure non-pharmacy approaches are documented each time and continue until results are 100 %. J. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly.	

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F 329	Continued From page 6 redirect R13 but it didn't help at this time. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 2) R13 was administered clonazepam 1 mg on 8/19/14, at 3:27 a.m. for "anxious." The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 3) R13 was administered clonazepam 1 mg on 8/21/14, at 9:46 p.m. for behavioral issues. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 4) R13 was administered clonazepam 1 mg on 8/25/14, at 2:52 a.m. for agitation. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 5) R13 was administered clonazepam 1 mg on 8/26/14, at 12:10 a.m. for sleep. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 6) R13 was administered Risperdal 0.25 mg on 8/27/14, at 6:43 p.m. for behavioral issue of repeating same things. There were no resident progress notes dated 8/27/14, which would reflect the use of a non-pharmacological approach prior	F 329		

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F 329	Continued From page 7 to and in addition to the use of the medication being administered. 7) R13 was administered clonazepam 1 mg on 8/30/2014, at 8:43 p.m. for agitation and restlessness. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 8) R13 was administered clonazepam 1 mg on 8/31/2014, at 8:12 p.m. for being anxious. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 9) R13 was administered Risperdal 0.25 mg on 9/2/14, at 11:22 a.m. for premedication for getting hair done. At 8:00 p.m. R13 was administered clonazepam 1 mg for hollering at staff, very anxious and attempting to stand per self. There were no resident progress notes dated 9/2/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 10) R13 was administered clonazepam 1 mg on 9/4/2014, at 1:41 a.m. for sleep. In addition, Risperdal 0.25 mg was administered at 6:45 p.m. for behavior at p.m. snack. There were no resident progress notes dated 9/4/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 11) R13 was administered clonazepam 1 mg on 9/6/2014, at 12:46 p.m. for wanting to go home.	F 329		

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F 329	Continued From page 8 There were no resident progress notes dated 9/6/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 12) R13 was administered clonazepam 1 mg on 9/8/2014, at 7:56 p.m. for sleep. There were no resident progress notes dated 9/8/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 13) R13 was administered clonazepam 1 mg on 9/9/2014, at 6:37 p.m. for sleep. There were no resident progress notes dated 9/9/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 14) R13 was administered clonazepam 1 mg on 9/15/2014, at 8:10 p.m. for " help me, where am I " in a loud voice. There were no resident progress notes dated 9/15/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. During the survey conducted on 9/15/14, from 4:00 p.m. to 8:00 p.m. 9/16/14, from 8:00 a.m. to 4:30 p.m. on 9/17/14, from 7:00 a.m. to 3:30 p.m. and 9/18/14, from 8:00 a.m. to 12:00 p.m. R13 was observed to utilize a wheelchair, participated in meals in the dining room, sat in the common areas and participated in activities. At no time during the observations was R13 observed to display adverse behaviors or have difficult while in crowded areas.	F 329		

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F 329	Continued From page 9 On 9/17/14, at 7:13 a.m. Licensed practical nurse (LPN)-B was observed to change R13's ankle dressing. R13 remained calm and nonresistant during the entire dressing change. On 9/18/14, at 9:35 a.m. registered nurse (RN)-B confirmed the above PRN medications were given and the record lacked documentation of non-pharmacological interventions being attempted prior to the administration of the PRN medication. R47 was administered PRN antianxiety medication without non-pharmacological interventions attempted prior to the administration of the medication. R47's Physician Order Report dated 8/18/2014-9/18/2014, revealed diagnoses including Parkinson's disease, anxiety and congested heart failure (decrease in heart function to pump blood). In addition, this Physician Order Report included Ativan (antianxiety medication) 1 milligram (mg) twice a day PRN for anxiety. R47's quarterly Minimum Data Set (MDS) dated 8/12/14, indicated R47 was cognitively intact. R47's care plan dated 8/20/14, identified approaches to his mood by providing 1-1 visits, provide supportive visits, allow R47 to vent feelings and to administer medication as prescribed by the physician. R47's care plan indicated R47 was at risk for changes in mood or behavior related to the use of an antidepressant and behaviors related to	F 329		

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F 329	Continued From page 10 anxiety and agitation. Interventions directed staff to administer medications as ordered, monitor for mood or behavior changes, intervene as needed and social service visits monthly and as needed. R47's Clinical Documentation - Essentia Psychotropic Drug Review dated 8/10/14, indicated the specific behaviors or moods which would warrant the use of medication would be R47 verbalizing increased anxiety, wringing of hands, hollering and acting repetitively. Non-pharmacological interventions for staff to attempt included: 1:1 visits, redirection, diversion activities (such as going outside) and going to his wife's apartment. R47's Point of Care Behavior Category Report for 8/18/14, through 9/17/14, revealed R47 had not exhibited behavioral symptoms during this time. R47's PRN Medication Administration History record and progress notes from 8/18/14, through 9/17/14, revealed the following: 1) R47 was administered Ativan 1 mg on 8/28/14, at 12:08 a.m. for complaints of anxiety, unable to sleep and yelling out. There were no resident progress notes dated 8/28/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 2) R47 was administered Ativan 1 mg on 9/6/14, at 1:38 p.m. for a behavior issue - very anxious. There were no resident progress notes dated 9/6/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered.	F 329		

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F 329	Continued From page 11 3) R47 was administered Ativan 1 mg on 9/11/14, at 3:24 p.m. for complaints of being very anxious. There were no resident progress notes dated 9/11/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 4) R47 was administered Ativan 1 mg on 9/15/14, at 12:08 a.m. for a behavior issue - R47 complaining of anxiety. There were no resident progress notes dated 9/15/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. During the survey conducted on 9/15/14, from 4:00 p.m. to 8:00 p.m. 9/16/14, from 8:00 a.m. to 4:30 p.m. on 9/17/14, from 7:00 a.m. to 3:30 p.m. and 9/18/14, from 8:00 a.m. to 12:00 p.m. R\473 was observed to utilize a wheelchair, participated in meals in the dining room, sat in the common areas and participated in activities. At no time during the observations was R47 observed to display adverse behaviors. On 9/18/14, at 10:20 a.m. RN-A verified documentation for non-pharmacological interventions was lacking prior to the administration of the PRN Ativan for R47. A facility policy regarding development/implementation of non-pharmacological interventions was not provided.	F 329		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	F 369		10/24/14

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F 369	Continued From page 12 The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the recommended adaptive eating equipment for 3 of 3 residents (R3, R42, R44) observed during an evening meal in the south dining room. Findings include: R3 was not provided a lipped plate for enhanced independent eating as directed by the care plan. R3's Physician Order Report dated 8/18/2014 - 9/18/2014, identified R3's diagnoses as Alzheimer's, dementia, esophageal reflux and nutritional deficiency. R3's annual Minimum Data Set (MDS) dated 7/8/14, indicated R3 had severe cognitive impairment and required limited assist with eating. R3's care plan dated 7/16/14, indicated R3 was at a nutritional risk and occupational therapy (OT) had recommended built up utensils and a lipped plate for feeding. On 9/15/14, during the evening meal from 4:37 p.m. until 5:30 p.m. R3 was observed seated in her wheelchair at the dining room table in the south dining room. R3's place setting had built up silverware; however her meal was served on a regular plate. Throughout the meal, licensed	F 369	It is the policy of FCLC to ensure the adaptive equipment that has been recommended by dietary, nursing, or occupational therapy will be on the table for resident use as identified by care plan. A. Residents R3, R42, R44 have been reviewed for proper adaptive equipment by therapy and care plans have been updated. B. RN Coordinators or their designee will complete dysphagia screen on admission, if problems are observed therapy referral will be generated. C. Therapy will reassess for proper adaptive equipment with referrals, on quarterly screening, and with any change of condition. D. Dietary Manager will be responsible to update Dining room information chart as changes occur. E. Dietary Manager or her designee will audit by observation to ensure all residents are provided with required adaptive eating equipment and care plans are followed with meals weekly x 4 weeks and randomly thereafter and will document audits results. F. All staff attendees educated for compliance with care planning for proper adaptive equipment at Licensed staff meeting October 1, 2014 and NAR/Dietary/Activity/community assist	

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F 369	Continued From page 13 practical nurse (LPN)-A was observed to assist R3 with eating by encouraging her to eat and helping her get the food items on her silverware. R42 was not provided adaptive silverware to enhance independent eating as directed by the care plan. R42's Physician Order Report dated 8/18/2014-9/18/2014, identified R42's diagnoses as Alzheimer's, dementia, nutritional deficiency and adult failure to thrive. R42's quarterly Minimum Data Set (MDS) dated 7/22/14, indicated R42 had severe cognitive impairment and required extensive assist with eating. R42's care plan dated 7/30/14, indicated R42 was at a nutritional risk and directed staff to provide built up silverware at meals to promote independent feeding. On 9/15/14, during the evening meal from 4:37 p.m. until 5:30 p.m. R42 was observed seated in her wheelchair at the dining room table in the south dining room using regular silverware. Nursing assistant (NA)-A was observed assisting R42 with her meal by putting food items on her fork. R44's Physician Order Report dated 8/18/14-9/18/14, indicated R44's diagnoses as liver failure and malnutrition. R44's 14 day Minimum Data Set (MDS) dated 8/19/14, indicated R44 had severe cognitive impairment and required supervision with eating.	F 369	staff meeting on October 2, 2014. G. Staff not attending were provided education information on updated Dining room information chart, to be read/understood prior to their next scheduled shift and with all new employee orientation. Completion date 10-24-14. H. Compliance will be added to our QA program by DON and reported to QAPI meetings quarterly.	

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F 369	Continued From page 14 R44's care plan dated 9/2/14, indicated R44 had a nutritional risk and was to have an inner lip plate and built up utensils at meals. On 9/15/14, during the evening meal from 4:37 p.m. until 5:30 p.m. R44 was observed seated in his wheelchair at the dining room table in the south dining room. R44's place setting was observed to have built up silverware; however his meal was served on a regular plate. The South Dining Room seating chart dated 9/15/14, indicated R3 and R44 required built up silverware and a lipped plate and R42 required built up silverware. On 9/15/14, at 5:10 p.m. the dietary manager (DM) confirmed the dietary staff were responsible for setting the tables and ensuring the appropriate adaptive equipment was provided. The DM verified R3 and R44 were supposed to have their meals served on inner lipped plates and R42 was supposed to have built up silverware and verified these items had not been provided for this evening meal on 9/15/14. On 9/15/14, at 5:21 p.m. cook (C)-A confirmed she had not served R3 and R44's meal on a lipped plate nor had R42 been provided built up silverware for this evening meal. C-A verified this adaptive equipment should have been provided. On 9/17/14, at 12:04 p.m. the certified occupational therapy assistant (COTA)-A verified the recommendations from the department were for R3 and R44 to have built up silverware and a lipped plate and R42 was to have built up silverware.	F 369		

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F 369	Continued From page 15 LTC RESIDENT DIETARY PROGRAM AND DINING EXPERIENCE policy dated 6/2007, specified adaptive equipment that had been recommended by dietary, nursing or occupational therapy, would be on the table for resident use.	F 369		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the pharmacist identified the lack of clinical justification and non pharmacological interventions were utilized prior to the administration of an as needed (PRN) antianxiety or antipsychotic medication for 2 of 2 residents (R13, R47) whose medication regime was reviewed. Findings include: R13 received PRN antianxiety and antipsychotic medication without non pharmacological interventions attempted prior to the administration and R13's medical record lacked documentation of target behaviors that supported the use of	F 428	It is the policy of FCLC to ensure clinical justification and non pharmacological interventions are utilized prior to the administration of a PRN antianxiety or antipsychotic medication. A. On 9-24-14 Pharmacy consultant review and recommendations to nursing for R13 and R47 completed. B. Consultant pharmacy will audit PRN psych meds for proper target behaviors and report the number of inappropriate targets for prn use to DON each month. C. Psych Inservice by pharmacy consultant is scheduled for October 22, 2014 with major emphasis on non-pharmacy documentation for all direct	10/31/14

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F 428	Continued From page 16 antipsychotic medication. The consulting pharmacist failed to identify these irregularities. R13's Physician Order Report dated 8/18/2014-9/18/2014, revealed diagnoses including dementia with senile delusions, depression and anxiety. In addition, this Physician Order Report included Risperdal (antipsychotic) 0.25 milligrams (mg) once a day PRN for delusions and clonazepam (anti-anxiety medication) 0.5 mg once a day PRN for anxiety. R13's quarterly Minimum Data Set (MDS) dated 7/29/14, indicated R13 had severe cognitive impairment and nearly every day had feelings of hopelessness, feeling down and depressed. No signs or symptoms of delirium or psychosis were noted in this review period. R13's care plan dated 8/4/14, indicated R13's behaviors and mood problems consisted of hollering, feeling sad, little interest of pleasure doing therapy, feeling down, depressed or hapless, having little energy, trouble falling to sleep, delusions and a history of hallucinations. The goal was for R13 to be comfortable on the lowest effective medication dose. Interventions directed staff to offer R13 1-1 visits, verbal redirection, activities, administer medication as prescribed by the physician, monitor mood/behavior changes and document as needed. R13's Clinical Documentation - Essentia Psychotropic Drug Review dated 7/29/14, indicated the specific behaviors or moods which would warrant the use of medication would be hallucinations and/or delusions. Non pharmacological interventions for staff to attempt	F 428	care staff. Education will be provided by DON for staff not attending by October 31, 2014 D. RN Coordinators or designee will do medication chart audits for R13 and R47 weekly x 4 weeks and randomly thereafter. E. RN Coordinators or designee will audit 20 random PRN psych med administrations in resident records each month to make sure non pharmacy approaches are documented each time and continue until results are 100%. F. Compliance will be added to our QA program by DON and reported to quarterly QAPI meetings and also to quarterly Pharmacy and Therapeutics meetings.	

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F 428	Continued From page 17 included: 1:1 visits, snacks, activities, music or church. R13's Point of Care Behavior Category Report from 8/19/14, through 8/31/14, indicated no behavior data recorded. The Consultant Pharmacist Medication Review form dated 6/17/14, indicated R13 was on Risperdal 0.25 mg BID (twice a day) for delusions. The consulting pharmacist's recommendation to the physician was to trial a decrease of Risperdal to 0.25 mg every evening and every day PRN delusions to assess current dose or document ongoing need. The physician responded on 8/14/14, "see orders." The current Physician Order Report indicated the start date for Risperdal 0.25 mg PRN, once a day was 8/14/14. The PRN Medication Administration History record and R13's progress notes from 8/19/14, through 9/18/14, revealed the following: 1) R13 was administered Risperdal 0.25 mg on 8/19/14, at 4:02 p.m. for behavioral issue of yelling out. The resident progress notes by the activity staff dated 8/19/14, at 3:36 p.m. noted 1-1 activity was conducted with R13 in the lobby. R13 was awake and saying "get me otta here. I'm cold". The activity staff explained to R13 that she was inside the building and provided R13 with a blanket. The activity staff attempted to redirect R13 but it didn't help at this time. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered.	F 428		

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F 428	Continued From page 18 2) R13 was administered clonazepam 1 mg on 8/19/14, at 3:27 a.m. for "anxious." The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 3) R13 was administered clonazepam 1 mg on 8/21/14, at 9:46 p.m. for behavioral issues. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration. 4) R13 was administered clonazepam 1 mg on 8/25/14, at 2:52 a.m. for agitation. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration 5) R13 was administered clonazepam 1 mg on 8/26/14, at 12:10 a.m. for sleep. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration 6) R13 was administered Risperdal 0.25 mg on 8/27/14, at 6:43 p.m. for behavioral issue of repeating same things. There were no resident progress notes dated 8/27/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 7) R13 was administered clonazepam 1 mg on 8/30/2014, at 8:43 p.m. for agitation and	F 428		

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F 428	Continued From page 19 restlessness. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration 8) R13 was administered clonazepam 1 mg on 8/31/2014, at 8:12 p.m. for being anxious. The documentation did not reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication administration 9) R13 was administered Risperdal 0.25 mg on 9/2/14, at 11:22 a.m. for premedication for getting hair done. At 8:00 p.m. R13 was administered clonazepam 1 mg for hollering at staff, very anxious and attempting to stand per self. There were no resident progress notes dated 9/2/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 10) R13 was administered clonazepam 1 mg on 9/4/2014, at 1:41 a.m. for sleep. In addition, Risperdal 0.25 mg was administered at 6:45 p.m. for behavior at p.m. snack. There were no resident progress notes dated 9/4/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 11) R13 was administered clonazepam 1 mg on 9/6/2014, at 12:46 p.m. for wanting to go home. There were no resident progress notes dated 9/6/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered.	F 428		

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F 428	Continued From page 20 12) R13 was administered clonazepam 1 mg on 9/8/2014, at 7:56 p.m. for sleep. There were no resident progress notes dated 9/8/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 13) R13 was administered clonazepam 1 mg on 9/9/2014, at 6:37 p.m. for sleep. There were no resident progress notes dated 9/9/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 14) R13 was administered clonazepam 1 mg on 9/15/2014, at 8:10 p.m. for " help me, where am I" in a loud voice. There were no resident progress notes dated 9/15/2014, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. During the survey conducted on 9/15/14, from 4:00 p.m. to 8:00 p.m. 9/16/14, from 8:00 a.m. to 4:30 p.m. on 9/17/14, from 7:00 a.m. to 3:30 p.m. and 9/18/14, from 8:00 a.m. to 12:00 p.m. R13 was observed to utilize a wheelchair, participated in meals in the dining room, sat in the common areas and participated in activities. At no time during the observations was R13 observed to display adverse behaviors or have difficult while in crowded areas. On 9/18/14, at 9:35 a.m. registered nurse (RN)-B confirmed the above PRN medications had been given and the record lacked documentation of non-pharmacological interventions being attempted prior to the administration of the PRN	F 428		

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F 428	Continued From page 21 medication. R47 received PRN antianxiety medication without non pharmacological attempts prior to the administration of the medication and the consulting pharmacist failed to identify this irregularity. R47's Physician Order Report dated 8/18/2014-9/18/2014, revealed diagnoses including Parkinson's disease, anxiety, and congested heart failure (decrease in heart function to pump blood). In addition, this Physician Order Report included Ativan (antianxiety medication) 1 milligram (mg) twice a day PRN for anxiety. R47's quarterly Minimum Data Set (MDS) dated 8/12/14, indicated R47 was cognitively intact. R47's care plan dated 8/20/14, identified approaches to his mood by providing 1-1 visits, provide supportive visits and allow R47 to vent feelings; in addition, to administer medication as prescribed by the physician. R47's care plan indicated R47 was at risk for changes in mood or behavior related to the use of an antidepressant and behaviors related to anxiety and agitation. Interventions directed staff to administer medications as ordered, monitor for mood or behavior changes, intervene as needed and social service visits monthly and as needed. R47's Clinical Documentation - Essentia Psychotropic Drug Review dated 8/10/14, indicated the specific behaviors or moods which would warrant the use of medication would be R47 verbalizing increased anxiety, wringing of hands, hollering and acting repetitively.	F 428		

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F 428	Continued From page 22 Non-pharmacological interventions for staff to attempt included: 1:1 visits, redirection, diversion activities (such as going outside) and going to his wife's apartment. R47's Point of Care Behavior Category Report for 8/18/14, through 9/17/14, revealed R47 had not exhibited behavioral symptoms during this time. The PRN Medication Administration History record and the resident progress notes from 8/18/14, through 9/17/14, revealed the following: 1) R47 was administered Ativan 1 mg on 8/28/14, at 12:08 a.m. for complaints of anxiety, unable to sleep and yelling out. There were no resident progress notes dated 8/28/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 2) R47 was administered Ativan 1 mg on 9/6/14, at 1:38 p.m. for a behavior issue - very anxious. There were no resident progress notes dated 9/6/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 3) R47 was administered Ativan 1 mg on 9/11/14, at 3:24 p.m. for complaints of being very anxious. There were no resident progress notes dated 9/11/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. 4) R47 was administered Ativan 1 mg on 9/15/14, at 12:08 a.m. for a behavior issue - R47	F 428		

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F 428	Continued From page 23 complaining of anxiety. There were no resident progress notes dated 9/15/14, which would reflect the use of a non-pharmacological approach prior to and in addition to the use of the medication being administered. During the survey conducted on 9/15/14, from 4:00 p.m. to 8:00 p.m. 9/16/14, from 8:00 a.m. to 4:30 p.m. on 9/17/14, from 7:00 a.m. to 3:30 p.m. and 9/18/14, from 8:00 a.m. to 12:00 p.m. R\473 was observed to utilize a wheelchair, participated in meals in the dining room, sat in the common areas and participated in activities. At no time during the observations was R47 observed to display adverse behaviors. On 9/18/14, at 10:20 a.m. RN-A verified the documentation for non-pharmacological interventions were lacking prior to the administration of PRN Ativan for R47. On 9/18/14, at 12:14 p.m. the consulting pharmacist verified his expectations are that non-pharmacological interventions should be attempted and documented prior to the administration of a PRN antianxiety and/or antipsychotic medication. The pharmacist stated the goal was to slowly eliminate the Risperdal for R13, however, when it was being used it should have been administered for appropriate symptoms.	F 428		
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.	F 465		10/24/14

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F 465	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the hood vents were kept clean above the range in the kitchen. This had the potential to affect all 44 residents who resided in the facility and received food from the kitchen. In addition, the facility failed to ensure each resident room was well maintained, for 8 of 8 residents (R11, R14, R15, R16, R29, R32, R46 and R51) whose rooms were observed to be in need of repair. Findings include: On 9/15/14, at 1:24 p.m. an initial tour of the kitchen was completed. The four hood vents located over the range were noted to be dirty with a build-up of grease and dust. Cook (C)-A stated the dietary staff did not do any cleaning of the hood vents. C-A added, the hood vents were cleaned by the maintenance staff and she did not know the last time they were cleaned. On 9/18/14, at 9:23 a.m. the dietary manager (DM) stated the maintenance staff were responsible for cleaning the hood vents monthly. The DM provided a Hood and Vent Monthly Cleaning Schedule which indicated the dietary staff had cleaned the hood vents on 8/14/14. The DM stated the maintenance staff did the hood vent cleaning by placing them in the dishwasher. The DM stated there was no policy regarding how often the hood vents were to be cleaned. An environmental tour was performed with the environmental services director (ED) on 9/18/14,	F 465	Tag F465 Kitchen Exhaust hood cleaning. The kitchen hood has been cleaned using a pressure washer and degreaser to remove any grease or dust. The Dietary manager and the Facility Manager have written a procedure for cleaning the kitchen hood which included a monthly cleaning by maintenance and hiring a professional cleaning company annually to deep clean all duct works. This work will be completed by October 24 2014. The dietary manager Amy Thompson will monitor that the work is completed monthly. The Facility Manager will be responsible for completing the work. R11 This wall damage will be repaired and painted. To be completed before 10/24/14. The Facility Manager will be responsible for monitoring that the repair has been completed by the maintenance staff. Environmental rounds will be conducted semiannually to find and correct any future issues. R14 The scuffed paint will be painted and the black marks will be scrubbed off with a magic eraser. To be completed before 10/24/14. The Facility Manager will be responsible for monitoring that the repair has been completed by the maintenance staff. Environmental rounds will be conducted semiannually to find and correct any future issues.	

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	245512	A. BUILDING _____ B. WING _____	09/18/2014

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F 465	Continued From page 25 from 10:15 a.m. to 11:00 a.m., during which the following was observed: R11's room, the bed was placed with the head and right side against the wall. On the wall behind the repositioning bar on the right side of the bed there were visible scuff marks with peeling areas of paint and cracks in the top layer of sheet rock in the shape of the entire repositioning bar. R14's room there were several visible black scuff marks with three areas of missing paint peeling at the edges with approximately 3 x 1 inches next to the left edge of the head of the bed. R15's room, there were full-length closets on the wall opposite the resident's bed. On the lower right edge of the right hand closet door there was a foot of laminate missing and an irregular shaped area of missing laminate approximately 5 x 2 inches. Both areas exposed bare wood. In the bathroom of the same room there was an irregular shaped yellow stain on the floor extending from the front to back of the toilet. R15 had stated during the initial tour of the facility by surveyors that the stain was from a roommate that, "missed the toilet." R16's room, there was a small, three drawer wooden stand placed next to the resident's bathroom door with a sharp, one inch piece of the wood partially broken and extending out from the lower right edge of the middle drawer. R29 and R32's shared bathroom, there were five dark gray sticky areas to the left of the toilet. ED stated it was "probably from the wax" and the bathroom floor needed stripping.	F 465	R15 The missing laminate will be patched or replaced. The stains are most likely created from the chemical used to clean the toilets which discolors the wax. The wax will be stripped off the flooring and new wax will be installed. To be completed before 10/24/14. The Facility Manager will be responsible for monitoring that the repair has been completed by the maintenance staff. Environmental rounds will be conducted semiannually to find and correct any future issues. R16 The bed side table with the broken wood will be repaired or replace. To be completed before 10/24/14. The Facility Manager will be responsible for monitoring that the repair has been completed by the maintenance staff. Environmental rounds will be conducted semiannually to find and correct any future issues. R29 & R32 The stains are most likely created from the chemical used to clean the toilets which discolors the wax. The wax will be stripped off the flooring and new wax will be installed. To be completed before 10/24/14. The Facility Manager will be responsible for monitoring that the repair has been completed by the maintenance staff. Environmental rounds will be conducted semiannually to find and correct any future issues. R46 This wall damage will be repaired and painted. To be completed before 10/24/14. The Facility Manager will be responsible	

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F 465	Continued From page 26 R46's room, there was a scuffed and gouged area in the sheetrock on the wall at the head of the bed. At the head of the bed, there were three areas where the sheetrock was cracked, broken and partially missing the top layer. R51's bathroom, next to the toilet, there was a four inch moon-shaped area of missing flooring which exposed bare floor with cracks that extended out from the missing area. The ED stated the flooring would need to be replaced. During interview, on 9/18/14, at 10:15 a.m., the ED stated a team of three, which included himself, the facility infection control director and the facility risk management director, performed an every six month inspection of resident areas and rooms. The ED stated a list of necessary repairs or changes was made and then distributed to the maintenance staff to perform the repairs. The most recent inspection was done in July of 2014 and the repair list had been given to the facility maintenance staff two weeks previous to the survey. The ED stated there was a system for facility staff to communicate maintenance concerns. The staff was to enter the problem into a computerized system which would be routed directly to the environmental services department. During the environmental tour, the ED confirmed the areas of concern and verified that the areas required repair and were not on the maintenance list compiled in July. The ED indicated the concerns could have been overlooked by the team during the last walk-through inspection. Review of the facility policy dated 8/2007, titled, First Care Medical Services Room Checks,	F 465	for monitoring that the repair has been completed by the maintenance staff. Environmental rounds will be conducted semiannually to find and correct any future issues. R51 The cracked flooring rubber base boards were replaced on 10/17/14. This work was monitored by the Facility Manager and work was completed by Vern□s Flooring Company.	

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F 465	Continued From page 27 identified the purpose of room checks was to ensure that resident rooms were kept in a well maintained, safe atmosphere.	F 465		

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	245512	A. BUILDING **01 - NURSING HOME** B. WING _____	**09/16/2014**

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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, First Care Living Center 01 Main Building 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

Electronically Signed | 10/17/2014

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 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 First Care Living Center is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activates room to the north east corner were constructed. Theses additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms and in common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire	K 000		

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K 000	Continued From page 2 detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 50 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect residents, all kitchen staff and visitors. Findings Include: On facility tour between 11:30 AM and 2:30 PM on 09/16/2014, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Facility Manager (MM), the	K 069	K 69 Tag for the Kitchen Fire suppression system inspection missed from October of 2013. This inspection was not completed. The service company hired to complete this task has been replace with a new company. There has been a reminder added to the Maintenance and Facility managers computer to ensure a reminder is in place to check for the completion of this task before it is due. This was completed on 10/17/14 and will be monitored by the Facility Manager and work completed by Northland Fire Company.	10/17/14

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K 069	Continued From page 3 facility failed to provide 1 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient practice was verified by the Facility Manager (MM).	K 069		