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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z17P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00678

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245563**

2.STATE VENDOR OR MEDICAID NO.
(L2) **475240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN PINE ACRES NURSING HOME**
(L4) **427 MAIN STREET NORTHEAST**
(L5) **MENAHGA, MN** (L6) **56464**

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 **1/21/2014** (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 **65** (L18)

13.Total Certified Beds **65** (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
	65			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE
Lyla Burkman, Unit Supervisor
Date : 02/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Kate JohnsTon, Enforcement Specialist
Date: 03/17/2014 (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
06/01/1991
(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 03/26/2014 CO. Z17P

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/25/2014
(L33)

DETERMINATION APPROVAL

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 1/15/2014, the facility is certified for 65 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245563

March 17, 2014

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

Dear Mr. Erickson:

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 15, 2014, the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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
245563	A. Building B. Wing	1/21/2014

Name of Facility	Street Address, City, State, Zip Code
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **01/15/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/15/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/15/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/15/2014**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **01/15/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/15/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/15/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/15/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/15/2014**
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

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/KJ	1/23/14	28035	1/21/2014
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
12/6/2013			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

RE: Project Number S5563024

Dear Mr. Erickson:

On December 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 6, 2013. 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 January 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2013, effective January 15, 2014 and therefore remedies outlined in our letter to you dated December 20, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Lyla Burkman/bt

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2104 Fax: 218-308-2122

Enclosure

cc: Licensing and Certification File

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
245563	A. Building B. Wing	1/21/2014

Name of Facility	Street Address, City, State, Zip Code
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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 F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 01/15/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 01/15/2014	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 01/15/2014
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/15/2014	ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 01/15/2014	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 01/15/2014
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 01/15/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 01/15/2014	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 01/15/2014
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

Reviewed By ✓ State Agency	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2-3-14
Reviewed By ____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/6/2013	____	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: Z17P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00678

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245563**

2.STATE VENDOR OR MEDICAID NO.
(L2) **475240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN PINE ACRES NURSING HOME**
(L4) **427 MAIN STREET NORTHEAST**
(L5) **MENAHGA, MN** (L6) **56464**

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 **12/06/2013** (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 **65** (L18)

13.Total Certified Beds **65** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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):

At the time of the standard survey completed December 6, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NE II 01/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 01/23/2014 (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
06/01/1991
(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

Certified Mail # 7012 3050 0001 9094 7161

December 20, 2013

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

RE: Project Number S5563024

Dear Mr. Erickson:

On December 6, 2013, 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

<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, Unit Supervisor
Minnesota Department of Health
705 - 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

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 January 15, 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 January 15, 2014 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 March 6, 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 June 6, 2014 (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 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
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
	245563	A. BUILDING _____ B. WING _____	12/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

(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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS-2567. However the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or conclusions set forth in the Statement of Deficiencies.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	The DON did re-educate the LPN responsible for the citation about privacy and doing eye drops, checking treatment areas and monitoring lungs in a public area. At the LPN meeting on 12/17/13, this was discussed. All staff were reminded to not give eye drops, check a treatment area or do lung monitoring in a public place. Plan to also review this at the RN meeting on 12/31/13. A policy will be developed related to administration of medications, doing treatments and lung monitoring in a private place, not in a public place. All RN, LPN and TMA staff will be educated on this policy and sign off that they have read the policy. Approved w addendum 1-6-14 SB	1/15/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1-3-14

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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	245563	A. BUILDING _____ B. WING _____	12/06/2013

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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure privacy was provided during an observation of a resident's body part for 1 of 1 resident (R87) in the sample whose right leg wound was observed in a public area. In addition, the facility failed to ensure privacy was maintained for 1 of 1 resident (R52) in the sample whose lungs were assessed in a public area. Also, privacy was not maintained for 1 of 1 resident (R26) in the sample who received eye drops in a public area. This had the potential to affect 44 residents who were in the main area. Findings include: R87's privacy was not maintained while the right knee was examined in a public area. R87's admission Minimum Data Set (MDS) dated 11/21/13, indicated R87 had severe cognitive impairment. The December treatment record indicated R87 had a non-healing ulcer on the right anterior knee and treatment was provided twice a day. On 12/2/13, at 4:46 p.m. license practical nurse (LPN)-A asked R87 by the nurses station if he could look at his knee. There were eight other residents in the area. LPN-A was observed to check R87's skin condition of the right knee and	F 164	DON will watch LPN/TMA as they do eye drops, lung monitoring and treatments. Random observational audits will be completed on both morning and p.m. staff. DON will monitor this weekly x 2 months and then monthly for a year. Findings will be documented and kept in the DON office. This was discussed at the QA meeting 12/30/13. This will be discussed at each QA meeting in 2014.	

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F 164	Continued From page 2 did not ask R87 if it was okay to do this in the presence of other residents. On 12/3/13, at 4:23 p.m. LPN-A stated normally he would do this in the resident's room "time permitting." LPN-A stated R87 had an abrasion on the right knee. LPN-A stated he was checking the knee and would do the treatment in the evening. LPN-A also stated he had never thought about how this could affect other residents in the area. On 12/5/13, at 10:57 a.m. R87's right knee was observed to have an abrasion which was approximately 4 centimeters (cm) x 4 cm. At 2:09 p.m. the director of nursing (DON) stated LPN-A should have taken R87 to his room. The DON stated, "It should be common sense." R52's lungs were assessed in the main dining area with 44 other residents in attendance. R52's Diagnosis Report dated 12/5/13, indicated diagnoses of congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure) and dementia. R52's quarterly MDS dated 1/29/13, indicated R52 had severe cognitive impairment and required extensive staff assist with activities of daily living. On 12/2/13, at 5:25 p.m. LPN-A was observed to approach R52 while seated in the main dining room. LPN-A asked R52 if he was short of breath or coughing anything up. LPN-A then, without asking R52 for permission, stated to R52 that he wanted to listen to his lungs. This conversation could be heard three tables away. LPN-A	F 164		

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F 164	Continued From page 3 proceeded to place a stethoscope on R52's chest and listened to R52's lung sounds through his t-shirt. At the time of the observation, R52 had three peers seated at his table, 41 other residents and one visitor present in the dining room. On 12/3/13, at 4:24 p.m. LPN-A confirmed he had assessed R52's lungs when R52 was seated at his table in the main dining room. LPN-A was unable to recall if he had asked R52 for permission to conduct this assessment in a public area. LPN-A confirmed the dining area was not a private setting to conduct R52's lung assessment. On 12/5/13, at 1:37 p.m. the DON verified staff should not conduct resident assessments in the middle of the dining area and stated these assessments should have been conducted in a more private area. The facility Medication Administration Policy dated 11/8/05, did not address providing privacy during the medication administration process. R26 received eye drops while sitting in the hallway in front of several residents. R26's quarterly MDS dated 10/16/13, identified R26 as having no cognitive impairments. On 12/2/13, at 5:06 p.m. LPN-A was observed to walk up to R26 and state, "Ok [R26] we got an eye drop for you." LPN-A proceeded to administer the eye drops in the hallway while R26 sat in a wheelchair with several other residents present in the same area. LPN-A did not ask R26 for permission to administer the eye drops in front of the other residents.	F 164		

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F 164	Continued From page 4 On 12/2/13, at 5:35 p.m. LPN-A stated he tries to give the eye drops in R26's room, however, LPN-A confirmed the eye drops were administered in the hallway in front of other residents. On 12/4/13, at 9:45 a.m. R26 stated staff often administered the eye drops in the hallway before supper, R26 stated, "it's a common occurrence." On 12/5/13, at 2:09 p.m. the DON stated staff were expected to administer eye drops in the resident's room. The DON reported it was not acceptable to give eye drops in the lobby or hallway with other residents present and the nurse should have asked the resident to go back to their room or somewhere that was private.	F 164		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	This resident's care plan was amended to say, "Assist of 1 to shave/trim facial hair. Does at times refuse to have this done especially around mole. Encourage her to allow shaving and trimming, but follow her wishes." Will have Grooming Sheets in the bathing area. Staff is to note with each bath if resident needs facial shaving/ trimming or not. These sheets will be signed and dated. Will develop policy related to care planning if resident does not want facial hair trimmed/shaved. Will educate RN staff and have them sign that they have read the policy.	1/15/2014

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F 279	Continued From page 5 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a plan of care for 1 of 1 female resident (R77) who required grooming assistance for the removal of facial hair. Findings include: R77's quarterly Minimum Data Set dated 10/17/13, noted R77 had moderate impaired cognition and required extensive assist of one staff for completing personal hygiene including shaving. The MDS also indicated R77's diagnoses included osteoporosis, generalized pain, adult failure to thrive and aftercare healing of fractured ribs. R77's current plan of care (POC) dated 7/1/13, indicated R77 had an alteration in activities of daily living and required assistance with oral care, bathing, dressing, combing hair and washing face. The POC lacked indication of the need to shave facial hair. On 12/3/13, at 8:52 a.m. R77 was observed seated in a wheelchair in the hallway, several long and curly facial hairs were growing out of a mole above the left side of the upper lip. On 12/4/13, at 7:11 a.m. trained medication aid (TMA)-B was observed providing R77 morning cares. R77 was observed to have several long and curly facial hairs growing out of a mole above	F 279	Each day (Monday-Friday) the Grooming Sheets will be brought to the RN's office. If a resident needs facial grooming or facial trimming, the RN will notify the LPN for that resident. If a resident refuses to have facial hair trimmed or shaved, RN will put this on the care plan. The RN will check that the facial grooming was done the same day it was reported as needing to be done. DON will monitor and document compliance weekly. The DON will oversee this and it will be monitored by the DON by checking the care plans of the residents for change weekly. Documentation will be kept in the DON office. This was discussed at the QA meeting on 12/30/13. This will be discussed at each QA meeting in 2014.	

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F 279	Continued From page 6 the left side of the upper lip. TMA-B stated R77 needed assist of one for grooming. TMA-B then combed R77's hair and provided oral care, when finished with morning cares, TMA-B pushed R77 in the wheelchair to the dining room for breakfast without shaving R77's facial hair. During interview on 12/5/13, at 3:24 p.m. the director of nursing (DON) reported staff shave facial hair for women on their bath day, then provided a grooming checklist which included checking for facial hair. The DON reported she expected residents to be shaved, she also confirmed it should have been included on R77's POC.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grooming assistance for the removal of facial hair was provided for 1 of 1 female resident (R77) who required staff assistance for grooming. Findings include: R77's quarterly Minimum Data Set dated 10/17/13 noted R77 had moderate impaired cognition and required extensive assist of one	F 312	Facial hair was trimmed on resident (R77) A Grooming Sheet will be filled out with each bath given. This will be signed and dated by the bath aide. This will be taken to the RN office the same day the bathing was done. The RN will review the Grooming Sheets and notify the LPN if a resident continues to need shaving/ trimming of facial hair or has refused to allow staff to shave/trim facial hair. These will be kept in the RN office. A policy will be developed related to grooming of facial hair. This will be read and signed by all bath aides, LPNs, TMAs and RNs. All NARs will be educated regarding facial grooming at each NAR meeting in 2014.	1/15/2014

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F 312	Continued From page 7 staff for completing personal hygiene including shaving. R77's current plan of care (POC) dated 7/1/13, indicated R77 had an alteration in activities of daily living and required staff assistance with oral care, bathing, dressing, combing hair and washing face. The POC lacked indication of the need for assistance to shave facial hair. On 12/3/13, at 8:52 a.m. R77 was observed seated in a wheelchair in the hallway, several long and curly facial hairs were growing out of a mole above the left side of the upper lip. On 12/4/13, at 7:11 a.m. trained medication aid (TMA)-B was observed providing R77 morning cares. R77 was observed to have several long and curly facial hairs growing out of a mole above the left side of the upper lip. TMA-B stated R77 needed assist of one for grooming. TMA-B then combed R77's hair and provided oral care, when finished with morning cares, TMA-B pushed R77 in the wheelchair to the dining room for breakfast without shaving R77's facial hair. On 12/4/13, at 7:20 a.m. TMA-B stated staff shaved R77's facial hair on bath day and reported R77's last bath was on 12/3/13. TMA-B stated staff also shaved facial hair between baths if needed. On 12/5/13, at 3:24 p.m. the director of nursing (DON) confirmed staff shaved facial hair for women on their bath day, then provided a grooming checklist which included checking for facial hair. The DON stated the facility did not have a grooming policy. The also DON stated she expected residents to be shaved.	F 312	RN will check the resident who were noted to need facial grooming the same day that it was reported to them to be sure it was completed. The RN will insure compliance and keep this documentation in her office. This will be monitored by the DON by checking the Grooming Sheets weekly. This was discussed at QA meeting on 12/30/13. This will be discussed at each QA meeting in 2014.	

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F 312	Continued From page 8 On 12/6/13, at 8:49 a.m. R77 again was observed to have long, curly facial hairs growing from mole above the upper lip. The DON was present during the observation and confirmed the facial hair growing out of the mole needed to be shaved off.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accident hazards involving a call light had been investigated and interventions had been implemented to minimize further incidents for 1 of 1 resident (R48) in the sample who was found entangled in the call light cord. Findings include: R48's Diagnoses Report dated 12/5/13, indicated R48's diagnoses included dementia, macular degeneration and memory loss. R48's quarterly Minimum Data Set (MDS) dated 10/22/13, identified R48 had severe cognitive impairment and required extensive assistance of two or more staff for bed mobility.	F 323	We did remove the 11' long call light cord and replaced it with a 7' long cord. At each LPN meeting this next year, DON will review what events should prompt staff to write an incident report and who to notify. The Incident Report Sheet will be updated to reflect "strangulation hazards". Is this a life threatening incident? If so, primary RN DON and administrator need to sign and date when the RN, Don and administrator were notified. DON did explain at the LPN meeting on 12/17/13 what needs to be documented on Incident Reports and that the RN and DON will continue to educate all TMA/LPN as to what to report as an incident, how to document this and who to report it to at each monthly LPN/TMA meeting. Will develop a policy as to what to report to RN, DON and administrator. If a life threatening event has occurred e.g. elopement, fall, strangulation hazard, suicide attempt or suicide statement, this will be reported to RN, DON and administrator. New interventions will be put into place	1/15/2014

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F 323	Continued From page 9 During review of the interdisciplinary progress notes for R48 on 7/13/13, the following progress note written by trained medication aide (TMA)-C was noted: "Resident was found by Housekeeping with her call light around her neck. I repositioned resident and readjusted call light. Will continue to monitor." No further documentation including an incident report or investigation related to this incident was found in the residents record. The director of nursing (DON) was interviewed on 12/4/13, at 9:16 a.m. and stated she had not recalled hearing about this incident where R48 was found having a call light cord wrapped around her neck on 7/13/13. An incident report was requested related to this aforementioned incident and the DON stated that there was no incident report found related to this incident. Registered nurse (RN)-B was also interviewed on 12/4/13, at 9:21 a.m. and stated that she had not recalled any staff reporting this incident. The DON and RN-B stated that an incident report should have been made, and the incident should have been reported to the charge nurse so the situation could have been assessed to determine what happened, and if there needed to be actions taken so the incident would not reoccur. RN-A who was the charge nurse on the day shift on 7/13/13, was interviewed on 12/4/13, at 10:53 a.m. and stated that TMA-C had not reported that R48 had been found with the call light cord wrapped around her neck. TMA-C was no longer employed with the facility and could not be interviewed.	F 323	immediately, including removal of hazards, if a life threatening event has occurred, to insure the safety of the resident. Will have all LPNs, TMAs and RNs sign that they have read the policy. Will discuss what to report to nursing staff at each monthly NAR meeting and have CNAs who are present sign that they attended the meeting. All incident reports are to be given to the DON to review and monitor after the RN has reviewed them. All fall reports and other incidents (bruise, skin tear, skin ulcer, other change in skin condition, resident to resident altercation, elopement or unsafe wandering, ingestion of unsafe items, unsafe cigarette smoking, strangulation hazards, suicide attempts, suicide statements) are reviewed daily at 0915 report meeting attended by administrator, DON, RNs, SS, Dietary, Activity, Medicare nurse and MDS nurse. Incident reports continue to be reviewed at 0915 reports on weekend with RN and LPNs. This was discussed at the QA meeting on 12/30/13. this will be discussed at each QA meeting in 2014.	

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F 323	Continued From page 10 On 12/4/13, 2 of 3 housekeeping (housekeeper A, and housekeeper B) staff were interviewed and neither one of them had been the housekeeper that reported R48 had been found with the call light cord wrapped around her neck. Housekeeper C could not be reached for interview during the survey. During interview with nursing assistant (NA)-A on 12/4/13, at 9:30 a.m. stated she was responsible for the care of R48 on 12/4/13, during the day shift. NA-A established that she was unaware of any incidents where the call light had gotten caught around the neck of R48. NA-A stated that she had not been instructed to change the call light positioning or position the call light for R48 in any sort of special manner. NA-A stated she was unaware of any room or environment changes for R48 since July of 2013. On 12/3/13, at 9:54 a.m. R48 was observed sleeping in bed. The head of the bed was observed parallel to the wall where the call light was plugged into a box on the wall. When facing this wall straight on, the call light box was affixed to the wall to the left of the head board, and the call light cord was strung around the back of the head board (between the wall and the head board), and tucked on the right side of the bed, clipped to the bed. R48's plan of care (POC) dated 10/24/13, had not identified anything related to checking or placing the call light for R48. Review of the INCIDENT REPORT POLICY (undated) identified the following: "PURPOSE: To ensure that all incident reports are filed in an organized manor. POLICY: The Director of	F 323		

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F 323	Continued From page 11 Nurses will process incident reports. Non-reported incident reports will be kept on an annual basis related to the Quality Assurance meeting schedule. Reported incidents will be kept for two years. PROCEDURE: 1. The D.O.N. will receive completed incident reports from the RN's. 2. All incident reports to be kept in the D.O.N.'s office 3. Fall committee meetings and QAR meetings will track any noticeable patterns and look for solutions." The INCIDENT FOLLOW-UP PLAN identified the following process "Incident example: fall skin tear, bruise occurs->Licensed Nurse completes report and documents incident in chart (either a Fall Report or Incident Report as appropriate)->Nurse Manager reviews Incident Report and completes post-incident analysis section of form.->DON or designee reviews for possible vulnerable adult issue->Interdisciplinary assessment completed.->Recommendations given to Nurse Manager.->DON receives from and files in chronological order. Reports to monthly Fall Committee for review and recommendation.-> Fall Committee Report posted and given to LPN's and RN's." The DON was again interviewed on 12/4/13, at 11:42 a.m. during which she confirmed that the incident had not been reported and investigated according to the facility policy. The DON further stated the call light and cord should have been assessed and interventions should have been implemented to minimize the chance R48 would get the call light cord wrapped around her neck again.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334	The DON with the assistance of another RN will receive a signed and dated form noting the resident or resident representative was given the Vaccine Informaiton Sheet.	1/15/2014

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F 334	Continued From page 12 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal	F 334	The DON with assistance of another RN will keep the signed and dated forms in a binder instead of a loose folder in the office and in the resident chart. DON and another RN will have a list of residents and check off as consents are received. DON and another RN will check on the day of the vaccination that the signed and dated form is present prior to giving the injection to a resident. DON and another RN will check that form is present. This will be monitored by the DON by checking the chart that all forms have been scanned into the chart within a week after immunization was given. This was discussed at the QA meeting on 12/30/13. This will be discussed at each QA meeting in 2014.	

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F 334	Continued From page 13 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident or resident's representative with the required education related to the influenza vaccination for 2 of 5 residents (R26, R30) reviewed for immunizations. Findings include: R26's diagnoses list in R26's medical record indicated diagnoses which included peripheral vascular diseases, diabetes, and hypertension.	F 334		

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F 334	Continued From page 14 Review of R26's medical record revealed R26 was administered influenza vaccine on 9/12/13, however, R26's medical record lacked documentation R26 or R26's legal representative was provided education regarding the risks, benefits and potential side effects of the influenza vaccine prior to the administration of the vaccine. R30's diagnoses list in R30's medical record indicated diagnoses which included chronic pulmonary heart disease, hypertension and diabetes. Review of R30's medical record revealed R30 was administered the influenza vaccine on 9/12/13. However, R30's medical record lacked documentation that R30 or R30's legal representative was provided education regarding the risks, benefits and potential side effects of the influenza vaccine prior to the administration of the vaccine. The facility policy dated 5/08, titled, "Influenza Vaccine Policy" identified: Each resident/family would be given a copy of information related to the influenza vaccine. The policy also indicated this notification would be recorded on the Annual Influenza Vaccine Record which would be kept in the resident's individual medical record. On 12/4/13, at 1:15 p.m. the director of nursing (DON) verified the required influenza vaccine documentation was missing from R26 and R30's medical records and confirmed the facility's influenza vaccine policy was not followed.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356	A new form was developed to reflect accurately the actual hours per shift that the RN, LPN, TMA and CNA work.	1/15/2014

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F 356	Continued From page 15 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and post the actual hours worked for nursing staff directly responsible for resident care per shift. This had the potential to affect all 64 residents who resided in the facility. Findings include:	F 356	The form is filled out each day at the beginning of each shift and posted near the front lobby. A policy and procedure will be developed to reflect to explain how to fill out the form and who is responsible for filling it out. The form will be reviewed with the schedule daily to check for accuracy. This will be reviewed every morning by the DON, if she is not present the RN in charge will review this. This will then be given to the administrator. This was discussed at the QA meeting on 12/30/14. This will be discussed at each QA meeting in 2014.	

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F 356	Continued From page 16 On 12/2/13, at 2:40 p.m. during the initial tour of the facility, a Report of Nursing Staff Directly Responsible For Residents Care form was observed on an 8 inch x 11 inch sheet of paper inserted in a plastic wall sleeve on the wall of the lobby area of the facility. The posted nurse staffing information lacked the actual shift hours worked by licensed and unlicensed staff responsible for providing direct resident care. Review of the forms provided by the facility titled Report of Nursing Staff Directly Responsible for Residents Care from 12/2/13 to 12/6/13, revealed the usual shifts licensed and unlicensed staff were scheduled to work, but did not identify the actual hours worked. On 12/6/13, at 8:30 a.m. the director of nursing (DON) verified the Report of Nursing Staff Directly Responsible for Residents Care form posting information was incorrect with no actual shift hours worked by licensed or unlicensed staff. The DON stated, we have some staff that only work a four hour shift and we should be posting that as well. A policy was requested, the DON stated, "We do not have a policy for nurse staff posting."	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Dietary employees individually in-serviced on 12/02/13, 12/03/13, 12/04/13 and again as a group on 12/27/13 regarding dishwasher temperature protocol. In-service consisted on how to monitor the temperature, document the temperature and report problems regarding the temperature of the dishwasher.	1/15/2013

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F 371	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize the possibility of food borne illness due to their dishwashing machine not functioning according to the manufacturer's instructions. This had the potential to affect 61 residents residing in the facility who were served prepared meals from the kitchen. Findings include: On 12/2/13, at 1:21 p.m. an initial tour of the kitchen was completed with the dietary supervisor (DS). The DS stated the facility used a low temperature dishwasher. - At 1:36 p.m. a dishwasher cycle was observed and the rinse temperature was noted to reach 108 degrees Fahrenheit (F). The manufacturer's instructions on the dishwasher read 120 degrees F minimum. The DS stated they had never documented the dishwasher final rinse temperature. - At 1:38 p.m. a second cycle of the dishwasher was completed and the final rinse temperature was 100 degrees F and this was verified by the DS. The DS also stated the heat booster for the dishwasher was approximately ten years old. - At 1:39 p.m. the DS stated all the resident dishes go through the dishwasher. On 12/3/13, at 1:26 p.m. the DS stated maintenance staff (MS)-A had turned the temperature up on the heat booster for the dishwasher.	F 371	The dishwasher temperature is checked and documented two times a day. This is to be done by two different dietary employees. Any temperature that reads below 120 degrees is to be rechecked. If the temperature continues to read below the recommended 120 degrees the dietary employee is to report the low temperature to the maintenance department or dietary supervisor. When the dietary employee reports a problem they are to document this on the sheet where the dishwasher temperatures are documented. Dietary Supervisor to monitor weekly that the temperatures of the dishwasher are being taken, documented, that any problems were reported, and that correct temperatures are maintained. If protocol is not being followed, the dietary supervisor will address individual employee involved. Further problems will be brought to the Quality Assurance Meeting.	

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F 371	Continued From page 18 - At 1:28 p.m. a dishwasher cycle was observed and the final rinse temperature was noted to reach 118 degrees F and was verified by the DS. On 12/4/13, at 1:25 p.m. a dishwasher cycle was observed and the final rinse temperature was noted to reach 120 degrees F. On 12/5/13, at 11:21 a.m. MS-A stated on 12/3/13, a maintenance staff had turned up the temperature on the heat booster. He also stated on 12/4/13, the heat booster was turned up again. The manufacturer's manual for the dishwasher dated 6/7/13, indicated the dishwasher must provide a minimum temperature of 120 degrees F.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	The resident's name was put on the insulin pen that had no name on it. Stickers were made up with the resident's name and "give as indicated on emar." These are to be placed on each insulin pen that is not labeled from the drug store. Insulin pens that were not dated, were dated. The cartridge that had expired dates were taken back to the drug store after confirming with the pharmacists that they were not actually outdated but rather the labels were not updated to reflect the actual expiration date for each medication.	1/15/2014

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F 431	Continued From page 19 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label insulin pens/vials when opened for 2 of 14 residents (R41, R43) reviewed receiving insulin. In addition, the facility failed to establish a system to ensure expired medications were not available for use for 1 of 7 residents (R3) observed during the medication pass. Findings include: Insulin pens/vials were not consistently labeled with an open date, or the date was not readable. During the medication storage review on 12/5/13, at 1:46 p.m. until 2:30 p.m. trained medication aide (TMA)-A and licensed practical nurse (LPN)-C confirmed R41 and R43's insulin pen/vials were not labeled with the date they were opened, or the date had been smeared leaving it unreadable. LPN-A confirmed R41's NovoLog	F 431	Each time the new cartridges are sent over (every two weeks on Thursday evening) the nurses who check them in will check expiration dates on the label. If the date reflects an expiration date that has passed, they will be sent back to the drug store the next morning. LPN's were told at the LPN meeting on 12/17/13 to be sure the medications are labeled with the resident's name, date when insulin is opened and the expiration date is looked at prior to giving a medication. Will develope or review current policies and procedures related to having resident's name on each medicaiton, date insulin pen was opened/started on each pen, checking expiration dates on each medication prior to giving a medicaiton. Will have all TMAs. LPNs and RNs read and sign that they have read the policy. DON will check all medication in the med room and on the carts every 2 weeks x 2 months and then monthly for any expired medications, that all insulin pens are labeled and insulin pen are dated as to when they were opened. This will be monitored by the DON and documentation will be kept in the DON office.	

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F 431	Continued From page 20 insulin was outdated as it had been dispensed on 8/8/13. TMA-A confirmed R43's Lantus insulin was outdated as it had been dispensed on 11/6/13. On 12/5/13, at 3:30 p.m. director of nursing (DON) provided a copy of the facility's Policy for Eye Drops and Insulin Disposal dated 11/11. This policy directs staff to dispose of insulin 28 days after it is opened. During the medication observation, R3 was administered expired medications. During medication administration observation on 12/2/13, at 7:18 p.m. LPN-A prepared R3's evening medications. R3's Tramadol medication was observed in a cartridge with a typed label that included an expiration date of 10/16/13, LPN-A confirmed the medication was expired, then proceeded to dispense the expired medication into a cup, crushed the medication and added applesauce. At 7:22 p.m. observed LPN-A give R3 the expired medication in applesauce. During interview on 12/2/13, at 7:26 p.m. LPN-A confirmed he gave R3 the expired medication and R3 did swallow all of the medication. LPN-A stated he never even thought to look at the expiration date on the medication cartridges. On 12/3/13, at 3:45 p.m. the DON reported the facility probably had a "whole slew" of expired medications, she stated the pharmacist just has not changed the labels, then stated the medication cartridges were filled every two weeks.	F 431	This was discussed at the QA meeting on 12/30/13. It will be discussed at each QA meeting in 2014.	

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F 431	Continued From page 21 On 12/6/13, at 9:35 a.m. the consulting pharmacist reported he made monthly visits to the facility. He reported they did not audit the medication carts for expired medications. He then stated they did look for expired medications in the emergency kits, medication rooms and refrigerators. On 12/6/13, at 10:11 a.m. the dispensing pharmacist reported the pharmacy refilled the medication cartridges every two weeks. The pharmacist stated when a medication was ordered their computer system should update the labels with the new expiration dates. The dispensing pharmacist did confirm the pharmacy should have updated the labels and did not, then stated the medications were not actually expired. On 12/6/13, at 10:00 a.m. the DON reported staff were expected to look at the expiration date on all medications before administering them. The DON stated the facility had not provided any education for medication administration, she stated staff should already have that knowledge once they get out of school. The DON reported she did not complete any type of monitoring, such as audits, to ensure there are no expired medications in circulation. The DON also stated she went through all three medication carts and found several expired medication cartridges, enough to fill a large bag, then returned them to the dispensing pharmacy for new labels. The facility's Medication Administration Policy dated 11/8/05, did not identify the need to check for the expiration of a medication before administration. The facility's undated Pharmacy Services Policy	F 431		

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F 431	Continued From page 22 indicated all drugs and biological's used in the facility should be labeled in accordance with currently accepted professional principles.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	Will improve our Infection Control form to track infections which will reflect which hall the resident is on, if the antibiotic worked, what labs were done prior to DX. Will start an Infection Control Committee on 1/14/14 which will consist of the DON, another RN, Housekeeping Supervisor, TMA and NAR. We will update or develop the policies as need related to infection control and isolation. We will analyze the infections in the facility for staff and residents and determine if any trends are present. We will meet monthly. The Infection Control Program will investigate, control and seek to prevent infections in the facility. It will decide what procedures, such as isolation or other measures, should be applied to an individual resident. It will maintain a record of incidents and corrective actions related to infections. It will develop transmission of infection, address multi drug resistant organisms, handling linens, isolation precautions, what to do if a resident has c-diff and other types of infectious diseases. Will develope policy noting proper hand washing and changing of gloves during a dressing change. Will have all Rns, LPNs and TMAs read and sign policy.	1/15/2014

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F 441	Continued From page 23 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate infection control technique for 1 of 1 resident (R52) observed receiving a supra-pubic dressing change. In addition, the facility failed to ensure infection surveillance was completed timely to determine any trends and potential infection outbreaks. Also, the facility did not track employee illnesses/infections. This practice had the potential to affect all 62 residents currently residing in the facility. Findings include: Proper hand hygiene was not observed during the dressing change for R52's supra pubic catheter (tube which is inserted through a small hole in the abdomen which drains urine from the bladder). R52's diagnoses identified on his Diagnosis Report included congested heart failure (decrease in heart function to pump blood), diabetes, hypertension (high blood pressure), dementia and urinary retention. R52's quarterly Minimum Data Set (MDS) dated 1/29/13, indicated R52 had severe cognitive impairment and required extensive staff assist with activities of daily living, toileting and personal hygiene.	F 441	Will monitor for trends on a weekly basis. If trends are noted, they will be acted upon at that time. The Infection Control Committee will give monthly report of any trends of infection to the administrator. The infection reports will also be part of the QA Meetings. Will observe dressing change weekly x 2 months and then for one year. These audits will be documented and kept in the DON office. This was discussed at QA meeting on 12/30/13. This will be monitord by the DON.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	12/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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F 441	Continued From page 24 On 12/4/13, at 9:08 a.m. licensed practical nurse (LPN)-B was observed to gather her supplies and enter R52's room. R52 was observed in the lying position in his recliner. LPN-B received permission to complete the dressing change on R52's supra pubic catheter. LPN-B was observed to donne a pair of gloves and slightly pull down R52's sweatpants and assessed the catheter site. LPN-B sprayed silver solution on a gauze pad and using her right gloved hand wiped around the supra pubic catheter site. LPN-B disposed of the gauze pad into the nearby garbage bin. LPN-B proceeded to place her gloved right pointer finger into a small medicine cup containing zinc oxide ointment and then spread the zinc oxide ointment around the supra pubic catheter site. LPN-B then opened a split gauze dressing and placed it around the supra pubic catheter. During this time LPN-B was observed to have not removed her soiled gloves nor wash her hands. On 12/4/13, at 9:15 a.m. LPN-B removed her gloves and washed her hands in R52's bathroom. On 12/4/13, at 9:18 a.m. LPN-B confirmed she had not washed her hands prior to donning the gloves to do the supra pubic catheter dressing change nor had she change her gloves and wash her hands between cleaning the supra pubic site and applying the zinc oxide ointment. On 12/5/13, at 11:32 a.m. director of nursing (DON) verified it was her expectation for staff to wash their hands prior to completing catheter	F 441		

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	245563	A. BUILDING _____ B. WING _____	12/06/2013

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F 441	Continued From page 25 care and gloves should be changed and hands washed prior to a new set of gloves being donned after cleaning a supra pubic site and applying ointment. Physician orders dated 12/2/13, direct staff to apply zinc oxide 40% ointment once a day around R52's supra pubic catheter. The facility's Green Pine Acres Urinary Catheterization policy and procedure dated 12/2010, directed staff to utilize standard precautions, use gloves when manipulating the catheter site and to practice hand hygiene before and after. On 12/04/13, at 1:15 p.m. the DON confirmed the facility lacked pertinent polices/procedures related to the prevention of infection. Polices lacking (but not limited to) are: -Infection Prevention and Control Program -Surveillance -Transmission Based Precautions -Communicable Disease Reporting -Prevention and Control of Transmission of Infection -Multi Drug Resistant Organisms's -Handling Linens -Isolation precautions -C-Diff	F 441		

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	245563	A. BUILDING _____ B. WING _____	12/06/2013

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F 441	Continued From page 26	F 441		

The DON stated staff completed an Infection Report on any resident who was diagnosed or showed signs/symptoms of an infection. Some of the items collected include: site of infection, symptoms, diagnostic test, results, organism. There were ten reports for the month of November 2013 and ten of those reports were not complete. The DON stated she had not even looked at November or December's reports yet. The DON also stated she filed the reports and then quarterly will prepare an infection (IC) report for the Quality Assurance (QA) meeting. The last report, failed to identify if there were any trends or patterns of infection. There was no tracking of infections, ongoing analysis or interpretation of the findings in order to prevent the spread of infection in the facility.

Infection control summary:

	UTI	URI	GI	Skin	Other
July	3	4	0	2	3
August	7	3	0	7	0
September	4	1	0	6	1
October	4	5	1	0	2

On 12/5/13, at 9:17 a.m. the DON stated she was responsible for the monitoring and implementation of the infection control program for the facility and verified there was not a comprehensive system in place to evaluate and determine trends or patterns to prevent the spread of infection in the facility. The DON added, she had thought about looking at the residents illness in relation to the staff but had not included that yet.

F334

1. The DON with the assistance of another RN will receive a signed and dated form noting the resident or resident representative was given the Vaccine Information Sheet.
2. The DON with the assistance of another RN will keep the signed and dated forms in a binder instead of a loose folder in the office and in the resident chart. DON and another RN will have a list of residents and check off as Vaccine Information Sheets are received.
3. DON and another RN will check on the day of the vaccination that the signed and dated form is present prior to giving the injection to a resident.
4. DON and another RN will check that Vaccination Information Sheet is present.
5. This will be monitored by the DON by checking the chart that all forms have been scanned into the chart within a week after immunization was given.
6. This was discussed at the QA Meeting on 12-30-13. This will be discussed at each QA Meeting in 2014.

Administrator

1-6-14

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

F5563023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building (1964 original building and 1969, 1996, 1999 additions) A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Green Pine Acres Nursing Home 01 Main Building was found 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. Green Pine Acres Nursing Home was constructed in 5 different years. The original building was built in 1964, is 1-story with a partial basement and was determined to be Type II (111) construction. In 1969 an addition was constructed to the west of the original building, is 1-story, no basement and was determined to be Type II (111) construction. In 1996 the Administration building and connecting link were constructed to the south east corner of the original building. It is 1-story without a basement and was determined to be Type V (111) construction. This addition is separated from the existing facility by at least a 2-hour-rated fire barrier. In 1999 a laundry addition was constructed to the north west of the original building, is 1-story , without a basement. In 2004 a kitchen addition to the north west of the 1969 addition was constructed. It is 1-story without a basement and was determined to be Type II (111) construction. The building is divided into 4 smoke zones by 30 minute and 90 minute fire barriers.	K 000		

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

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 The entire facility is protected with an automatic sprinkler systems installed in accordance with NFPA 13 Standard for the installation of Sprinkler Systems 1999 edition with quick response heads in all areas except in hazardous areas where standard response heads are used. The facility has a fire alarm system with smoke detectors in the corridor system, in all common areas and is installed in accordance with NFPA 72 " The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored off site and has automatic fire department notification. The facility has a capacity of 65 beds and had a census of 64 at the time of the survey. This facility was surveyed as two separate buildings. The main building as existing, including the 1996 administration building and the 1999 laundry addition, with the 2004 kitchen addition as a separate building as new construction. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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	245563	A. BUILDING **03 - KITCHEN ADDITION** B. WING _____	**12/03/2013**

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K 000	INITIAL COMMENTS FIRE SAFETY 03 Kitchen Addition A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Green Pine Acres Nursing Home 03 Kitchen Addition was found 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 18 New Health Care. Green Pine Acres Nursing Home was constructed in 5 different years. The original building was built in 1964, is 1-story with a partial basement and was determined to be Type II (111) construction. In 1969 an addition was constructed to the west of the original building, is 1-story, no basement and was determined to be Type II (111) construction. In 1996 the Administration building and connecting link were constructed to the south east corner of the original building. It is 1-story without a basement and was determined to be Type V (111) construction. This addition is separated from the existing facility by at least a 2-hour-rated fire barrier. In 1999 a laundry addition was constructed to the north west of the original building, is 1-story , without a basement. In 2004 a kitchen addition to the north west of the 1969 addition was constructed. It is 1-story without a basement and was determined to be Type II (111) construction. The building is divided into 4 smoke zones by 30 minute and 90 minute fire barriers.	K 000		

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