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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZBH0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 **01/09/2014** (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)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (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
	119			
(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):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on January 9, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NE II 01/31/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/18/2014 (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
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/23/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245368

February 18, 2014

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

Dear Ms. Jokinen:

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 December 31, 2013 the above facility is certified for:

119 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 119 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

January 31, 2014

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368024

Dear Ms. Jokinen:

On December 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 21, 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 9, 2014 the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 29, 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 November 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2013, effective December 31, 2013 and therefore remedies outlined in our letter to you dated December 11, 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,

Kamala Fiske-Downing

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

Enclosure
cc: Licensing and Certification File

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
245368	A. Building B. Wing	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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 **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **12/13/2013**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **12/13/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/13/2013**
ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **12/13/2013**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **12/13/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/31/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/13/2013**	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/kfd	01/31/2014	18619	01/09/2014
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
11/21/2013			

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
245368	A. Building B. Wing **01 - MAIN BUILDING 01**	1/29/2014

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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	Correction Completed **11/25/2013**	ID Prefix	Correction Completed **11/25/2013**	ID Prefix	Correction Completed **11/25/2013**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0054	
ID Prefix	Correction Completed **12/10/2013**	ID Prefix	Correction Completed **12/17/2013**	ID Prefix	Correction Completed **12/11/2013**
Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0069		Reg. # **NFPA 101** LSC K0147	
ID Prefix	Correction Completed **12/19/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0155		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KK/kfd	01/31/2014	03006	01/29/2014
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
11/20/2013			

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
245368	A. Building B. Wing **02 - SUB ACUTE**	1/29/2014

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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	Correction Completed **11/25/2013**	ID Prefix	Correction Completed **12/31/2013**	ID Prefix	Correction Completed **12/10/2013**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **12/31/2013**	ID Prefix	Correction Completed **12/19/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0147		Reg. # **NFPA 101** LSC K0155		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KK/kfd	01/31/2014	03006	01/29/2014
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
11/20/2013				

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00298	A. Building B. Wing	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20545** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **12/13/2013**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **12/13/2013**	ID Prefix **20930** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **12/13/2013**
ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **12/13/2013**	ID Prefix **21000** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **12/13/2013**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp.** LSC	Correction Completed **12/31/2013**
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/kfd	01/31/2014	18619	01/09/2014
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
11/21/2013				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZBH0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 **11/21/2013** (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)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (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 Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	119			
(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 Date :
Rebecca Haberle, HFE NE II 01/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/17/2014 (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
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5368

At the time of the standard survey completed November 21, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 6997

December 11, 2013

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368024

Dear Ms. Jokinen:

On November 21, 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;

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

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

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

DEPARTMENT CONTACT

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

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 December 31, 2013, 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 December 31, 2013 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 February 21, 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 May 21, 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, 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
	245368	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(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 verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and complete a significant change assessment for 1 of 1	F 274	1-2-14 Approved w/ revisions to pg 22 + 23 SB F274 - D 1. Corrective Action: A. IDT reassessed Resident #214 B. Significant Change ARD 11/25/13. C. MDS Date of completion for Resident #214, 11/27/13 2. Corrective Action as it applies to Other Residents: A. The policy/procedure for condition change and reporting was reviewed. B. The procedure was reviewed with team on 11/27/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shauna Jokinen | TITLE: Executive Director | (X6) DATE: 12/20/13

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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F 274	Continued From page 1 resident (R214) in the sample who had identified declines in cognition, ability to feed self and significant weight loss. Findings include: R214's admission Minimum Data Set (MDS) dated 9/22/13, indicated R214's diagnoses included Parkinson's disease, congestive heart failure and diabetes mellitus. The MDS also indicated R214 had intact cognition, was independent in feeding and his/her current weight was 182 pounds without a significant weight loss. R214's five day Medicare required MDS dated 10/25/13, indicated R214 had moderate cognitive impairment, required extensive assistance with feeding and current weight was 157 pounds with a significant weight loss identified. On 11/20/13, at 8:50 a.m. nursing assistant (NA)-A was observed to assist R214 with the breakfast meal. NA-A was observed to encourage R214 to take each bite of the meal. R214's responses to the assistance was observed to vary from appropriate responses to not responding at all. NA-A was observed to feed R214 less than 25% of the meal. At 9:45 a.m. the survey staff attempted to interview R214, however, R214 did not respond. On 11/20/13, at 11:52 a.m. R214 was observed to be assisted with the noon meal. R214 was observed leaning to the right while seated in the wheelchair. R214 was observed to have difficulty sitting upright and the nursing assistant staff was observed to assist R214 to sit upright in the wheelchair. R214 was fed the meal and consumed less than 25% .	F 274	3. Date of Completion: 12/13/13 4. Reoccurrence will be prevented by: A. Team reeducated on the reporting procedures and monitoring 12/11/13 and upon hire, annually, and as needed. B. Review of condition change by IDT at morning stand up meetings Monday through Friday. C. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. 5. The Correction will be monitored by: A. DON or MDS Coordinator. B. DON will report summary of condition change to QAPI Committee.	

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F 274	Continued From page 2 Review of R214's interdisciplinary (IPN) notes dated 10/15/13, indicated R214 was hospitalized after sustaining a heart attack and returned to the facility on 10/18/13. On 11/21/13, at 10:30 a.m. the registered dietitian (RD)-A confirmed R214 had sustained a significant weight loss. She stated this may have been due to fluid loss secondary to medications prescribed for congestive heart failure (CHF) upon admission and/or may have been due to actual weight loss. According to the Center for Medicaid/Medicare Services (CMS) Resident Assessment Instrument (RAI) Manual version 3.0 Chapter 2 -0.3 states that a significant change MDS is to be considered if: 1. The concern will not normally resolve itself without interventions by staff or by implementing standard disease-related clinical interventions. 2. Impacts more than one area of the resident's health status and 3. Requires interdisciplinary review and/or revision of the care plan. On 11/21/13, at 11:25 a.m. registered nurse (RN)-C/MDS coordinator confirmed R214 had sustained a significant weight loss, a decline in cognitive abilities and now required extensive staff assistance with eating. She also confirmed the declines in R214's status were present at the time of the 5 day Medicare MDS and a significant change assessment should have been considered at that time. She confirmed R214's current decline in status and verified a significant change MDS had not been initiated by the facility.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 3 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the individual resident assessment accurately reflected the current dental status for 1 of 1 resident (R78) reviewed for dental concerns. Findings include:	F 278	F278 - D 1. Corrective Action: A. IDT reassessed Resident # 78 to ensure accuracy of dental status. B. Resident #78 dental status and oral care reflect actual dental status and oral hygiene needs. 2. Corrective Action as it applies to Other Residents: A. The procedure for assessment and the forms for dentation assessment has been reviewed. B. The assessment forms were reviewed with team on 11/27/13. 3. Date of Completion: 12/13/13 4. Reoccurrence will be prevented by: A. Team reeducated assessment accuracy 12/11/13 and upon hire, annually, and as needed. B. Review of assessment accuracy Mondays at Lunch and Learn. C. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion.	

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F 278	Continued From page 4 R78's significant change Minimum Data Set (MDS) dated 10/2/13, indicated R78's diagnoses included dementia and diabetes mellitus. The MDS also indicated R78 had severe cognitive impairment, required extensive assistance with all activities of daily living and had no natural teeth or tooth fragments. R78's The Dental Care Area Assessment (CAA) dated 10/7/13, indicated R78 had full upper and lower dentures. R78's plan of care dated 11/2013, indicated R78 had upper and lower partials with some natural teeth. The Nursing Kardex or "closet care plan" dated 4/8/13, indicated R78 had upper and lower partials. On 11/19/13, at 9:10 a.m. R78 was observed eating in the dining room. R78's lower teeth were observed to consist of multiple natural teeth in various states of decay. The Dental Visits Summary dated 3/2/13, indicated R78 was seen at the dental office. The summary also indicated R78's upper plate had been repaired, the lower partial had been adjusted to fit with her natural teeth and the dentist had completed a filling on one of the natural teeth during the visit. The Functional/Safety Assessment dated 10/2/13, indicated R78 had a full upper denture, a partial lower denture and had a cracked lower tooth. On 11/20/13, at 1:00 p.m. R78 was observed to independently eat the noon meal. R78 was not observed to express any type of mouth or facial pain during the meal.	F 278	5. The Correction will be monitored by: A. DON, MDS Coordinator, Quality Coordinator. B. DON will report summary of accuracy findings to QAPI Committee.	

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F 278	Continued From page 5 On 11/20/13, at 1:15 p.m. registered nurse (RN)-A stated R78 had an upper full denture and a lower partial. She reviewed R78's care plan, MDS and the Dental CAA and confirmed the documents indicated three different types of oral care needs. On 11/20/13, at 1:30 p.m. nursing assistant (NA)-B stated R78 had a full upper denture, a lower partial denture and a few natural teeth which were in poor condition. On 11/21/13, at 8:40 a.m. RN-C/MDS coordinator stated the facility physically observes the residents via the Functional/Safety Assessments prior to the completion of the MDS. RN-C confirmed the functional assessment was correct, the MDS had been coded correctly indicating some or natural teeth, yet the CAA was not completed correctly and it should have matched the Functional Assessment. In addition, RN-C verified R78's plan of care and the "closet care plan" had not been updated to accurately reflect R78's current status.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	F280-D 1. Corrective Action: A. IDT reassessed Residents and revised care plans for residents # 36 (antipsychotic medication), # 78 (dental assessment) and # 214 (nutritional needs).	

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F 280	Continued From page 6 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care (POC) for 1 of 3 residents (R214) with identified nutritional concerns and for 1 of 3 residents (R36) reviewed for antipsychotic medications. Findings include: Nutritional Supplements: R214's POC dated 11/2013, identified R214 at risk for changes in weight, oral intake and cognition. The goal was to have R214 maintain weight at 180 pounds +/- 5 pounds. The POC directed the staff to assist with pureed or liquid diet, offer alternative foods and provide snacks. The POC did not direct the staff to offer nutritional supplements. R214's physician progress note dated 10/24/13, directed staff to change the diet to "pureed foods or only liquid diet [ensure/boost] if that is all that is tolerated.-- okay to adjust diet as tolerated." On 11/20/13, at 8:47 a.m. R214 was observed to be served cereal, a breakfast egg custard, coffee and juice. R214 was not observed to attempt to	F 280	2. Corrective Action as it applies to Other Residents: A. The procedure for care plan and documentation has been reviewed. B. The care plan forms were reviewed with team on 11/27/13. 3. Date of Completion: 12/13/13 4. Reoccurrence will be prevented by: A. Team reeducated on documentation requirements 12/11/13 and upon hire, annually, and as needed. B. Review of care plan compliance Mondays at Lunch and Learn. C. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. 5. The Correction will be monitored by: A. DON, MDS Coordinator, Quality Coordinator. B. DON will report summary of accuracy findings to QAPI Committee.	

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F 280	Continued From page 7 feed herself. -At 8:52 a.m. nursing assistant (NA)-A was observed to sit with R214 and assisted R214 with the meal. - At 9:11 a.m. R214 was observed to be wheeled away from the meal. R214 was observed to have consumed less than 25% of the meal. A nutritional supplement was not offered. On 11/20/13, at 11:52 a.m. R214 was observed to be served the noon meal. The meal consisted of pureed meat and pureed vegetable and fluids. NA-A again attempted to assist R214 with the meal. R214 did not attempt to eat independently. NA-A was observed to feed R214 a few bites of the meal. - At 12:20 p.m. R214 was observed to be wheeled away from the table. R214 had consumed less than 25% of the meal. A nutritional supplement was not offered. On 11/21/13, at 10:15 p.m. registered nurse (RN)-A stated R214 was not currently receiving nutritional supplements and confirmed Boost or Ensure had been identified during the 10/24/13, visit as potential interventions. She confirmed R214's POC had not been revised to reflect the addition of nutritional supplements. Antipsychotic medications: R36's POC dated 8/2013, indicated R36 was at risk for side effects of psychotropic medications. The POC also indicated R36 was friendly with staff but had verbalized feelings of loneliness, no-one liked her, withdrawn, poor motivation and was occasionally particular and critical towards others. The plan of care did not address how to	F 280		

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F 280	Continued From page 8 monitor R36's behavioral concerns. R36's Physician Orders dated 11/1/13, indicated an order for Klonopin (a benzodiazepine/ mood altering medication) 0.25 milligrams (mg) twice a day for the diagnosis of Adjustment reaction, dementia and depression. Lexapro (an antidepressant medication) 10 mg daily, Remeron (an antidepressant) 7.5 mg at bedtime, and Risperidone (an antipsychotic medication) 0.75 mg daily. All of the medications were identified to treat R36's adjustment reaction disorder, dementia, depression, anxiety or paranoia. During the course of the survey conducted on 11/18/13, from 6:10 p.m. to 8:30 p.m., on 11/19/13, from 8:00 a.m. to 6:30 p.m., on 11/20/13, from 7:00 a.m. to 3:30 p.m. and on 11/21/13, from 8:00 a.m. to 3:00 p.m. R36 was observed to be pleasant, polite and utilizing glasses and a headphone operated hearing device. R36 was not observed to display any type of behaviors. On 11/21/13, at 2:06 p.m. licensed practical nurse (LPN)-B and LPN-C stated they could not recall R36 displaying any type of behavior at the facility. They explained R36 had very poor eye sight and was very hard of hearing. They stated R36 occasionally became frustrated with staff because she was unable to communicate effectively with the staff. LPN-B stated R36 was one of the more pleasant residents in the facility. LPN-C added R36's medications had been continued due to family request and R36 had not displayed any adjustment disorder concerns as she had been residing in the facility for over a year. On 11/21/13, at 2:15 p.m. RN-A confirmed R36	F 280		

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F 280	Continued From page 9 had been receiving multiple mood altering medications without monitoring for the specific target behaviors. She confirmed the R36's POC had not been reviewed to ensure the facility was monitoring R36 for the specified target behaviors. A policy regarding care plan revision was requested but not provided.	F 280		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the appropriate procedures for medication administration via	F 322	F322-D 1.Corrective Action: A. IDT reassessed Resident # 196 and medication administration via a feeding tube 2. Corrective Action as it applies to Other Residents: A. The standard of practice for medication via a feeding tube will continue to be followed. B. The standard was reviewed with team on 11/20/13. 3. Date of Completion: 12/13/13 4. Reoccurrence will be prevented by: A. Team reeducated on medication administration per standard of practice 12/11/13 and upon hire, annually, and as needed. B. Periodic surveillance of medication administration will be conducted. C. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 10 feeding tube for 1 of 1 resident (R196) observed to receive a mixture of liquid and crushed medications administered together via a percutaneous endoscopic gastrostomy (PEG) tube (tube placed into the stomach for feeding). Findings include: R196's Client Diagnosis Report dated 10/21/13, indicated diagnoses of diabetes and dysphagia (difficulty swallowing). R196's quarterly Minimum Data Set (MDS) dated 10/26/13, indicated R196 had moderate cognitive impairment and required extensive assist with all activities of daily living. R196's plan of care (POC) dated 10/3/13, directed staff to administer the PEG tube feeding at 40 milliliters (ml) per hour for 16 hours with 50 ml flushes hourly. On 11/20/13, at 8:12 a.m. licensed practical nurse (LPN)-A was observed to crush the following medications: Lasix 20 milligrams (mg) (diuretic), vitamin D 1000 IU (international units), lisinopril 10 mg (for high blood pressure), Norvasc 5 mg (for high blood pressure), Cipro 500 mg (antibiotic), and aspirin 81 mg. LPN-A was observed to combine the crushed medications with the following liquid medications: gabapentin 100 mg (for neuropathic pain), Lortab 7.5/500 mg (for pain), potassium chloride 20 mEq (milliequivalents) (electrolyte supplement) and polyethylene glycol 3350 powder (for constipation) mixed in 8 ounces of water. LPN-A was observed to enter R196's room, wash his hands, gathered a syringe to administer the medications, donned a pair of gloves and flushed	F 322	5. The Correction will be monitored by: 1. DON, Clinical Care Coordinators, Quality Coordinator. 2. DON will report summary of compliance findings to QAPI Committee.	

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F 322	Continued From page 11 R196's PEG tube with water. LPN-A confirmed he had flushed R196's PEG tube with 50 cubic centimeters (cc's) of water prior. LPN-A exposed R196's PEG tube, unclamped and removed the plug on the end of the PEG tube and connected the open ended syringe to the PEG tube. LPN-A was observed to proceed to pour the cocktailed medications (mixture of liquid and crushed medications) into the open end of the syringe and allowed the medication to be administered by gravity. Upon administration of the medications, LPN-A was observed to flush the PEG tube with 240 cc's of water. On 11/20/13, at 8:40 a.m. LPN-A verified R196 did not have an order to cocktail medications. On 11/20/13, at 9:20 a.m. director of nursing (DON) confirmed R196 had no order for cocktailing medications. The DON also confirmed the facility did not have a policy specific for administering medications via a PEG tube, however, stated it was her expectation that the facility staff followed the standard of practice which directs staff to administer medications one at a time and flush in between each medication.	F 322		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F325-D 1.Corrective Action: A. IDT reassessed Resident # 214 for significant weight loss. B. Significant Change ARD 11/25/13. C. MDS Date of completion for Resident #214, 11/27/13	

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F 325	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to promptly identify and assess significant weight loss and implement interventions according to physician orders for 1 of 3 residents (R214). Findings include: R214's admission Minimum Data Set (MDS) dated 9/22/13, indicated R214 was diagnosed with Parkinson's disease, congestive heart failure (CHF) and diabetes mellitus. The MDS also indicated R214 had intact cognition, was independent in eating and current weight was 182 pounds without a significant weight loss. R214's Nutritional Status Care Area Assessment (CAA) dated 9/23/13, identified R214 had diagnoses that may affect nutritional status and was at risk for weight loss. R214's five day Medicare required MDS dated 10/25/13, indicated R214 had moderate cognitive impairment, required extensive assistance with feeding and R214's current weight was identified at 157 pounds with a significant weight loss identified. R214's initial Nutritional Assessment Data Collection dated 9/22/13, indicated R214's weight was 182 pounds and identified R214 at moderate risk for weight loss. The Nutritional Progress note dated 10/25/13, indicated R214's weight was 157 pounds and indicated R214 was receiving	F 325	2. Corrective Action as it applies to Other Residents: A. The policy/procedure for condition change and reporting was reviewed. B. The procedure was reviewed with team on 11/27/13. 3. Date of Completion: 12/13/13 4. Reoccurrence will be prevented by: A. Team reeducated on the reporting procedures and monitoring 12/11/13 and upon hire, annually, and as needed. B. Review of condition change by IDT at morning stand up meetings Monday through Friday. C. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. 5. The Correction will be monitored by: A. DON or MDS Coordinator. B. DON will report summary of condition change to QAPI Committee.	

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F 325	Continued From page 13 comfort cares and anticipation of further weight loss was expected. R214's physician progress note dated 10/24/13, identified R214 had sustained a progressive decline over the past 2 months and R214's family had consented to have R214 changed to a "comfort only approach" with orders stating do-not-resuscitate and do-not-intubate (DNR/DNI). The note also indicated R214 was experiencing significant confusion, eating paper, refusing to eat regular foods and spitting out food. The note indicated the physician had changed R214's diet to "pureed foods or only liquid diet [ensure/boost] if that is all that is tolerated.-- okay to adjust diet as tolerated." Review of the Nursing-Food Service Communication/Diet Order Form dated 10/24/13, indicated R214's diet had changed to pureed consistency and "boost if needed." Review of R214's weights indicated the following information: 9/23/13 - weight of 186 10/12/13- weight 196 10/15-10/18/13 R214 was hospitalized with diagnoses including CHF and a heart attack. 10/25/13 - weight 157 10/30/13- weight 141 R214's plan of care (POC) dated 11/2013, identified R214 at risk for changes in weight, oral intake and cognitive changes. The POC indicated R214's goal was to maintain weight at 180 pounds +/- 5 pounds. The POC directed staff to assist R214 with pureed or liquid diet, offer alternative foods and provide snacks.	F 325		

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F 325	Continued From page 14 R214's current Physician's Orders (not signed) printed on 11/15/13, directed staff to give R214 a 2 gram sodium restricted diet. The orders did not include nutritional supplements. On 11/20/13, at 8:47 a.m. R214 was observed to be served cereal, a breakfast egg custard, coffee and juice. R214 was not observed to attempt to feed herself. -At 8:52 a.m. nursing assistant (NA)-A was observed to sit with R214 and assisted R214 with the meal. -At 9:11 a.m. R214 was observed to be wheeled away from the meal. R214 was observed to have consumed less than 25% of the meal. R214 was not offered / provided a nutritional supplement. On 11/20/13, at 11:52 a.m. R214 was observed to be served the noon meal. The meal consisted of pureed meat and pureed vegetable and fluids. NA-A was observed to attempt to assist R214 to eat. R214 was not observed to attempt to eat independently. NA-A was observed to feed R214 a few bites of the meal. -At 12:20 p.m. R214 was wheeled away from the table. R214 was observed to have consumed less than 25% of the meal. R214 was not offered / provided a nutritional supplement. R214's Medication Administration Record for November 2013, did not include nutritional supplements. On 11/21/13, at 10:15 p.m. registered nurse (RN)-A stated R214 was not currently receiving nutritional supplements and confirmed Boost or Ensure had been identified during the 10/24/13, visit as potential interventions.	F 325		

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F 325	Continued From page 15 On 11/21/13, at 10:17 a.m. RN-B stated R214 had been changed to comfort cares on 10/24/13, and additional nutritional interventions were not implemented at that time. On 11/21/13, at 10:30 a.m. the registered dietician (RD)-A verified R214 was on comfort cares and would be given a liquid diet which would include nutritional supplements (Boost or Ensure) only if R214 was not tolerating the pureed diet. She confirmed R214 had sustained a significant weight loss which was partially due to medications to treat/reduce fluids related to congestive heart failure and may be due to actually decreased nutritional intake. She confirmed she was aware R214's oral nutritional intake had decreased but since she was on comfort cares, additional nutritional interventions had not been implemented. She indicated that according to the facility policy, residents who were on comfort cares were not to get additional interventions. Review of the Comfort Care policy revised on 11/2012, did not address nutritional status of the resident. On 11/21/13, at 10:30 a.m. RN-A reviewed R214's physicians orders dated 10/24/13, and confirmed the facility had not transcribed the orders for nutritional supplements as directed by the physician. On 11/21/13, at 10:40 a.m. RD-A confirmed the Comfort Care policy did not direct the staff to stop any potential nutritional interventions to assist in maintaining weight for the residents receiving comfort cares. She confirmed the facility had not	F 325		

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F 325	Continued From page 16 attempted any interventions to prevent further weight loss for R214. On 11/21/13, at 11:30 a.m. the RN-C confirmed R214 had sustained a significant weight loss and additional interventions to minimize/reduced continued weight loss had not been implemented.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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:	F 329	F329-D 1. Corrective Action: A. IDT reassessed Resident # 36 and assessed clinical indications for continued use of psychotropic (mood altering) medications, including interventions and have implemented further monitoring with goal of attempting reduction. 2. Corrective Action as it applies to Other Residents: A. The procedure for assessing clinical indications for continued use of psychotropic medications was reviewed, including interventions. B. The continued use of psychotropic (mood altering) medications of all other residents was reviewed on 11/27/13.	

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F 329	Continued From page 17 Based on observation, interview and document review the facility failed to identify the clinical indications and monitoring for the continued use of psychotropic medications for 1 of 3 residents (R36). Findings include: R36's quarterly Minimum Data Set (MDS) dated 10/30/13, indicated R36's diagnoses consisted of depression, adjustment reactive disorder and Alzheimer's dementia. The MDS also indicated R36 had intact cognition. In addition, the MDS also indicated R36 had reported to staff she felt tired, depressed, bad about her self, had trouble concentrating and had a poor appetite. The MDS indicated staff had not observed any type of mood indicators and identified R36 as displaying verbal aggression one time during the assessment period. R36's Behavioral Symptoms Care Area Assessment (CAA) completed on 8/16/13, at the time of the annual MDS indicated R36 had major depressive disorder with recurrent psychosis, paranoid ideation and verbal irritation. R36's Physician Orders dated 11/1/13, included orders for Klonopin (a benzodiazepine/ mood altering medication) 0.25 milligrams (mg) twice a day for the diagnosis of Adjust reaction, dementia and depression was started 6/10/13. Lexapro (an antidepressant medication) 10 mg daily, Remeron (an antidepressant) 7.5 mg at bedtime was started on 3/27/13, and Risperidone (an antipsychotic medication) 0.75 mg daily was started on 3/27/13. All of the medications were to treat R36's adjustment reaction disorder, dementia, depression, anxiety or paranoia. The physician orders identified the following behaviors for each medication:	F 329	3. Date of Completion: 12/31/13 4. Reoccurrence will be prevented by: A. Team reeducated on continued use of psychotropic (mood altering) medications requirement 12/11/13 and upon hire, annually, and as needed. B. Review of compliance by IDT 4th Wednesday monthly. C. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. 5. The Correction will be monitored by: DON, Clinical Care Coordinator, Quality Coordinator. A. DON will report summary of accuracy findings to QAPI Committee.	

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F 329	Continued From page 18 -Klonopin target behaviors: increased concerns about placement here and adjustment. Repetitive complaints of perceived health issues, and medications. Sleeplessness, verbalizations of sadness, loneliness, helplessness, withdrawn, feeling nobody liked her. -Lexapro target behaviors: increased concern about placement here and adjustment. Repetitive complaint of perceived health issues and medication, sleeplessness, verbalizations of sadness, loneliness, helplessness, withdrawn, feeling like nobody liked her. -Remeron target behaviors: sleeplessness, verbalization of sadness, loneliness and helplessness, withdrawn, feeling nobody liked her and she has no friends, adjustment to nursing home placement and long term care placement. -Risperidone target behaviors: concerns about placement here and adjustment, repetitive health complaints and medications. R36's plan of care (POC) dated 8/2013, indicated R36 was at risk for side effects of medications. The POC indicated R36 was friendly with staff but had verbalized feeling of loneliness, no-one liked her, withdrawn, poor motivation and R36 was occasionally particular and critical towards others. The POC did not address how to monitor R36 for any type of behavioral concerns. During the course of the survey conducted on 11/18/13, from 6:10 p.m. to 8:30 p.m., on 11/19/13, from 8:00 a.m. to 6:30 p.m., on 11/20/13, from 7:00 a.m. to 3:30 p.m., and on 11/21/13, from 8:00 a.m. to 3:00 p.m. R36 was	F 329		

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F 329	Continued From page 19 observed to be pleasant, polite and utilizing glasses and a headphone operated hearing device. R36 was not observed to display any type of behaviors. Review of R36's Point of Care behavioral documentation report ran on 11/21/13, indicated the facility had been monitoring R36 for behaviors such as verbal abuse, physical abuse, wandering and social isolation. The Point of Care system did not include quantitative/qualitative documentation related to adjustment disorder, feeling like nobody liked her, having no friends, sleeplessness, repetitive health complaints, concerns about her medications and anxiety or paranoia. On 11/21/13, at 2:00 p.m. registered nurse (RN)-A reviewed the report and stated R36 had displayed 4 episodes of verbal aggression towards others in the past 180 days. Review of R36's interdisciplinary progress notes (IPN) for the past three months (9/21/13 - 11/21/13) indicated R36 had not displayed any type of behavioral concerns. The clinical record indicated R36 had been evaluated by a nurse practitioner/psychiatric specialist on 11/12/13. During the visit, the nurse practitioner did not recommend changes to R36's medications. R36 was also seen by the same nurse practitioner on 10/16/13, at that time the documentation indicated "continue with current psychiatric medications... Any reduction in psychiatric medication would result in increased anxiety and depression and would have a negative effect on [R36's name] well being and level of function."	F 329		

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F 329	Continued From page 20 On 9/10/13, the consultant pharmacist identified Risperdal as not having an approximate diagnoses for the continued use of the medication. The primary physician identified Major Depression as the diagnosis for continued use. However, review of the clinical record lacked documentation indicating R36 was depressed. On 11/21/13, at 2:06 p.m. licensed practical nurse (LPN)-B and LPN-C stated they could not recall R36 displaying any type of behavior at the facility. They explained R36 had very poor eye sight and was very hard of hearing. They stated R36 occasionally became frustrated with staff because she was unable to communicate effectively with the staff. LPN-B stated R36 was one of the more pleasant residents in the facility. LPN-C added R36's medications had been continued due to family request and stated R36 had not displayed any adjustment disorder concerns as she had been residing in the facility for over a year. On 11/21/13, at 2:15 p.m. RN-A confirmed R36 had been receiving multiple mood altering medications without monitoring for the specific target behaviors. In addition she confirmed R36 was receiving multiple medications to treat the same behaviors. A policy regarding target behavior monitoring and appropriate diagnoses for antipsychotic medications was requested but not provided.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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

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F 371	Continued From page 21 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to distribute food during meals using proper hand hygiene for 6 of 19 residents (R112, R106, R36, R153, R214 and R79) who received their meals in the Woods Dining room. In addition the facility failed to maintain sanitary conditions in the main kitchen and kitchenettes. This practice had the potential to effect 105 residents who ate meals served out of the main kitchen. Findings include: The Woods Dining room: On 11/19/13, at 11:40 a.m. dietary aide (DA)-C was observed to begin to serve the food to the residents in the Woods dining room. DA-C was observed to have gloves on and proceeded to pick up individual pieces of paper that indicated each resident's meal requests on them and place them back down. With the same gloved hands, DA-C was observed to reach into a bag of buns, remove a bun and proceed to prepare a sloppy Joe (barbeque sandwich) for the resident. DA-C was observed to pick up a dietary request slip	F 371	**REVISED F371 1/2/14** F371-F 1.Corrective Action: A. IDT reassessed food distribution for Residents # 112, #106, #36, #153, #214 and #79. 2. Corrective Action as it applies to Other Residents: A. The standard of practice for food distribution and maintain sanitary conditions will continue to be followed. B. The standard was reviewed with team on 11/19/13. 3. Date of Completion: 12/13/13 4. Reoccurrence will be prevented by: A. Team reeducated on proper food handling technique, including, hand-washing, donning of gloves, hairnet/beard protectors, aprons, proper storage of cups, cleaning of kitchen equipment, labeling, dating and storage of food items, cleaning of ice machines, general cleaning of all kitchen areas and equipment.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 371	Continued From page 22 and place it next to the prepared plate on the counter. -At 11:42 a.m. DA-C was observed to dish up a serving of tater-tot hotdish, pick up a dietary meal slip and placed the piece of paper directly on the plate next to the food. Nursing staff were then observed to carry the plate into the Woods dining room and served it to a resident. -At 11:44 a.m. DA-C was observed to pick up several of the dietary slips, crumble them into a ball and toss them into the garbage, she then reached into the bag of buns and prepared another sandwich. Shortly there-after, R112 requested a cheese sandwich. DA-C was observed to prepare the sandwich by removing the cheese from the wrapper, remove bread from the bread bag with her opposite hand and assembled the sandwich with same gloved hands. DA-C was not observed to change her gloves or wash her hands prior to directly touching the food. -At 11:47 a.m. DA-C was observed to prepare a cheese burger for R106. DA-C continued to touch the bun with the same contaminated gloves. Once the burger was assembled, DA-C served the meal to R106. -At 11:51 a.m. DA-C was observed to drop a knife onto the floor, pick up the knife, place it in the sink, washed her hands and removed the gloves. -At 11:53 p.m. DA-C confirmed this was the first time she had washed her hands since the meal distribution had started. DA-C verified 19 residents were served from the Woods Dining room.	F 371	B. Review of Kitchen Cleaning Schedule, including all community kitchen areas, was reviewed and updated as needed. Random weekly audits x 1 month then monthly x 3 with findings reported to QAPI Committee for discussion. 5. The Correction will be monitored by: A. DON, Clinical Care Coordinators, Quality Coordinator and Food Services Manager. B. DON will report summary of compliance findings to QAPI Committee.	

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	245368	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 23 On 11/20/13, at 7:52 a.m. DA-A was observed in the Woods Dining room serving breakfast to the residents. DA-A was observed to wear a glove on his left hand as he carried a bowl of cereal from the kitchenette area into the dining room and serve the cereal to R36. DA-A returned to the kitchenette, picked up a bag of bread, retrieve two slices of bread and placed them into the toaster. When the toast was done, DA-A was observed to pick up the toast and butter it by holding the bread in place with his bare hand. - At 7:54 a.m. DA-A placed the toast on a plate and placed two more slices of bread in the toaster. DA-A was then observed to pick up the dietary request slips with his bare hand and carry the meal into the dining room. -At 8:10 a.m. DA-A was observed to place two eggs into a pan for poaching. DA-A was observed to wash his hands, pick up bread with bare hands and began to toast it. -At 8:13 a.m. DA-A was observed to walk into the dining room, place a meal in front of R153. DA-A placed his hand directly on the table as he served the meal. DA-A returned to the kitchenette, touched the microwave and dished up the next meal. DA-A was not observed to wash his hands prior to checking the microwave / and before dishing up the next meal. DA-A was also observed to open the freezer door and remove two frozen waffles from bag and place them into the toaster. At no time was DA-A observed to wash his hand between serving R153 and directly touching the toast and waffles with his bare hands.	F 371		

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F 371	Continued From page 24 -At 8:43 a.m. DA-A was observed to wash his hands, place a glove on his left hand and open the cupboard door to retrieve cold cereal. DA-A then dished a bowl, set it on the counter and moved a resident request slip. He then picked up a boiled egg and peeled it with both hands. DA-A then reached into the bread bag, picked up slices of bread and placed them into the toaster. -At 8:45 a.m. with both hands, DA-A was observed to fill two soufflé cups, one with peanut butter the other with jelly. He then removed the toast, buttered it with both hands and placed it on the plate and then went to the sink and washed his hands. On 11/20/13, at 11:55 a.m. nursing assistant (NA)-A entered the Woods Kitchenette, walked behind DA-A while he continued to serve the meal. NA-A was observed to wash her hands in the kitchenette sink. NA-A was not observed to apply a hairnet while in the kitchenette during the meal service. NA-A was observed to enter the kitchenette area two additional times during the meal service, once to obtain jelly for R214 and once to obtain juice for R79. At no time was NA-A observed to attempt to apply a hair net. On 11/20/13, at 12:00 p.m. the certified dietary manager (CDM) observed DA-A serving the meals in the Woods Dining Room. The CDM confirmed DA-A repeatedly contaminated his hand/s during the meal service and confirmed DA-A did not wash his hands as needed. He also confirmed NA-A was to be wearing a hair net while in the kitchenette. The Personal Hygiene policy dated 3/05, directed	F 371		

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F 371	Continued From page 25 staff to follow proper hygiene and food handling techniques at all times. On 11/20/13, from 11:30 a.m. until 1:45 p.m. the kitchen tours were completed with the dietary supervisor (DS) and the following was noted: Wood Lane: -15 plastic, eight ounce cups were observed stored wet in the Wood Lane kitchen cupboard. At the time of the observation, dietary aide (DA)-A stated he had put the plastic cups in the cupboard about 9:00 a.m. after they had come out of the dishwasher. DA-A stated he had shook the water off the plastic cups prior to putting them into the cupboard, however, the cups were still noted to be wet. -The ice/water machine was observed to have a thick white substance/ corrosion in and around the dispenser spout. Norway Lane: -The refrigerator freezer was observed to have a plastic bag with approximately 10 slices of bacon in it and a large plastic bag with link sausages in it. Both bags were not labeled, dated or sealed. At the time of the observation, DA-A and Cook-A, stated both of the bags had been in the freezer about a week. -The water/ice machine was observed to have a thick white substance/ corrosion in and around the dispenser spout. Spruce Lane: - The refrigerator freezer was observed to have a	F 371		

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F 371	Continued From page 26 plastic bag full of bacon with approximately ten slices of bacon in it and a large bag of sausage. The plastic bags were not labeled, dated or sealed. -The ice/water machine was observed to have a thick white substance/ corrosion in and around the dispenser spout. At the time of the observation the DS stated staff routinely wiped the machine down, however, the maintenance department was responsible for cleaning. He added, he would contact them regarding the cleaning schedule. Lodge Lane: -The ice machine side vents were observed to have a thick coat of dust like material. At the time of the observation, the DS verified the ice machine required cleaning -The floor was observed to have a thick coat of dust/matter in the corners/edges of entire the ceramic flooring. Main kitchen: In the main kitchen, a large plastic bag of pork patties was observed un-sealed, not labeled and undated. -The hood above the large stove was observed to have a thick coat of gray matter. At the time of the observation, the DS verified the hood required cleaning and stated the maintenance department was responsible for cleaning. -a thick coat of dust was observed behind the large stove. At the time of the observation, the DS stated the cleaning task was currently on a weekly cleaning schedule, however, needed to be cleaned more often. -Two large mixers were observed to have dried	F 371		

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F 371	Continued From page 27 batter below the motor unit and required cleaning. At the time of the observation, the DS verified the findings and stated the mixers were to be cleaned right after being used. -The waste basket below the sink where dietary staff washed their hands was observed to not have a cover. At the time of the observation, the DS verified the findings and stated he would purchase a new waste basket that had a cover. -The can opener was observed to have a thick coat of yellow matter. At the time of the observation, DA-B stated the can opener was not on a cleaning schedule but stated she wiped it down when dirty. At the time of the observation, the DS stated he would look up the manufacturers cleaning recommendations. At 1:30 p.m. the DS stated he had a cleaning person that " just cleans," so he did not have a cleaning schedule for the kitchen staff, however, stated he planned to make a cleaning schedule. At 1:45 p.m. the DS stated he had contacted the maintenance department (MD)-A and he verified the ice/water machines were to be cleaned every six months, however, stated he thought they were being cleaned one time a year. At this time the DS stated he would be making a cleaning schedule for the dietary department to assure all items were on a timely cleaning schedule. The "After Service Follow-up Report" form dated 6/10/13, indicated the exhaust system was cleaned including: hood, filters and fan. The Food Handling policy reviewed and revised 1/2011, directed staff to label, date and cover all food items.	F 371		

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F 371	Continued From page 28 The undated, Nugget Ice Machine use and care manual, indicated to clean and sanitize the ice machine every six months for efficient operation. The manual also indicated to weekly remove grill from scrap ice tray and wipe splash panel, scrap ice tray and grill with sanitizer and water solution	F 371		

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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. 01 Main Building (1900, 1972, 1992 and 2000 additions) A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Grand Village 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 18 New 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	K 000	POC ok JR 12-23-13 RECEIVED DEC 20 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawna Warner — TITLE: Executive Director — (X6) DATE: 12/20/13

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.

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

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us Fax Number 651-215-0525 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 Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in between the original building and the 1992 west	K 000		

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K 000	Continued From page 2 addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 103 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations and testing of corridor doors, it was determined that one corridor door did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.3.6.1. This deficient practice could allow the products of combustion to spread beyond the room of fire origin and negatively impact all 119 residents, any visitors and staff of this facility. Findings include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations and testing of at least 80 corridor doors, by surveyor 03006, revealed that the laundry room	K 018	K 018 The laundry room corridor identified during survey was adjusted to ensure that it would latch properly in accordance with NFPA 101, Section 19.3.6.1. Will monitor doors to make sure they latch properly in accordance with NFPA 101, Section 19.3.6.1. Added task to routine maintenance program scheduled for every 30 days. Date of correction: 11/25/13 Environmental Services Director will monitor to prevent reoccurrence.	

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K 018	Continued From page 4 corridor door did not latch. This deficient practice was confirmed by the Maintenance staff at the time of the inspection and during the exit conference.	K 018		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations and testing of the delayed egress exit doors, it was determined that 1 exit door is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 7.2.1.6. This deficient practice could negatively affect the 12 residents, any visitors and staff of the Norway unit by delaying by more than 30 seconds, their exiting in an emergency. Findings include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations and testing of the 12 delayed egress exit doors, by surveyor 03006, revealed that the Norway unit east exit door did not sound an alarm nor release in accordance with LSC 7.2.1.6, even though the door is labeled "Keep Pushing Door Will Releases After 15 Seconds". This deficient practice was confirmed by the Maintenance staff at the time of the inspection and during the exit conference.	K 038	K 038 The Norway community exit door was adjusted so alarm sounds and door releases after 15 seconds in accordance with LSC 7.2.1.6 when panic bar on door is held (for 15 seconds). Will monitor applicable doors to make sure they alarm and release properly in accordance with LSC 7.2.1.6. Added task to routine maintenance program scheduled for every 30 days. Date of Correction: 11/25/13. Environmental Services Director will monitor to prevent reoccurrence.	

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K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observations of the automatic smoke detectors, that are on the fire alarm system, it was determined that 3 are not in accordance with NFPA 72 " The National Fire Alarm Code" 1999 Edition section 2-3.5.1. The deficient practice of improper installation of smoke detectors could cause a delay in alarming occupants in a fire emergency, which would negatively impact all 119 residents, any visitors and the staff of this facility. Findings include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations, by surveyor 03006, revealed that: 1) The smoke detector in Spruce Wing, room 121 is within the air flow of the HVAC system, 2) The smoke detector in the corridor by room 508 is within the air flow of the HVAC system, and 3) The smoke detector in the middle of the connecting link between Birch and Norway units is within the air flow of the HVAC system. These deficient practices were confirmed by the Maintenance staff at the time of the inspection and during the exit conference.	K 054	K 054 Smoke detectors in Spruce Wing room 121, the corridor by room 508 and the middle of the connecting link between Birch and Norway communities were all relocated in accordance with NFPA 72, Section 2-3.5.1. ESC, facility's fire alarm company vendor, will inspect annually to ensure that Grand Village is in compliance with NFPA 72, Section 2-3.5.1. Date of Correction: 11/25/13. Environmental Services Director will monitor to prevent reoccurrence.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056		

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K 056	Continued From page 6 for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and an interview with staff it was determined that the automatic fire sprinkler system has not been installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems and NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow a fire to progress throughout the building and negatively effect all 119 residents, any visitors and the staff of the facility. Findings include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations, by surveyor 03006, revealed that: 1) Approximately 6 sprinkler heads in the main kitchen are covered with lint and dirt, 2) The activities storage room may not be properly sprinkler protected in accordance with an ordinary hazard. (No documentation was available to indicate that the 2 heads in this room	K 056	K 056 Sprinkler heads in the main kitchen were cleaned on 11/25/13. Viking, facility's sprinkler system contractor assessed storage area in the activities storage room and relocated one head to comply with the Standard on 12/10/13. Viking, facility's sprinkler contractor, added a sprinkler head in the small open closet in the activities storage room so that is sprinkler protected on 12/10/13. Cleaning and maintenance of sprinkler heads was added to Routine Maintenance Program to ensure cleaning at least monthly. Date of Correction: 12/10/13. Environmental Services Director will monitor to prevent reoccurrence.	

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	245368	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/20/2013

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K 056	Continued From page 7 can properly protect this room), and 3) The small open closet in the activities storage room is not sprinkler protected. These deficient practices were confirmed by the Maintenance staff at the time of the inspection and during the exit conference.	K 056	K 069 Electrician was hired to add shunt trip breakers to ensure that all electrical services located under the kitchen hood, including those serving the oven, shut down upon hood suppression activation as required by NFPA 96. JN Johnson, contractor for facility's ansul system inspection and maintenance will check system to ensure compliance with NFPA 96 at each inspection. Date of Correction: 12/17/13. Environmental Services Director will monitor to prevent reoccurrence.	
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 a review of documentation and an interview with staff, it was determined that the kitchen hood suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2000), Section 19.3.2.6 and NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation (edition 1998) section 1-3.1. This deficient practice could negatively affect any residents, any visitors and the staff in the kitchen area. Findings Include: Prior to the facility tour at approximately 11:30 am, on 05/30/2013, a review of the hood suppression system inspection report form J.N.Johnson dated 7-22-13 and an interview with Maintenance staff, by surveyor 03006, revealed that the some of the electrical services located under the kitchen hood including those serving the ovens do not shut down upon hood suppression activation as required by NFPA 96. This deficient practice was confirmed by the	K 069		

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K 069	Continued From page 8 facility Maintenance staff at the time of discovery and at the exit conference.	K 069		
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined that not all electrical equipment are used in accordance with NFPA 70 "The National Electrical Code" (NEC) 1999 edition. This deficient practice could cause over heating of the device causing a fire that will negatively impact all 119 residents, any visitors and staff of the facility. Findings Include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations, by surveyor 03006, revealed that: 1) Some hanging clothes have been allowed to be in contact with the hot surface of the blanket warmer found in a closet, and 2) A cart was found directly in front of the electrical panels in the Birch Wing storage area These deficient practices were confirmed by the facility Maintenance staff at the time of discovery and at the exit conference.	K 147	K 147 Clothes were removed from the area where blanket warmer is located on 11/25/13. Housekeeping cart was removed from in front of the electrical panels in Birch Wing storage area on 11/25/13. Staff were re-educated on 12/11/13 at All Staff Mandatory Education Fair to notify maintenance if they identify a potential safety hazard and housekeeping was specifically re-educated to not store a cart located directly in front of an electrical panel. Safety Committee conducts quarterly environmental inspections to identify potential fire or other safety hazards and addresses and audits any concerns identified to prevent further occurrence. Environmental Services Director will monitor to prevent reoccurrence.	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the	K 155		

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K 155	Continued From page 9 building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a review of facility policies it was determined that the facility staff does not have a written out of service policy for the automatic fire alarm system in accordance with NFPA 101 The Life Safety Code (2000 edition) sections 19.3.4.1 and 9.6.1.8. This deficient practice could negatively impact all 119 residents, any visitors and staff if the system is out of service and no alternative method of detecting a fire is provided. Findings Include: Prior to the facility tour on November 20, 2013, approximately 11:40 am, a review of the Grand Village fire system impairment/ fire watch policy, by surveyor 03006, revealed that: 1) The fire system impairment/ fire watch policy does not address when a fire watch is need for the impaired fire alarm system, and 2) The fire system impairment/ fire watch policy does not have a contact list. These deficient practices were confirmed by the facility Maintenance staff at the entrance conference and at the exit conference.	K 155	K 155 Policy was updated on 12/16/13 to add the fire alarm system, in addition to the sprinkler system, when addressing the need for a fire watch if either system is down. Safety Committee reviewed policy update on 12/19/13. A "contact list" was also added to the policy to indicate the parties that require notification in the event of a fire alarm or sprinkler system impairment lasting more than 4 hours. Safety Committee reviewed policy update on 12/19/13. Policies are reviewed annually by the Administrator and/or the appropriate committee. Date of Correction: 12/19/13. Environmental Services Director and Administrator will monitor to prevent reoccurrence.	

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

F5368022

PRINTED: 12/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING 02 - SUB ACUTE B. WING _____	11/20/2013

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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. 02 Sub-Acute 2004 Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Grand Village 02 Sub-Acute 2004 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 18 New 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	K 000	POC ok FB 12-23-13 RECEIVED DEC 20 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-31-13

EXIT: 11-21-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shauna Johnson — TITLE: Executive Director — (X6) DATE: 12/20/13

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 Or by e-mail to: Marian.Whitney@state.mn.us Fax Number 651-215-0525 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 Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in between the original building and the 1992 west addition. It is 1-story, without a basement and is	K 000		

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K 000	Continued From page 2 Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 103 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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K 018 SS=F	Continued From page 3 Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observations and testing of corridor doors, it was determined that one corridor door did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.3.6.1. This deficient practice could allow the products of combustion to spread beyond the room of fire origin and negatively impact all 119 residents, any visitors and staff of this facility. Findings include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations and testing of at least 80 corridor doors, by surveyor 03006, revealed that the shower room 564 corridor door did not latch. This deficient practice was confirmed by the Maintenance staff at the time of the inspection and during the exit conference.	K 018	K 018 Readjusted the shower room 564 corridor door to latch properly in accordance with NFPA 101, Section 19.3.6.1. Will monitor doors to make sure they latch properly in accordance with NFPA 101, Section 19.3.6.1. Added task to routine maintenance program scheduled for every 30 days. Date of correction: 11/25/13 Environmental Services Director will monitor to prevent reoccurrence.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in	K 029		

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K 029	Continued From page 4 accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations of 20 hazardous areas, it was determined that 1 is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.2.1. This deficient practice could allow the products of combustion to travel from this hazardous area into the corridor system if a fire occurs within the room, which would negatively impact all 119 residents, any visitors and the staff of the facility. Findings include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations, by surveyor 03006 revealed that cable and conduit penetrations in the mechanical room by room 526 have not been properly sealed. This deficient practice was confirmed by the Director of Maintenance and the Administrator at the time of the inspection and during the exit conference.	K 029	K029 Cable and conduit penetrations in the mechanical room by room 526 were properly sealed in accordance with NFPA 101, Section 19.3.2.1 on 11/25/13. Will notify and train staff and contractors to seal all penetrations to ensure compliance with NFPA 101, Section 19.3.2.1. Date of correction: 12/31/13. Environmental Services Director will monitor to prevent reoccurrence.	
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations it was determined that	K 062	K 062 Sprinkler head located in the Lodge kitchen was cleaned to remove any grease and dirt build up in accordance with NFPA 25.	

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K 062	Continued From page 5 the automatic fire sprinkler system has not been maintained in accordance with NFPA 25 The Standard for Inspection, Maintenance of Water Based Suppression Systems (1999 edition). This deficient practice could prevent the proper operation of the automatic fire sprinkler system which could allow a fire to progress throughout the building and negatively affect all 119 residents, any visitors and the staff of the facility. Findings include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations, by surveyor 03006, revealed that the Lodge kitchen sprinkler head had grease and dirt built up on it. This deficient practice was confirmed by the Maintenance staff at the time of the inspection and during the exit conference.	K 062	Sprinkler heads were added to Routine Maintenance Program scheduled to be checked at least monthly for compliance. Date of Correction: 12/10/13 Environmental Services Director will monitor to prevent reoccurrence.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined that not all electrical equipment are used in accordance with NFPA 70 "The National Electrical Code" (NEC) 1999 edition. This deficient practice could cause over heating of the device causing a fire that will negatively impact all 119 residents, any visitors and staff of the facility. Findings Include: During the facility tour on November 20, 2013 between 12:30 pm and 2:30 pm, observations, by	K 147	K 147 Switch cover was re-installed properly over the switch box to cover exposed electrical wiring in the Lodge mechanical room by the sprinkler main on 11/25/13. Will provide notification and education to staff and contractors to ensure compliance with NFPA 70 "The National Electrical Code" (NEC) 1999 Edition. Date of Correction: 12/31/13. Environmental Services Director will monitor to prevent reoccurrence.	

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K 147	Continued From page 6 surveyor 03006, revealed that an electrical switch box, in the lodge mechanical room by the sprinkler main is open, exposing the electrical wiring. This deficient practice was confirmed by the facility Maintenance staff at the time of discovery and at the exit conference.	K 147	K 155 Policy was updated on 12/16/13 to add the fire alarm system, in addition to the sprinkler system, when addressing the need for a fire watch if either system is down. Safety Committee reviewed policy update on 12/19/13. A "contact list" was also added to the policy to indicate the parties that require notification in the event of a fire alarm or sprinkler system impairment lasting more than 4 hours. Safety Committee reviewed policy update on 12/19/13. Policies are reviewed annually by the Administrator and/or the appropriate committee. Date of Correction: 12/19/13. Environmental Services Director and Administrator will monitor to prevent reoccurrence.	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a review of facility policies it was determined that the facility staff does not have a written out of service policy for the automatic fire alarm system in accordance with NFPA 101 The Life Safety Code (2000 edition) sections 19.3.4.1 and 9.6.1.8. This deficient practice could negatively impact all 119 residents, any visitors and staff if the system is out of service and no alternative method of detecting a fire is provided. Findings Include: Prior to the facility tour on November 20, 2013, approximately 11:40 am, a review of the Grand Village fire system impairment/ fire watch policy, by surveyor 03006, revealed that: 1) The fire system impairment/ fire watch policy does not address when a fire watch is need for	K 155		

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K 155	Continued From page 7 the impaired fire alarm system, and 2) The fire system impairment/ fire watch policy does not have a contact list. These deficient practices were confirmed by the facility Maintenance staff at the entrance conference and at the exit conference.	K 155		