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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZT2G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00818

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245265**

2.STATE VENDOR OR MEDICAID NO.
(L2) **003543200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST FRANCIS HOME**
(L4) **2400 ST FRANCIS DRIVE**
(L5) **BRECKENRIDGE, MN** (L6) **56520**

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 **05/26/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor 06/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist 06/03/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
06/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/08/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/26/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245265

June 3, 2015

Mr. David Nelson, Administrator
St Francis Home
2400 St Francis Drive
Breckenridge, Minnesota 56520

Dear Mr. Nelson:

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 May 26, 2015 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

June 3, 2015

Mr. David Nelson, Administrator
St Francis Home
2400 St Francis Drive
Breckenridge, Minnesota 56520

RE: Project Number S5265024

Dear Mr. Nelson:

On April 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 16, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 1, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 26, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 16, 2015, effective May 26, 2015 and therefore remedies outlined in our letter to you dated April 28, 2015, will not be imposed.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

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

Enclosure

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245265	A. Building B. Wing	5/26/2015

Name of Facility	Street Address, City, State, Zip Code
ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**05/26/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**05/26/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**05/26/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	LB/mm	06/03/2015	28035	05/26/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 4/16/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245265	A. Building B. Wing **02 - MAIN BUILDING**	6/1/2015

Name of Facility	Street Address, City, State, Zip Code
ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

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 **04/17/2015**	ID Prefix	Correction Completed **05/26/2015**	ID Prefix	Correction Completed **04/17/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0025		LSC K0038		LSC K0154	
ID Prefix	Correction Completed **04/17/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0155		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	06/03/2015	27200	06/01/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/14/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZT2G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00818

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245265**

2.STATE VENDOR OR MEDICAID NO.
(L2) **003543200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST FRANCIS HOME**
(L4) **2400 ST FRANCIS DRIVE**
(L5) **BRECKENRIDGE, MN** (L6) **56520**

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 **04/16/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Christina Martinson, HFE NEII — 05/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/22/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/26/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0044

April 28, 2015

Mr. David Nelson, Administrator
St Francis Home
2400 St Francis Drive
Breckenridge, Minnesota 56520

RE: Project Number S5265024

Dear Mr. Nelson:

On April 16, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) , as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 26, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 July 16, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 16, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File 5265s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

(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	5/19/15 Approved SB	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral cares as directed by the care plan for 1 of 1 resident (R7) who required assistance with grooming and personal cares. Findings include: R7's care plan revised on 5/15/13, identified R7 required assistance with grooming. On 4/15/15, the care plan was updated to include R7 had own teeth, dental hygiene students cleaned/examed R7's teeth 1-2 times per year and R7 would	F 282	To correct the action of following the care plan to provide oral cares for the resident that was affected, education to staff that work with that resident was provided immediately through our huddle board system. This education was provided for two weeks, April 17 through May 1, 2015. The facility has identified that all other residents that need oral care provided for them, could potentially be affected. To correct this again, education was provided to all direct care givers through our huddle board communication process and educated for two weeks on both neighborhoods. Measures that are put into place to ensure it will not recur, is an audit process to observe and monitor oral cares are being provided to residents. This audit is to be done on a daily basis for two weeks and will be reviewed by nursing administration weekly for modifications due to what the audits reveal. This audit process will also be reviewed through our facility QA process and recommendations will be given by QA committee to ensure the solution is sustained. This corrective action will be completed by May 26, 2015. RESPONSIBILITY: DON	5-26-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	5-12-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

(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 282	Continued From page 1 sometimes allow a toothette for oral cares if R7 did not want a toothbrush used. The resident care sheet dated 4/14/15, directed staff to provide R7 oral cares before drinking. During observation of morning cares on 4/15/15, from 8:09 a.m. to 8:30 a.m. nursing assistant (NA)-A assisted R7 with personal cares which included washing her face, perineal cares and dressing. During this observation, R7 was not assisted with nor offered the opportunity for completion of oral cares. R7's natural teeth were observed with areas of white matter build up between them. -At 8:30 a.m. following the observation, NA-A assisted R7 to the dining room and gave her a drink of water. During interview on 4/15/15, at 8:35 a.m. NA-A confirmed she was finished with R7's morning cares and stated R7 had all natural teeth and needed assistance to brush them however, she had completely forgot to provide R7 oral cares. NA-A stated staff were directed to brush R7's teeth twice a day and she normally would do oral cares before breakfast. NA-A stated there were no specific guidelines regarding R7's oral care on the resident care sheet. During interview on 4/15/15, at 8:58 a.m. licensed practical nurse (LPN)-A confirmed R7 required extensive assistance for oral care and would expect staff to complete it every morning with morning cares. LPN-A further clarified, if R7	F 282		

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F 282	Continued From page 2 would refuse oral cares, staff needed to attempt oral cares with a toothette. During interview on 4/16/15, at 11:55 a.m. the director of nursing (DON) confirmed R7 required assistance with oral cares and would expect staff to complete the cares as directed in R7's care plan and the facility policy. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral cares for 1 of 1 resident in the sample (R7) who was dependent upon staff for grooming and personal cares. Findings include: R7's annual Minimum Data Set (MDS) dated	F 312	To correct the action to provide oral cares for the resident that was affected, education to staff that work with that resident was provided immediately through our huddle board system. THis education was provided for two week, April 17 through May 1, 2015. THe facility has identfied that all other resdients that need oral care provided for them could potentially be affected. To correct this again, education was provided to all direct care givers through our huddle board communication process and educated for two weeks on both neighborhoods. Measures that are put into place to ensure it will not recur, is an audit process to observe and monitor oral cares are being provided to residents. THis audit is to be done on a daily basis for two weeks and will be reviewed by nursing administration weekly for modifications due to what the audits reveal. This audit process will also be reviewed through our facility QA process and recommendations will be given by QA committee to ensure the solution is sustained. This corrective action will be completed by May 26, 2015. RESPONSIBILITY: DON	5-26-15

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F 312	Continued From page 3 1/25/15, identified R7 was severely cognitively impaired and had a diagnoses of dementia. The MDS indicated R7 required extensive assistance for completion of personal hygiene tasks. R7's care plan revised on 5/15/13, identified R7 required assistance with grooming. On 4/15/15, the care plan was updated to include R7 had own teeth, dental hygiene students cleaned/examined R7's teeth 1-2 times per year and R7 would sometimes allow a toothette for oral cares if R7 did not want a toothbrush used. The resident care sheet dated 4/14/15, directed staff to provide R7 oral cares before drinking. During observation of morning cares on 4/15/15, from 8:09 a.m. to 8:30 a.m. nursing assistant (NA)-A assisted R7 with personal cares which included washing her face, perineal cares and dressing. During this observation, R7 was not assisted with nor offered the opportunity for completion of oral cares. R7's natural teeth were observed with areas of white matter build up between them. -At 8:30 a.m. following the observation, NA-A assisted R7 to the dining room and gave her a drink of water. Review of R7's annual dental exam dated 7/7/14, indicated R7 had all natural teeth with bleeding and red, swollen gums and moderate gingivitis. Ultrasound used in exam, R7 tolerated procedure. Heavy calc. lower anterior's, plaque/debris throughout.	F 312		

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F 312	Continued From page 4 Review of dental progress note dated 2/9/15,-dental oral exam indicated R7 had heavy plaque along the gum line and needed help with brushing with concentration at the gum line. During interview on 4/15/15, at 8:35 a.m. NA-A confirmed she was finished with R7's morning cares and stated R7 had all natural teeth and needed assistance to brush them however, she had completely forgot to provide R7 oral cares. NA-A stated staff were directed to brush R7's teeth twice a day and she normally would do oral cares before breakfast. NA-A stated there were no specific guidelines regarding R7's oral care on the resident care sheet. During interview on 4/15/15, at 8:58 a.m. licensed practical nurse (LPN)-A confirmed R7 required extensive assistance for oral care and would expect staff to complete it every morning with morning cares. LPN-A further clarified, if R7 would refuse oral cares, staff needed to attempt oral cares with a toothette. During interview on 4/16/15, at 11:55 a.m. the director of nursing (DON) confirmed R7 required assistance with oral cares and would expect staff to complete the cares as directed in R7's care plan and the facility policy. The facility policy titled Denture Care and Oral Hygiene revised on 10/10, indicated care would	F 312		

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F 312	Continued From page 5 be provided for the residents as part of AM and PM cares and would be done more frequently should condition warrant.	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	To correct the facilities daily nursing hours posting form, modification to the form has been done to ensure all points stated in the regulation have been clearly documented. This form will be posted daily in three areas of our facility (outside of the social worker office, entrance to the Prairie neighborhood and entrance to the River neighborhood). The current day will be posted each morning by the scheduler or charge nurse and updated throughout the day if there are modifications to the hours. THe nursing hours posting now clearly posts the facility name, current date, total number and actual worked hours for RN's, LPN's and CNA's, and resident census. THis posting will be audited for appropriate and current information by the DON weekly, through July 8. THis corrective action plan will be reviewed through our QA committee to ensure the solution is sustained. THis corrective action will be completed by 4-17-15.	4-17-15

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F 356	Continued From page 6 by: Based on observation, interview and document review, the facility failed to ensure the actual hours worked for nursing facility staff were posted. This had the potential to affect all 77 residents in the facility and visitors. Findings include: On 4/15/15, at 7:55 a.m., the facility's daily nursing hours posting, titled Report of Nursing Staff Directly Responsible for Resident Care dated 4/15/15, was observed posted on a bulletin board next to the social service office. The form listed the date, the daily census, class of nursing personnel and total hours per day for morning shift, afternoon shift and night shift. The times of the shifts (the actual hours worked) were not identified on the form, nor were any short shifts listed. Review of daily nursing staff reports dated from 3/19/15-4/12/15, revealed all reports lacked the resident census. Review of daily nursing staff reports dated from 4/13/15-4/16/15, revealed all reports lacked the actual hours worked for all staff responsible for resident care. During interview on 4/16/15, at 11:44 a.m., the director of nursing (DON) confirmed the daily posting of nursing hours lacked the actual hours worked. The DON stated the facility had just changed the daily staffing format on 4/13/15, due to the prior format not meeting the regulation of	F 356		

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F 356	Continued From page 7 including the facility census. The DON stated when staff developed the new form, the census was added and the shift times which then the actual hours worked was left off. The DON confirmed both formats lacked required information. Review of the facility's Nursing staff hours policy dated 5/14, indicated posting nursing staff hours was to inform the residents and family of numbers of RNs, LPNs, Na-Rs that were present in the building as well as the actual hours worked to care for the residents on all three shifts.	F 356		

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

F526502H

PRINTED: 04/28/2015
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
	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**04/14/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS HOME	**2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520**

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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 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 YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey St Francis Home 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 St Paul, MN 55101	K 000	Pcok FB 5-19-15 RECEIVED MAY 14 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-26-15

EXIT: 4/16-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	5-12-15

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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	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**04/14/2015**

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as one building. St Francis Home is part of the St Francis Healthcare Campus. It was built in 2005, is a 1-story building, without a basement and was determined to be Type V (111) construction. It is separated from St Francis Healthcare Center with 3- hour fire barriers and is divided into 4 smoke zones with 1-hour fire barriers. The entire building is completely protected by an automatic fire sprinkler system equipped with quick response sprinkler heads. The Automatic Fire Sprinkler system has been installed 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 throughout the corridor system, in areas open to the corridors, and common areas. The Fire Alarm System has been installed	K 000		

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K 000	Continued From page 2 in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are into the fire alarm system and all sleeping rooms have 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. The facility has a capacity of 80 beds and had a census of 77 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET.	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA	K 025	These openings were sealed with FireStop on 4-17-15 RESPONSIBILITY: DIRECTOR OF PLANT OPERATIONS	4-17-15

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K 025	Continued From page 3 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/14/2015, it was observed that the Prairie Meadows smoke barrier had a 1/4 inch penetration around the top of a 3 inch black pipe that was found to be passing through the smoke barrier wall. These deficient practices were confirmed by the Director of Maintenance (SM).	K 025		
K 038 SS=D	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. 18.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide 1 of several exit discharge walking surfaces in accordance with NFPA 101 Life Safety Code (00) edition, Sections 19.2.7, and 7.1.6.2. This deficient practice could affect residents, staff and visitors if emergency evacuation via this discharge was necessary. Findings include:	K 038	A contractor has been hired to repair this sidewalk to be completed within two weeks. RESPONSIBILITY: DIRECTOR OF PLANT OPERATIONS	5-26-15

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K 038	Continued From page 4 On facility tour between 10:30 AM to 2:30 PM on 04/14/2015, it was observed that the hard path exit discharge by resident room 949 has an uneven walking surface due to a 3 inch heave in the cement sidewalk located 3 feet from the exit door. These deficient practices were confirmed by the Director of Maintenance (SM).	K 038		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler 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 system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff. Findings include:	K 154	This policy has been updated to include current contact information and time frames for a firewatch. RESPONSIBILITY: DIRECTOR OF PLANT OPERATIONS	4-17-15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS HOME	**2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 5 On facility tour between 10:30 AM to 2:30 PM on 04/14/2015, during record review and an interview with the Director of Maintenance (SM), the facility failed to update and provide a complete list of contact information on the automatic fire sprinkler system out of service policy. The policy was lacking current Deputy State Fire Marshal contact information; and the policy also did not specify the need to activate a fire watch nor delineate a time duration for an outage that would trigger a fire watch. These deficient practices were confirmed by the Director of Maintenance (SM).	K 154		
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 record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff.	K 155	This policy has been updated to include current contact information and times to institute a firewatch. RESPONSIBILITY: DIRECTOR PLANT OPERATIONS	4-17-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**04/14/2015**

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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
K 155	Continued From page 6 Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/14/2015, during record review and an interview with the Director of Maintenance (SM), the facility failed to update and provide a complete list of contact information on the fire alarm system out of service policy. The policy was lacking current Deputy State Fire Marshal contact information; and the policy also did not specify the need to activate a fire watch nor delineate a time duration for an outage that would trigger a fire watch. These deficient practices were confirmed by the Director of Maintenance (SM).	K 155		