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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DRRF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00041

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245490**
2.STATE VENDOR OR MEDICAID NO.
(L2) **915525200**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK HILLS LIVING CENTER**
(L4) **1314 EIGHTH STREET NORTH**
(L5) **NEW ULM, MN** (L6) **56073**

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 **01/07/2018** (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 **94** (L18)
13.Total Certified Beds **94** (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 ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(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 :
Holly Kranz, Unit Supervisor 01/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/09/2019 (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
08/01/1987
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245490

January 9, 2019

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Dear Administrator:

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 28, 2018 the above facility is certified for:

94 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 94 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 9, 2019

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: Project Number S5490030

Dear Administrator:

On December 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on November 29, 2018.

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 7, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 2, 2019 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 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 28, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 29, 2018, effective December 28, 2018 and therefore remedies outlined in our letter to you dated December 11, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DRRF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00041

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245490**
2.STATE VENDOR OR MEDICAID NO.
(L2) **915525200**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK HILLS LIVING CENTER**
(L4) **1314 EIGHTH STREET NORTH**
(L5) **NEW ULM, MN** (L6) **56073**

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 **11/29/2018** (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 **94** (L18)
13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(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 :
Wendy Dobie, HFE NE II 12/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/01/2019 (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:

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(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

Electronically delivered
December 11, 2018

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: Project Number S5490030

Dear Administrator:

On November 29, 2018, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 8, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by March 1, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by May 29, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(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 On 11/26/18 through 11/29/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		12/27/18

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

Electronically Signed | 12/18/2018

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
	245490	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(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 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe and comfortable environment for 1 of 5 residents (R34) observed with a heavily soiled wheelchair and 1 of 1 resident (R7) observed to have a damaged side rail. Findings include: R34's diagnosis report, dated 11/29/18 indicated a diagnosis of Alzheimer's disease and hemi-plegia.	F 584	F584-D Safe/Clean/Comfortable/Homelike Environment Corrective Action: Resident's wheelchair was immediately washed and RNA involved received education. Residents in the facility already have a weekly wheelchair wash schedule that is completed on their bath days during the night shift. Staff are also trained to wash wheelchairs as needed. Education will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(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 584	Continued From page 2 R34's quarterly Minimum Data Set, dated 9/27/18, revealed R34 had severe cognitive impairment, and required extensive assistance from staff for repositioning, hygiene, and transferring from one surface to another. R34's wheelchair was observed on 11/28 /18 at 12:49 p.m., to be soiled on both side panels and the interior and exterior side walls, with thick, dried-on debris. In addition, the wheelchair cushion was heavily soiled with debris on the top, side and bottom surface. Nursing assistant (NA-A) was present and after she lifted R34 out of the wheelchair with the mechanical lift after a transfer at this time, confirmed R34's wheelchair was dirty and stated R34's wheelchair "is cleaned on bath day by the night shift, and as needed by the NAR on the floor." During interview on 11/28/18 at 1:17 p.m., registered nurse (RN-B) confirmed that the wheelchair was heavily soiled and needed cleaning. During a follow-up interview the nurse manager, RN-A, stated she had added the task of wheelchair washing to the work list for the nursing assistants to complete on R34's bath day. RN-A revealed that in between washing she would expect the nursing assistant assigned to R34 to keep the chair clean by wiping the surface down as needed. The facility policy for Cleaning and disinfection of resident care items and equipment, revised July 2014 indicated: Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Center for Disease Control recommendations for disinfection.	F 584	provided at a mandatory meeting scheduled for December 19th and 27th. Side rails have been replaced. Maintenance already has a quarterly schedule to audit bedframes, side rails, mattresses etc. Staff will be educated during the December All Staff Mandatory meeting to report any damage equipment immediately by filling out a maintenance slip or calling the on call maintenance phone depending on urgency. Actual/Proposed Completion Date: 12/27/2018 Person Responsible for Correction/Monitoring: Case Manager, DON, Infection Control Nurse, Maintenance Director and Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(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 584	Continued From page 3 On 11/26/18, at 3:00 p.m. R7's bilateral quarter siderails at the head of the bed (HOB) were observed to have chunks of material missing from many areas of the rails. There was also some exposed frame from within the siderail. R7 stated she utilized the rails to turn herself. On 11/29/18, at 3:55 p.m. R7's siderails were inspected with the maintenance director. The rails on the bed were raised, both rails had large gauges approximately 2-6 inches in length throughout the rails. The side rails were composed of a rigid foam like material on the outside of the rail; the rail on the right side of the HOB was gauged far enough into the middle of the rail where the metal was showing. R7 was present in the room and stated, "They've been like that for a long time". The maintenance director confirmed the rails were damaged and needed to be replaced and was surprised staff had never notified him about them.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		12/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(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 600	Continued From page 4 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in a timely manner for 1 of 1 residents (R33) reviewed for abuse who was left on the bedpan for four hours after requesting help with toileting. Findings include: R33's annual Minimum Data Set (MDS) dated 9/10/18, indicated the resident has an intact cognition, is occasionally incontinent of urine, requires extensive assistance of 2 for transfers and positioning in bed and requires extensive assistance of one for toilet use and personal hygiene. R33's face sheet, dated 11/29/18 listed diagnoses of acquired absence of unspecified leg above knee, pain, and dermatitis (red itchy rash). R33's care plan,initiated 9/19/17 identified an alteration in ADL (activities of daily living) function related to diagnoses of obesity, phantom limb syndrome with pain, osteoarthritis and occasional bladder incontinence as evidenced by resident receiving assistance with all mobility/ADL functions. Interventions listed included assistance of 1 or more staff with toileting tasks - uses bedpan. The most recent care plan update, dated 3/21/18 did not include any newly revised interventions. Upon interview on 11/26/18, at 12:43 p.m. R33 stated that on 5/11/18, she was placed on the bed	F 600	F600 Free from Abuse and Neglect Corrective Action: The alleged staff members that were involved in this incident received education and a written warning. One of the staff members no longer works here. Staff will be educated at the all staff mandatory meeting that is scheduled for December 19th and 27th, 2018 on VA reporting and documentation. The Director of Social Services is now placing all complaints/concerns through the grievance and risk management process. Facility will continue to utilize the risk management protocol and discuss during daily stand up and report to OHFC and/or Maarc if applicable. Actual/Proposed Completion Date: 12/27/2018 Person Responsible for Correction/Monitoring: Case Manager, Household Coordinator, LSW, Staff Development, DON and Administrator.	

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F 600	Continued From page 5	F 600		

pan between 10 p.m. and 11 p.m. prior to a staffing shift change. R33 stated she feel asleep and awoke at 2:15 and put her call light on, as she was still sitting on the bed pan. When nursing assistant (NA)-D answered R33's call light, she asked if R33 needed the bed pan to which R33 stated she was still on the bed pan and had not been off since it was originally placed. R33 stated she told the nursing staff that morning about being on the bed pan for 4 hours and also informed the licensed social worker about the incident. R33 also stated that she now informed all staff members in the event she falls asleep while on the bedpan to either raise or lower the head of her bed, which will wake her up. She further stated she was "worried it will happen again."

Upon interview on 11/28/18, at 7:29 a.m. R33 stated her skin on her buttocks was very sensitive and if she gets wet or they leave her to long on the bed pan, it got red, irritated and peeled. R33 stated after being on the bed pan for four hours, she had a burning sensation on her skin and a purple spot appeared, which R33 reported as still being present with occasional burning and itching. She further stated her medical provider started her on a skin protectant to assist in healing and prevention of reoccurrence.

Upon observation on 11/28/18, at 7:50 a.m of R33's skin condition, a light purple spot 4 centimeters (cm) was noted on R33's right upper back thigh. An area above the purple spot had redness around it, corrresponding to the edges of R33's brief. R33's skin was also red along the intergluteal cleft on both sides, no skin peeling was present.

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F 600	Continued From page 6	F 600		

Upon interview on 11/28/18, at 7:50 a.m., nursing assistant (NA)-B stated she had heard about the situation where R33 was left on the bedpan for 4 hours back in 5/18 when it happened. She further stated the purple spot on R33's posterior upper thigh had been there awhile, however, was unable to identify for how long.

Upon observation and interview on 11/29/18, at 8:30 a.m., licensed practice nurse (LPN)-A observed R33's posterior purple spot on her upper thigh stating it was a skin discoloration but didn't look like a topical bruise, rather, was deeper than that and was a light purple color.

Upon interview on 11/29/18, at 8:55 a.m. registered nurse (RN)-C stated this incident was discussed in stand up meeting and clarified this was a daily meeting with the interdisciplinary team where issues with skin, falls, etc...or any new developments were discussed. She further indicated she thought licensed social worker (SS)-A "took care of it [the incident related to the bedpan]". RN-C stated there should be a progress note in R33's medical record. Upon review of progress notes and the risk management reports, RN-C stated she could not "find anything related to this incident."

Upon interview on 11/29/18, at 10:31 a.m. the director of nurses (DON) stated she was not aware of this alleged abuse/neglect event and confirmed there was no risk management report or progress note completed. The DON further stated, "No way would I think 5 hours or anything over an hour on a a bed pan is okay."

Upon interview on 11/29/18, at 11:22 a.m. with SS-A and RN-C, SS-A stated that according to

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F 600	Continued From page 7	F 600		

her notes, R33 reported the alleged event on 5/14/18 stated that on 5/11/18, at approximately 10:25 p.m. R33 was placed on the bed pan per her request. At 2:30 a.m., NA-D came to R33's room asking if she would like the bedpan, to which R33 stated the bed pan was still under her. SS-A stated there was no injury except that R33 complained of burning on her skin where the bed pan had been.

Upon interview 11/29/18, 1:21 p.m. SS-A stated she spoke with RN-C after speaking to R33 regarding the event. She stated "I'm confident we did something [about the issue with the bed pan], but I just don't know what." She further stated there was no documentation of the incident with R33 except for a few personal notes.

The facility policy entitled Abuse Policy and Procedure, dated 9/22/17 stated:
-It is the policy of this facility that our residents will be free from abuse (verbal, mental, sexual or physical), neglect...Residents will be protected from abuse, neglect and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and the facility will monitor our policies, procedures, training programs, systems, etc., to assist in prevention resident abuse.
- It is the policy of this facility that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated.
-Overview of Seven Components of Abuse Policy:
-Screening
-Training
-Prevention
-Population

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F 600	Continued From page 8 -Identification -Investigation -Reporting and Response Requirements	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of	F 609	F609 Reporting of Alleged Violations	12/27/18

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F 609	Continued From page 9 abuse/ neglect to the state agency (SA) and facility administrator for 1 of 1 residents (R33) reviewed for allegations of abuse. Findings include: R33's annual Minimum Data Set (MDS) dated 9/10/18, indicated the resident has an intact cognition, is occasionally incontinent of urine, requires extensive assistance of 2 for transfers and positioning in bed and requires extensive assistance of one for toilet use and personal hygiene. R33's face sheet listed diagnosis of acquired absence of unspecified leg above knee, pain, and dermatitis (red itchy rash). Upon interview 11/26/18, 12:43 p.m. R33 stated she was placed on the bed pan on 5/11/18, between 10 p.m. and 11 p.m. prior to shift change. R33 reported she fell asleep, and awoke at 2:15 and put her call light after realizing she was still on the bed pan. When nursing assistant (NA)-D answered R33's call light, she asked if R33 needed the bed pan, and R33 stated she was still on the bed pan from the previous time. R33 stated she told the nursing staff that morning about being on the bed pan for four hour,s and also informed the licensed social worker about the incident. Upon interview on 11/29/18, at 11:22 a.m. the licensed social worker (SS)-A stated that according to her notes, R33 reported the alleged event to her on 5/14/18, stating that on 5/11/18 at approximately 10:25 p.m. R33 was placed on the bed pan per her request and left there for about four hours. SS-A stated there was no injury	F 609	Corrective Action: The alleged staff members that were involved in this incident received education and a written warning. One of the staff members no longer works here. Staff will be educated at the all staff mandatory meeting that is scheduled for December 19th and 27th, 2018 on VA reporting and documentation. The Director of Social Services is now placing all complaints/concerns through the grievance and risk management process. Facility will continue to utilize the risk management protocol and discuss during daily stand up and report to OHFC and/or Maarc if applicable. Actual/Proposed Completion Date: 12/27/2018 Person Responsible for Correction/Monitoring: Case Manager, Household Coordinator, LSW, Staff Development, DON and Administrator.	

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F 609	Continued From page 10 except the resident complained of burning on skin where the bed pan had been. SS-A further indicated she did not report this as there was no injury. Registered nurse (RN)-C, was also present during the interview. Although the facility had been aware of the incident since 5/14/18, no reports had been made to the SA or administrator. Upon interview on 11/29/18, at 12:53 p.m. the director of nursing (DON) stated that she was not aware of this alleged neglect event and confirmed there was no risk management report completed. She further confirmed the event was not reported to the SA in a timely manner. The facility's policy entitled Abuse Policy and Procedure, dated 09/22/2017, included that all alleged violations involving abuse, neglect, exploitation or mistreatment must be reported as soon as possible, but no later than 24 hours following the events. The report should be made at a minimum to the Administrator and Director of Nursing Services.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		12/27/18

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F 610	Continued From page 11 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate, prevent, correct or implement abuse/neglect prohibition procedures related to alleged abuse/neglect for 1 of 1 resident (R33) reviewed for allegations of abuse who was left on the bed pan for an extended period of time. Findings include: R33's annual Minimum Data Set (MDS), dated 9/10/18 indicated the resident has an intact cognition, is occasionally incontinent of urine, requires extensive assistance of 2 for transfers and positioning in bed and requires extensive assistance of one for toilet use and personal hygiene. R33's face sheet, printed 11/29/18 listed diagnosis of acquired absence of unspecified leg above knee, pain, and dermatitis (red itchy rash). R33's care plan initiated 9/19/17 identified an alteration in ADL (activities of daily living) function related to diagnoses of obesity, phantom limb syndrome with pain osteoarthritis...and occasional bladder incontinence as evidenced by resident receiving assistance with all mobility/ADL functions. Interventions dated 9/19/17 identified R33 requires assistance of 1 or more personal	F 610	F610 Investigate/Prevent/Correct Alleged Violation Corrective Action: The alleged staff members that were involved in this incident received education and a written warning. One of the staff members no longer works here. Staff will be educated at the all staff mandatory meeting that is scheduled for December 19th and 27th, 2018 on VA reporting and documentation. The Director of Social Services is now placing all complaints/concerns through the grievance and risk management process. Facility will continue to utilize the risk management protocol and discuss during daily stand up and report to OHFC and/or Maarc if applicable. Actual/Proposed Completion Date: 12/27/2018 Person Responsible for Correction/Monitoring: Case Manager, Household Coordinator, LSW, Staff Development, DON and Administrator.	

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F 610	Continued From page 12	F 610		

physical assist with toileting tasks - uses bedpan. The last care plan update was dated 3/21/18 indicating no new interventions were placed following the alleged incident.

Upon interview on 11/26/18, at 12:43 p.m. R33 stated she was placed on the bed pan between 10 p.m. and 11 p.m. prior to shift change on 5/11/18. R33 reported she fell asleep, and awoke at 2:15 and put her call light on. When nursing assistant (NA)-D answered call light, she asked if R33 needed the bed pan to which R33 stated she was still on the bed pan from the previous time. R33 stated she told the nursing staff that morning about being on the bed pan for four hours, and also informed the licensed social worker about the incident. R33 also stated that she informed all staff members that in the event she falls asleep while on the bedpan to either raise or lower the head of her bed, which would wake her up. R33 further stated she was,"worried it will happen again."

Upon interview on 11/29/18, at 11:22 a.m. with the licensed social worker (SS)-A and registered nurse (RN)-C, SS-A stated that according to her notes, R33 reported the alleged event on 5/14/18 stating that on 5/11/18 at approximately 10:25 p.m. R33 was placed on bed pan per her request. At 2:30 a.m. NA-D came to residents room asking if she would like the bedpan to which R33 stated the bed pan was still under her. SS-A stated there was no injury except that R33 complained of burning on skin where the bed pan had been.

Upon interview on 11/29/18, at 12:53 p.m. the director of nursing (DON) stated that she was not aware of this alleged neglect event and confirmed

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F 610	Continued From page 13 there was no risk management report completed or progress note in R33's record. The DON further stated that the risk management program was their internal investigation process, so she would expect an incident report or at least a progress note to address this incident. Upon interview on 11/29/18, at 1:21 p.m. SS-A stated she spoke with RN-C after speaking to R33 regarding the event. SS-A stated, "I'm confident we did something but I just don't know what." She further stated there was no documentation except a few personal notes and was unable to provide evidence of a thorough investigation or corrective measures taken by the facility to prevent reoccurrence. The facility policy entitled Abuse Policy and Procedure, dated 9/22/17 indicated: - It is the policy of this facility that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. -Overview of Seven Components of Abuse Policy: -Screening -Training -Prevention -Population -Identification -Investigation -Reporting and Response Requirements	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		12/27/18

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F 684	Continued From page 14 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and monitor a tongue lesion/growth and failed to assess and provide proper positioning for 1 of 1 resident (R29) reviewed for non-pressure related skin conditions and positioning. Findings include: R29's current diagnoses included hemiplegia/ hemiparesis following a cerebral vascular accident (CVA), neuropathy, aphasia and muscle weakness. During observation on 11/26/18, at 4:00 p.m. R29 was noted to have a bluish colored lump/lesion located on the right side of her tongue (near the tip). R29 indicated her tongue was sore where the lump was located. Review of R29's annual minimum data set (MDS) assessment, dated 3/15/18 identified R29 as having short term memory problems with moderately impaired cognition. and requiring extensive assistance with personal cares. The MDS further identified R29 as being edentulous, having no abnormal mouth tissue (ulcers, masses, or lesions) and no inflamed gums or mouth pain. Review of the current quarterly MDS, dated 9/14/18 indicated no changes from the	F 684	F684 Quality of Care Plan of Correction: Monthly monitoring is in place. Case Manager consulted further with family the history of the lesion. Family confirmed that it is from many years ago following a stroke. Care plan now reflects history on lesion. Lesion will be monitored monthly. Case Manager will include lesion on future oral assessments. Son (POA) has stated that resident has had lesion for many years with no changes, therefor desires no further follow up. Resident is currently in therapy services to trial positioning devices while waiting for the arrival of the custom chair that had been previously ordered. Resident has had some resistance in therapy, but therapy continues to work with her. Education on quality of care will be provided in the all staff mandatory meeting on December 19th and 27th. Actual/Proposed Completion Date: 12/27/2018 Person Responsible for Correction/Monitoring: Case Manager,	

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F 684	Continued From page 15 annual assessment dated 3/15/18 R29's current plan of care identified R29 as being edentulous and having upper and lower dentures. R29 required assistance with brushing dentures, cleaning gums and rinsing mouth with mouthwash. Interventions: conduct an oral/dental evaluation upon admission, annually and as needed, observe/document/report any signs or symptoms of dental/oral problems (pain, abscess, white or smooth tongue, ulcers or lesions), provide dental/oral care and offer dental care visits. Review R29's current oral assessment, dated 9/14/18 identified R29 as having a diagnosis of CVA and epilepsy that may impact the resident's oral status. R29 receives warfarin (anticoagulant) that may contribute to oral problems. R29 has no natural teeth and wears upper and lower dentures. R29 has a pink tongue and gums. No visible mouth sores, lesions, masses, abscesses or ulcers and no pain. Requires minimal assistance with oral cares. R29's last dental appointment was 6/4/15. The assessment further indicated R29 has no dental/oral issues and the resident has declined routine oral visits. Observation on 11/28/18 at 9:55 a.m. R29 was eating breakfast independently. R29 was noted again to have a bluish lump/lesion located on the top right side of her tongue. When asking R29 if she had any discomfort/pain in the area with eating, R29 indicated she had pain by nodding her head "yes". Interview with trained medication aide/nursing assistant (TMA/NA)-A on 11/28/18, at 10:00 a.m. indicated R29 has had a lump/lesion on her	F 684	ADON, DON and Administrator	

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	245490	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH NEW ULM, MN 56073**

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F 684	Continued From page 16	F 684		

tongue for at least the past year. TMA/NA-A did not know what the lump/lesion was, the cause or if it had changed in appearance/size. TMA/NA-A further included the lump did not interfere with R29's eating and did not think it had caused her discomort.

Interview with TMA/NA-B on 11/28/18, at 10:05 a.m. indicated she was aware of R29's lump on the tongue. TMA/NA-B indicated R29's lump had been there for the past couple of months and thought she may have bit her tongue. TMA/NA-B was unsure if the condition of the lump had changed in appearance or size. During interview, TMA/NA-B asked R29 if she had tongue pain, R29 nodded her head "yes".

Interview with unit case manager (CM)-A, confirmed she was aware of R29's lump/lesion on the tongue, but failed to assess or include in the plan of care to monitor the area. CM-A further included she was unsure of what the lump/lesion was or if it had changed in appearance/size.

Positioning

During observation on 11/26/18, at 4:00 p.m. R29 was noted to be sitting in her wheelchair (W/C) in the hall with her right arm leaning to the right side and hanging between her W/C and leg. Her hand was hanging off of the seat of the W/C near her right knee. R29's right shoulder was also leaning to the right side. The arm was "flaccid" (weak/limp) as the resident was unable to move or position her arm independently.

Review of the annual MDS assessment dated 3/15/18, identified R29 as having short term memory problems with moderately impaired

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F 684	Continued From page 17	F 684		

cognition. R29 usually understands others. R29 requires extensive assistance with most activities of daily living (ADL's) including mobility. R29 has impairment of the upper and lower extremities on one side. R29 utilized a W/C. Review of the quarterly MDS assessment dated 9/14/18, noted no changes from the annual assessment dated 3/15/18.

Review of R29's current plan of care identified R29 as having impairment in ADL functioning related to right sided hemiplegia, secondary to CVA. R29 required assistance with ADL'S that included mobility/positioning. R29 utilizes a W/C and able to propel with her left arm. R29 has moderate cognitive impairment. The plan of care did not include R29's right sided hemiplegia or positioning needs.

Review of the current contracture risk assessment dated 9/14/18, R29 was identified as having limited assistance of the upper right and lower extremities with right sided paralysis, related to CVA. Range of motion (ROM) is done daily by staff. The assessment did not include or address positioning needs.

Review of an Occupational therapy evaluation dated 6/27/18 with a discontinued (D/C) date of 8/23/18, indicated R29 was referred by the primary physician to assess the resident for a different W/C. The current W/C did not provide adequate support for self-propelling and that it was too narrow for proper upper back support. Review of the treatment notes as well as the discharge note did not include an assessment/treatment for positioning or proper alignment of R29's right arm paralysis.

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F 684	Continued From page 18	F 684		

Observation on 11/28/18, at 9:55 a.m. R29 was sitting in her W/C eating breakfast. R29's right arm noted to be hanging down between her W/C and leg. Her hand was hanging off of the seat of the W/C near her right knee. R29's right shoulder was also leaning to the right side. The arm was flaccid and R29 was unable to move or position her arm independently. R29's right arm from below the shoulder to her fingertips noted to be slightly bluish in color. When asking R29 if she had pain in her right arm, she nodded her head "yes".

During interview with TMA/NA-B on 11/28/18, at 10:05 a.m.TMA/NA-B stated R29 often would let her right arm hang along her right side but would at times lift it with her left hand and place it on the arm rest. TMA/NA-B asked R29 if her right arm hurt while hanging along side of her, R29 responding by nodding her head "yes" TMA-NA-B further indicated she thought R29 used to have an arm positioning device in the past, but was unsure why she currently did not have one. TMA/NA-B confirmed the staff had not been positioning/supporting R29's right arm for proper alignment and comfort.

During observation on 11/29/18, at 9:07 a.m. R29 was noted to be sitting in her W/C in the hallway. R29's right shoulder/arm was leaning to the right side and hanging between her W/C and leg. The residents hand was hanging off of the edge of the W/C seat and her arm and hand were bluish in color. R29 was unable to lift her right arm or straighten her right shoulder when asked by the surveyor.

During interview with unit case manager (CM)-A on 11/29/18, at 9:10 a.m. CM-A confirmed she

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F 684	Continued From page 19 was aware of R29's right arm paralysis and that there was not a current plan of care in place to include proper positioning needs. CM-A indicated R29 had been assessed by OT for W/C self-propelling, but was not assessed for positioning needs for the resident's right arm. CM-A confirmed R29's right arm was not supported when sitting in her W/C and that the residents right arm would just "hang" to the right side. CM-A further indicated because R29 did not complain to her of pain in the right arm, she did not feel she needed to address positioning. During interview with certified occupational therapy assistant (COTA)-B on DATE & at TIME, COTA-B stated R29 had been assessed/evaluated for a different W/C to ease self-propelling. COTA-B indicated R29's left arm was assessed during the evaluation as well because the resident complained of pain in the shoulder. COTA-B confirmed R29's right arm had not been evaluated/assessed for positioning needs.	F 684		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		12/27/18

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F 755	Continued From page 20 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled and/or narcotic medications in 1 of 1 emergency kit (E-Kit) to prevent potential loss or diversion. This had the potential to affect any of the 83 residents present in the facility who may require controlled medications from the E-Kit. Findings include: On 11/28/2018, 11:59 a.m., the Deer Haven medication storage room tour was conducted with registered nurse (RN)-E. Located in a locked cupboard below the counter was a plastic tackle box which was identified by (RN)-E as the facility E-Kit. The E-Kit contained controlled substance medications including Ativan (an anxiolytic),	F 755	F755 Pharmacy Plan of correction: Staff was identifying if meds were used from the E-kit during shift to shift Narc count by answering yes or no. However, now facility has added to verify tag number on E-kit both in locked cabinet and in fridge at nurse to nurse shift count. We will continue to call for MD order and permission from pharmacy prior to using the E-kit and fax to the pharmacy the Oak Hills Emergency Medication Kit Inventory sheet identifying what medication was removed. Also added a section for nurses to write removed tag number and new tag number to the inventory sheets that are faxed to pharmacy. Pharmacy currently replaces	

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F 755	Continued From page 21 Morphine (narcotic pain reliever), Oxycodone (pain reliever/narcotic), Norco (narcotic pain reliever), and Valium (anxiolytic). The E-kit was secured with a numbered red plastic tag attached to the clasp of the box. (RN)-E indicated a form was filled out and faxed to the pharmacy to notify a medication was being removed and a black tag applied with a new number. Pharmacy, in turn, would switch out the E-Kits within 24-48 hours. (RN)-E further stated the next nurse would be notified if the E-Kit was used but would not report if the tag number changed, if it was in the designated storage location, or include the E-Kit during the end of shift narcotic count. A refrigerator within the medication storage room contained a small clear plastic box secured with a numbered plastic tag. (RN)-E identified the box as an E-Kit that required refrigeration. The E-Kit contained 3 vials of Lorazepam (injectable anxiolytic/controlled substance). (RN)-E verified there was no system in place to monitor the refrigerated E-Kit. During the interview on 11/29/18, 8:32 a.m., registered nurse (RN)-B indicated the E-Kit was rarely used and confirmed it was not accounted for at the end of shift narcotic count. During interview on 8/16/18, at 9:49 a.m., the director of nursing (DON) confirmed the facility did not have a process to monitor the E-Kits and did not monitor the presence or tag number for the E-Kit, which included controlled medications that had the potential for abuse. A facility policy titled Medication Ordering and Receiving From Pharmacy IC5: Emergency Pharmacy Service and Emergency Kits, last	F 755	E-Kit within 24 hours of use. Instead of monthly Narc audits we are now completing weekly Narc audit, which include auditing the E-kits. Nursing staff were educated on the new process of tag verification. Actual/Proposed Completion Date: 12/27/2018 Person Responsible for Correction/Monitoring: Case Manager, Staff Development, DON and Administrator	

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F 755	Continued From page 22 revised 6/2/2014, indicated: M. Accountability for controlled substances stored in the emergency kit maintained as follows: 3) The incoming and outgoing nurses verify the inventory of controlled substances at each change of shift or exchange of keys.	F 755		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide 2 of 2 residents (R38, R56) their meal preference during the supper meal on 11/26/18 in the Eagles Point dining room. Findings include: Review of the facility's supper menu for 11/26/18, indicated the entree choices to be oven fried chix (chicken) and mushroom cube steak. On 11/26/18, at 5:34 p.m. homemaker-D was observed dishing up a room tray for R38's supper meal. The laminated card with R38's menu choices indicated: chix thigh, b/b (buttered bread), and milk. Homemaker-D dished up a	F 806	F806 Resident Allergies, Preferences, and Substitutes Plan of correction: We have implemented a daily huddle with our PM dietary aides to specifically discuss the evening□s menu and anything they may need to know surrounding the meal along with alternative choices of other food items. Education concerning resident choice will be provided at the All Staff Mandatory Meeting on December 19th and 27th. Weekly mealtime audits will be conducted. Actual/Proposed Completion Date: 12/27/2018	12/27/18

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F 806	Continued From page 23 chicken breast for R38. On 11/26/18 at 5:40 p.m. homemaker-D was observed asking R56 which entree she would like for supper. R56 asked for dark meat chicken. Homemaker-D stated the only option was white meat; R56 opted for the mushroom cubed steak instead. On 11/26/18, at 6:05 p.m. surveyor observed the chicken pieces in the steam table and confirmed there was dark meat available (legs and thighs). At that time, surveyor confirmed with R56 that she was told they didn't have any dark meat chicken. R56 had already eaten part of the cubed steak and stated being no longer hungry enough to have the chicken. Homemaker-D was then interviewed and stated she didn't know the difference between white and dark meat as she didn't eat chicken. Homemaker-D did not ask other staff or R56 what the difference was when the resident had asked for dark meat. On 11/26/18, at 6:22 p.m. R38 was observed dozing in recliner in his room. R38's room tray was on the bedside table next to him; the resident had only consumed approximately 1/8th of his chicken breast. When interviewed at that time, R38 confirmed he had ordered a chicken thigh as that was what he preferred and was also easier for him to eat. Surveyor asked the resident if he would like the surveyor to see if they had any thighs left and the resident declined. When interviewed on 11/28/18, at 11:21 a.m. the dietary manager (DM) confirmed R38 and R56 should have been given what they had ordered/requested. DM further stated additional training would need to be provided with dietary	F 806	Person Responsible for Correction/Monitoring: Dietician, Dietary Manager, PM Cook and Administrator	

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F 806	Continued From page 24 staff as there were many young staff employed as homemakers that may not know the difference with chicken pieces. When interviewed on 11/29/18, at 2:33 p.m. the director of nursing (DON) and administrator confirmed the homemaker working in the Eagles Point dining room the evening of 11/26/18, should have asked if she didn't know the difference in the chicken pieces. Administrator further confirmed that R38 "loved" his chicken. DON and administrator stated many of the new homemaker staff were young and confirmed they would need additional training.	F 806		

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	245490	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/27/2018**

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K 000	INITIAL COMMENTS	K 000		

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 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Oak Hills Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/20/2018

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 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The nursing home is separated from an assisted living facility by 2-hour fire walls, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire door assemblies. BUILDING: This 2-story with no basement facility was constructed in 1995, is fully sprinklered, and was determined to be of Type II (111) construction. An addition was constructed in 2009, is two-stories, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101,	K 000		

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K 000	Continued From page 2 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 94 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		11/27/18

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	245490	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH NEW ULM, MN 56073**

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview the Facility did not ensure that the cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice could effect 83 of the 83 residents. Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/27/2018, during documentation review, it was revealed that documentation could not be located to show that the kitchen fire suppression	K 324	K324 □ Corrective Action: Maintenance Director contacted Fairmont Fire to ensure Oak Hills Living Center is on a 6 month inspection schedule. The inspection was missed due to a change in ownership from Clancy's to Fairmont Fire. The 6 month inspection schedule did resume in August of 2018. The maintenance director and administrator has created a calendar to ensure the Ansul fire suppression system in the kitchen is inspected in February 2019 and every 6 months thereafter. Actual/Proposed Completion Date: 11/27/2018 Person Responsible for Correction/Monitoring: Maintenance Director and Administrator	

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K 324	Continued From page 4 system was inspected within the required time frame. Inspection occurred on 8/20/2018 and no documentation available to show a inspection occurred in February 2018. This deficient practice was verified by the Facility Maintenance Director.	K 324		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 83 out of 83 residents.	K 353	K353 □ Corrective Action: Maintenance Director and Maintenance Assistant will be conducting quarterly inspections on the fire sprinkler system. The automatic sprinkler and standpipe	12/26/18

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K 353	Continued From page 5 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/27/2018, observation revealed that documentation could not be provided that showed that the fire sprinkler system had been inspected and tested on a quarterly basis during 2018 and records review indicated that the 5 year fire sprinkler inspection needed to be conducted.. This deficient practice was verified by the Facility Maintenance Director.	K 353	systems will be inspected, tested and maintained. Records of the inspections will be maintained in a secure location of the maintenance department. An outlook calendar reminder of this inspection has been put on the maintenance director, maintenance assistant and administrators calendars. Maintenance Director has contacted Olympic Fire Protection and has scheduled the 5 year sprinkler inspection which will be done December 26, 2018. Actual/Proposed Completion Date: The quarterly inspection of the fire sprinkler system was completed 12/18/2018. The 5 year sprinkler inspection has been scheduled with Olympic Fire Protection for December 26, 2018. Person Responsible for Correction/Monitoring: Maintenance Director and Administrator	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363		12/28/18

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K 363	Continued From page 6 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to ensure doors protecting corridor	K 363	K363 -	

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K 363	Continued From page 7 openings were in operable condition. This deficient practice could effect 83 of the 83 residents. Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363	Corrective Action: Maintenance department inspected fire/smoke doors and will have any repairs and corrections completed by 12/28/2018. An outlook calendar has been created on the maintenance director, maintenance assistant and administrators calendar for the annual inspection. Actual/Proposed Completion Date: 12/28/2018 Person Responsible for Correction/Monitoring: Maintenance Director, maintenance assistant and Administrator	

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K 363	Continued From page 8 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/27/2018, documentation could not be provided that showed that the Annual Fire/Smoke Door Inspection had occurred. This deficient practice was verified by the Facility Maintenance Director.	K 363		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1. (1). This deficient practice could affect 35 of 83 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier	K 372	K372- Corrective Action: Maintenance department fire calked penetration holes above the ceiling tiles in the Whispering Pines smoke barrier wall. All smoke barriers in the facility will be inspected and fire calked if needed by 12/28/2018.	12/28/18

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K 372	Continued From page 9 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/27/2018, 4 penetrations were observed above the ceiling tiles in the Whispering Pines smoke barrier wall. NOTE: All smoke barriers in the Facility need to be checked to ensure there are no penetrations in the smoke barriers. This deficient practice was verified by the Facility Maintenance Director.	K 372	Actual/Proposed Completion Date: 12/28/2018 Person Responsible for Correction/Monitoring: Maintenance Director, maintenance assistant and Administrator	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914		12/7/18

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K 914	Continued From page 10 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99). This deficient practice could	K 914	K914- Corrective Action: Maintenance Department inspected the physical condition, ground continuity, polarity check and ground retention on each electrical receptacle□s in each resident room. Repairs have been made to correct faulty outlets. We have also created an outlook calendar for the maintenance director, maintenance assistant and administrator as a reminder to have this completed on an annual basis. Actual/Proposed Completion Date: 12/7/2018 Person Responsible for Correction/Monitoring: Maintenance Director, maintenance assistant and Administrator	

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K 914	Continued From page 11 effect 83 out of 83 Residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/28/2018, during documentation review and interview, documentation could not be located to show that the non-hospital rated electrical respectables within the resident rooms are inspected and tested at intervals not exceeding 12 months. This deficient practice was verified by the Facility Maintenance Director.	K 914		