MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 05DB
Facility ID: 00675

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245487**

2. STATE VENDOR OR MEDICAID NO. (L2) **394347000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ELIZABETH MEDICAL CENTER**
(L4) **1200 FIFTH GRANT BOULEVARD WEST**
(L5) **WABASHA, MN** (L6) **55981**

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 **08/23/2018** (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) **09/30**

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

12. Total Facility Beds **100** (L18)

13. Total Certified Beds **100** (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
__ 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(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 :
Connie Brady, HFE NE II 10/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/15/2018 (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 **02/14/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
September 21, 2018

Administrator
St. Elizabeth Medical Center
1200 Fifth Grant Boulevard West
Wabasha, MN 55981

RE: Project Number S5319027

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.

Dear Administrator:

On August 23, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> 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 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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 2, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

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

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

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

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

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:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 23, 2018 (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 February 23, 2019 (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
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 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:

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

September 21, 2018

Administrator
St. Elizabeth Medical Center
1200 Fifth Grant Boulevard West
Wabasha, MN 55981

RE: Project Number F5487030

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.

Dear Administrator:

On September 17, 2018, a standard survey was completed at your facility by the Minnesota Department of Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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;
>
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> 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 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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 27, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 27, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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Original deficiencies not corrected and new deficiencies found during the revisit

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Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 17, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 17, 2019 (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
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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING ______ B. WING ______	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/23/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/20, 8/21, 8/22 and 8/23, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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	Gary Nederhoff 10012018	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to adhere to the	F 554	- Follow up observation and assessment of R24 completed 8/31/18.	9/28/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/28/2018

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
	245487	A. BUILDING ______ B. WING ______	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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 554	Continued From page 1 Assessment for Self Administration of Medications for 1 of 3 residents (R24) who self-administered a nebulizer medications. Findings include: Review of the medical record for R24 indicated he was admitted to the facility on 12/4/18 with advanced dementia. R24's quarterly Minimum Data Set (MDS) dated 6/1/18, identified severely impaired cognition. An assessment for self-administration of medications dated 6/27/18, identified R24 would not be safe to self-administer medications related to cognitive impairment, visual deficit, impaired motor coordination, and a history of non-compliance with medications. R24's Medical Plan of Care signed on 7/5/18 and August, 2018 MAR indicated resident is NOT ok to self-administer nebulizers after set-up. On 8/22/18 at 11:23 am, R24 was observed sitting in his wheelchair in his room with the nebulizer mask down around his neck, pulling on it while yelling "how do you run this contraption." When interviewed on 8/22/18 at 11:34, the registered nurse (RN)-D confirmed she had placed the nebulizer mask on R24 and left the room. RN-D had only been gone a couple of minutes before being alerted R24 had the mask around his neck and needed help, at which time she returned to his room and placed the mask back on and left the room again. RN-D confirmed that she checks back in with R24 a couple times during the duration of the nebulizer, but does leave him alone. RN-D explained not long ago all	F 554	- Review of all residents currently residing in facility receiving nebulizer completed regarding nebulizer administration by 9/28/18. - Review of policies "Self-Administration of Medication, Assessment of" and "Administering Medications through a Nebulizer" completed 9/28/18. - Education provided to facility nursing team members regarding policy, process and procedure for self-administration of medication, specifically nebulizers by 9/28/18. - Audits to be completed by DON/Designees to verify compliance with policy and procedures 2 x week x 4 weeks (10/1 - 10/31/18).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING ______ B. WING ______	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981**

(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 554	Continued From page 2 the residents had assessments for self-administration completed by a registered nurse and if they couldn't be alone, it would be stated on the medication administration record (MAR) following the medication order. RN-D reviewed the MAR and verified there was nothing confirming self-administration behind the order, at which time RN-D stated "I'm unsure of his order." When asking where else she could find the information, RN-D stated "I don't look for it elsewhere, if it's not stated then they are ok to be left alone and I check on them frequently." During an interview with the DON on 8/22/18 at 2:05 pm, DON confirmed assessments for self-medications administration were completed recently on all residents. DON verified there are to be no vials of medication at any resident's bedside table. She confirmed if appropriate, documentation would state "ok to leave alone with neb" on the medical plan care. DON verified R24's MAR stated "not ok to be alone after set-up." Review of Self-Administration of Medication, Assessment of policy last reviewed on 8/24/17 indicated each resident will be assessed mentally and physically to determine whether self-administering medication is clinically appropriate for the resident.	F 554		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		9/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING ______ B. WING ______	08/23/2018

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F 640	Continued From page 3	F 640		

each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must

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F 640	Continued From page 4 transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete, encode and transmit Death in Facility Record for 2 of 3 residents (R)1 and R2 reviewed for resident assessment. Findings include: Review of R1's electronic medical record (EMR) indicated R1 was admitted to the facility on 3/9/18. R1's progress note dated 4/13/18, indicated facility was notified R1's passed away at 4:45 a.m. Review of R1's Minimum Data Set (MDS) were reviewed and identified an entry assessment was completed on 3/13/18, and an admission assessment was completed on 3/20/18, R1 did not have a Death in Facility Tracking Record in the EMR. R2's EMR indicated R2 was admitted to the facility on 12/16/17. R2's progress notes indicated R2 passed away on 4/7/18. R2's MDS assessments were reviewed from 1/2/18 to 3/27/18. R2 did not have a Death in Facility Tracking Record in the EMR. An interview on 08/23/18 at 7:29 a.m., identified	F 640	- MDS corrections made to accurately reflect R1 and R2 outcome 8/23/18. - Review of all discharged residents from facility in time frame of 1/1/18 - 9/1/18 to verify discharge entry record entered by 9/28/18. - Review of policies "MDS Assessment", "MDS Assessment Coordinator", and "Electronic Transmission of the MDS" completed by 9/28/18. - Review of process for accurate completion and submission of Death in Facility Tracking Record completed by MDS Care Coordinators by 9/28/18. - Monthly audits x3 months to include review of discharged residents from facility and verification the facility tracking record complete and submitted by MDS Coordinators/Designee (October - December 2018).	

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F 640	Continued From page 5 registered nurse (RN)-A was unaware of R1's and R2's MDS assessments. RN-A explained R1 and R2's MDS assessments were completed by the prior MDS coordinator who was no longer employed at the facility. RN-A started as MDS coordinator in July 2018, following completion of an MDS training and certification program. RN-A was unsure why R1 and R2 had MDS assessments identified over 120 days. RN-A reviewed R1's progress notes and verified R1 was transferred to the emergency room and died in the hospital on 4/13/18. Additionally, RN-A verified R1 and R2 required completion and submission of Death Tracking Records within 14 days of their passing. During an interview on 8/23/18 at 8:45 a.m., the DON's expectation was to have MDS assessments be completed accurately and in a timely manner according to the RAI manual. Review of the facilities MDS Assessment policy indicated residents of the facility must have MDS assessments completed in accordance with the center for medicare services (CMS) guidelines as outlined in the Resident Assessment Instrument (RAI) Manual. Review of the RAI manual Version 3.0 Manual, version 1.15 R dated October 2017, indicated a Death in Facility Tracking Record was to be completed with in seven days after the resident's death and transmitted within 14 days after the resident's death.	F 640		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		9/28/18

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F 657	Continued From page 6 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan for 1 of 1 residents (R90) for appropriate use of a heating pad. Findings include: Review of the medical record for R90 indicated he was admitted to the facility on 4/30/18 with chronic low back pain, debility, and mild cognition impairment.	F 657	- Revised R90's care plan to reflect use of heating pad per resident choice 8/22/18. - Residents who present with a change in condition, return from hospital leave or are identified during daily clinical huddle (Monday - Friday) as having changes to their care needs will have their care plan reviewed and revised as indicated by IDT or designees.	

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F 657	Continued From page 7 R90's quarterly Minimum Data Set (MDS) dated 8/3/18, indicated R90 had intact cognition. A pressure sores & skin assessment dated 4/30/18 indicated R90 is at risk for skin breakdown due to age, decline in mobility, and diagnostic history. A pressure ulcer note dated 5/14/18 indicated review of R90's skin and stated "remains accurate and appropriate," when referencing the 4/30/18 assessment above. Review of R90's care plan updated 6/19/18, does not include the use of a heating pad. On 8/20/18 at 3:02 pm, a heating pad was observed at the head of R90's bed. Further review of documentation, including medical doctor (MD) progress note dated 7/18/18 and nurses notes dated 8/1/18 to 8/20/18, did not identify the use of a heating pad, or an order for the use of a heating pad. On 8/21/18 at 3:08 pm, during an interview with R90 in his room, R90 stated he has pain lower back pain all the time from an injury many years ago. When asked to rate his pain, he says it all depends on what he is doing and won't give a number. R90 denies pain keeping him awake at night or limiting his daily activities. R90 will take Tylenol on occasion (maybe once every four to five days) which does help. When asked about the heating pad, he stated he got it about two or three weeks ago and the staff are aware he has it. R90 denies ever getting burned from the heating pad and states he always wears his sweatshirt to bed to protect his skin. R90 expressed that this heating pad automatically shuts off after two hours and there are three temperatures on it, he always uses it on low	F 657	- Review of policy "Resident Care Plans, Development, Implementation and Revision" by 9/28/18. - Education provided to facility nursing team members regarding policy, process and procedure for Care Plan Timing and Revision by 9/28/18. - Care Plan audits to be completed by DON/Designee to verify compliance with policy and procedure 2x week x4 weeks (10/1 - 10/31/18).	

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F 657	Continued From page 8 temperature. On 8/22/18 at 8:15 am, the DON verified her awareness of R90's heating pad which was purchased from the facility pharmacy. DON was under the understanding that R90 had decided not to use the heating pad. DON called registered nurse (RN)-C to answer further questions. RN-C stated R90 had been complaining of left or right hip pain and wanted to bring in his own heating pad, at which time the facility ordered one. RN-C verified the heating pad has a UL cord, it is in good condition, and there was no direct skin contact. RN-C stated R90 decided he did not want to use the heating pad after he read the instructions. RN-C verified no assessment was completed and it was not added to the care plan because she was "under the impression that he wasn't using it." RN-C confirmed that she has not followed up with R90. DON and RN-C verified 8/8/18 was the purchase date of the heating pad. DON confirmed the she will have the nurse complete an assessment for use and safety, along with an evaluation of R90's skin. Review of policy titled Applying Cold/Warm Therapy, with last reviewed date of 8/21/18, was reviewed and indicated cold or warm compress must have a physician's order and a review the resident's care plan should be completed to assess for any special needs.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		9/28/18

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F 689	Continued From page 9 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate causal factors for a fall and failed to ensure interventions were implemented to reduce the risk of fall for 1 of 5 residents (R42) who was reviewed for accidents. Findings include: R42's current diagnoses according to the diagnosis list dated 8/23/18, included dementia, osteoarthritis (pain and stiffness in the joints), congestive heart failure, polyneuropathy (nerve damage), macular degeneration (progressive vision impairment), benign paroxysmal vertigo, (sensation of feeling off balance with spinning and dizziness), and chronic pain. R42's quarterly Minimum Data Set (MDS) assessment dated 6/18/18, indicated a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS further identified R42 required assistance of one person for transfers with inability to steady self without staff assistance. R42's care area assessment (CAA) for falls, dated 1/8/18, indicated R42 had a previous fall and was at moderate risk for falls related to impaired safety awareness. R42's fall risk assessment dated 7/8/18, indicated he was nonambulatory, required assist of one for	F 689	- R42 had a follow up assessment completed 8/23/18. - Residents that have fallen are identified during daily clinical huddle (Monday - Friday) and follow up fall assessment assigned if not yet completed. Review of resident falls from 8/23 - current are completed to ensure review of fall and potential root cause identified. - Review of policies "Assessing Falls and their Causes" and "Falls - Clinical Protocol" reviewed by 9/28/18. - Education of staff regarding reviewing every fall that occurs and attempt to identify potential cause of and new intervention related to fall by 9/28/18. - Audits to be completed by DON/Designee weekly x4 weeks (10/1 - 10/31/18) to verify follow-up assessments completed for each fall.	

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F 689	Continued From page 10 transfers, and was noncompliant. The assessment further identified R42 was able to use his call light appropriately, communicate his needs, but did transfer on his own even after reminders to ring for staff assist. R42's care plan, last reviewed 8/17/18, indicated R42 was at risk for falls related to weakness. Current interventions included: one assist with mobility, toileting, keep bed in low position, remind to use call light, call light within reach, seat belt on when in scooter and anticipate needs. Review of R42's incident report dated 7/14/18 at 5:30 p.m. revealed: Resident had been found on floor in bathroom. When asked what happened resident responded, "I'm sitting on the floor" and "get me up." The fall resulted in a skin tear to right elbow measuring 0.2 centimeters (cm) requiring a dressing to be placed. During observation and interview on 8/22/18, at 8:20 a.m. R42 was observed sitting in scooter, with right foot on floor, left foot on platform of scooter, leaning to the left asleep with seat belt latched. Nursing assistant (NA)-A indicated R42 would self transfer and needed frequent reminders to use his call light for help. She further indicated he wore a self releasing seat belt in scooter due to a previous fall but was not aware of any other interventions in place to prevent falls. During interview on 8/22/18, at 8:30 a.m. R42 indicated he transfers on his own even though staff have told him he shouldn't. During interview on 8/22/18, at 8:53 a.m. licensed	F 689		

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F 689	Continued From page 11 practical nurse (LPN)-B indicated many times R42 independently transfers self into bathroom, and has previously fallen. We encourage him to use a call light, but he is noncompliant. During interview on 8/22/18, at 1:32 p.m. registered nurse (RN)-D stated the facility used standard of care interventions such as grippy socks, proper foot wear, nonskid floor strips and night lights in addition to fall prevention interventions identified in care plan. RN-D further indicated a post fall investigation worksheet is completed to identify causal factors and new interventions; however, RN-D confirmed they had "missed it" and was unable to identify interventions implemented following R42's fall on 7/14/18. RN-D indicated an intervention could have been identified to prevent reoccurance of the fall. During interview on 8/22/18, at 2:30 p.m. the director of nursing (DON) stated R42's fall on 7/14/18 had not been reviewed by the interdisciplinary team. The DON further stated she was not sure why this was missed, but confirmed without the post fall investigation worksheet no evaluation or implementation of interventions had occurred. The facility policy titled Falls - Assessment/Reporting revised 2/1/95, included: to provide a means of evaluation of cause of fall, events for trending, tracking and initiating intervention.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		9/28/18

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F 755	Continued From page 12 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, 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 liquid Ativan Intensol (a schedule IV controlled substance used to reduce anxiety) was destroyed in a manner to reduce the risk of potential diversion which had potential to affect 3 of 3 residents (R15, R38, R93) observed to have medication awaiting	F 755	- R85 no longer has active order for Lorazepam, R96 passed away. - Review and revision of policy "Disposition of Medications in LTC Facilities" and "Narcotic Procurement/Accountability/Inventory/Des	

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F 755	Continued From page 13 destruction. In addition, the facility failed to ensure liquid Ativan Intensol was labeled and reconciled in a manner to allow routine counting and tracking of the medication to reduce the risk of diversion. This had potential to affect 2 of 2 residents (R85, R96) who had current orders for the medication. Findings include: Destruction On 8/20/18 at 4:33 pm, during a tour of the medication room on the 100 wing with licensed practical nurse (LPN)-A, LPN-A explained unused controlled medication were counted at each shift change until the director of nursing (DON), the clinic manager, or pharmacist removed them from the regular controlled lock box and placed in another lock box. LPN-A was unsure of the exact process for destroying discontinued controlled but believed the pharmacist took care of it. When interviewed on 8/22/18 at 8:15 am, DON confirmed the pharmacist comes once a month to complete medication destruction. DON verified her and the registered nurse (RN)-C do occasionally remove unused controlled and place them in a locked box labeled "controlled medication awaiting RPh destruction," but they do not destroy them. DON believes that the destruction of medications took place at the facility with two pharmacists. During a phone interview on 8/22/18 at 3:00 pm, with Pharmacist (RPh)-B, RPh-B verified that approximately two to three years ago they changed the destruction of medication process. RPh-B explained she takes the medications out	F 755	truction in LTC Facilities" completed 9/28/18. - Lorazepam Intensol bottles obtained by distributor that were labeled and able to be reconciled every shift and replaced current supply of Lorazepam Intensol that did not have ability to measure remaining amount 9/28/18. - Destruction of discontinued or expired controlled substances to be routinely completed by pharmacist and licensed staff in facility in accordance with policies as above. - Education of licensed team members and trained medication aides on revision in policies by 9/28/18. - Audits to verify all liquid controlled substances are labeled and reconciled in a manner to allow routine counting and tracking of the medication 2 x month x3 months (October - December 2018).	

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F 755	Continued From page 14	F 755		

of the facility and to another facility for destruction, and stated "even though regulations recommend medications be destroyed on site." RPh-B confirmed the DON and RN-C will sometimes remove unused controlled from access and put them inside a red tackle box. RPh-B further explained she picks up the unused controlled on a monthly basis and brings them to an offsite location for destruction; at which time medications are destroyed with two pharmacist. RPh-B confirmed no one in the facility verifies the count or signs off with her when she removes the medication from the facility.

On 8/22/18 at 3:55 pm, an observation of the "waiting for destruction by pharmacy" red tackle box was done with the DON. Verification of the contents was compared against the individual controlled record sheets. Three opened liquid Ativan Intensol bottles are amongst other medication in the container. Ativan Intensol bottles are dark in color without visible measurement identification on them. DON explained according to the RPh-B staff are to use a perpetual way to measure these Ativan Intensol amounts.

Reconcile

During an observation of the medication storage room on wing 100 on 8/20/18 at 4:33 pm, two dark colored vials of liquid Ativan Intensol with a label covering the entire bottle, preventing visibility of the measurement markings, were observed.

Review of R85's Medical Plan of Care, unsigned, indicated an order dated 8/21/18 for Lorazepam 2 mg/ml give 1 mg (0.5 ml) by mouth sublingual as

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	245487	A. BUILDING ______ B. WING ______	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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 755	Continued From page 15 needed every four hours. Review of R96's Medical Plan of Care, unsigned, indicated an order dated 8/2/18 for Ativan 2 mg/ml give 0.25 ml (0.5 mg) by mouth or sublingual two times a day. During an interview with registered nurse (RN)-B on 8/23/18 at 7:15 am, RN-B explained it is difficult to obtain an accurate measurement of Ativan Intensol because the label covers the measurement guide on the bottle and because of the dark colored bottle. RN-B expressed this perpetual measurement makes her "uncomfortable." Review of Narcotic Procurement/Accountability/Inventory/Destruction in Long-term Care Facilities policy with last revised date of 7/18/17, indicated an outdated or discontinued medication must remain in the long-term care facility to be destroyed by the pharmacist from St. Elizabeth's hospital and a licensed nurse or a second pharmacist. On 8/23/18 at 11:15 am, DON forwarded an email regarding past discussion between DON and pharmacist. Email dated 4/12/18, confirmed DON had noted liquid Ativan is not in a measurable container for controlled count and requested pharmacy to look in to ordering it in a container that has visual measurement. Return email dated 4/13/18 from RPh-B verified Lorazepam cannot be repackaged and that perpetual inventory of the product is allowed by State of MN Board of Pharmacy. A follow-up email dated 8/23/28 from RPh-C confirmed the wholesaler is able to get supply of previous brand and will order one to ensure the bottles have markings on side.	F 755		

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	245487	A. BUILDING ______ B. WING ______	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

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F 755	Continued From page 16 No further documentation was provided to confirm destruction of medications were completed by two pharmacists.	F 755		

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

F5487030

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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 000	INITIAL COMMENTS 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, (St. Elizabeth Health Care - 626 Shields Ave) 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 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/28/2018

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
	245487	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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 000	Continued From page 1 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 is a 1-story building and has a partial basement. This building was constructed in 1970 and was determined to be of Type II(111) construction. The Chapel is a 1-story addition and has a full basement. The chapel addition was constructed in December 2003 and was determined to be of Type II(111) construction. The Four Season Sun Room is a 1-story addition to and has a no basement. The Four Season Sun Room Addition was constructed in December 2012 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 81 beds and had a census of 71 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING	K 222		9/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING _______	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

(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 222	Continued From page 3 ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This **REQUIREMENT** is not met as evidenced by: The facility failed to comply with Life Safety Code (SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler	K 222	- Work orders were submitted for each of the 5 doors noted to be binding. Doors have all been adjusted to close properly. - Date of Completion: 9/19/18. - Person responsible for compliance and continued monitoring: Manager of Maintenance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

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K 222	Continued From page 4 and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4) This deficient practice could affect the safety of all (71) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 05:00 PM on 09/17/2018, observations and staff interview revealed the following: During walk-through of the facility observed the following exit doors were binding and not able to properly self-latch: (1) Wing 100 - West exit door (2) Wing 200 - East exit door (3) Wing 300 - North exit door (4) Addition 2002 - South exit door (5) Addition 2013 - Corridor exit door This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 222		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		9/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

(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 345	Continued From page 5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72) This deficient practice could affect the safety of all (71) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 05:00 PM on 09/17/2018, observation and documentation review revealed the following: During documentation review of completed Fire Drills - noted inconstant documentation practice and missing notations on the fire drill log-sheet of confirmation of signal receipt by the fire alarm monitoring vendor, time-stamp, and monitoring technician This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	- A new Fire Drill Test form has been created. The team will start using this and document the vendors name and ID number when calling after the alarm to verify the time of the test. The team will also report all times in military format. - Date of Completion: 9/19/18. - Person responsible for compliance and continued monitoring: Manager of Maintenance.	
K 353 SS=F	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,	K 353		9/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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 353	Continued From page 6 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: The facility failed to comply with Life Safety Code (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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (71) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 02:00 PM and 05:00 PM on 09/17/2018, observations and staff interview revealed the following: During walk-through of the facility, observed high storage in the following locations:	K 353	- Education provided to staff in the noted areas that items cannot be stored within 18 inches of a sprinkler head. I also inspected these areas a few days later and found all areas to be in compliance. - Date of Completion: 9/18/18. - Person responsible for compliance and continued monitoring: Manager of Maintenance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

(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 353	Continued From page 7 (1) Kitchen Dry Goods Storage Room (2) Kitchen Walk-In Freezer (3) Activities Room closets (4) 2003 Addition closet (5) Housekeeping Storage Room - Basement This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353		

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

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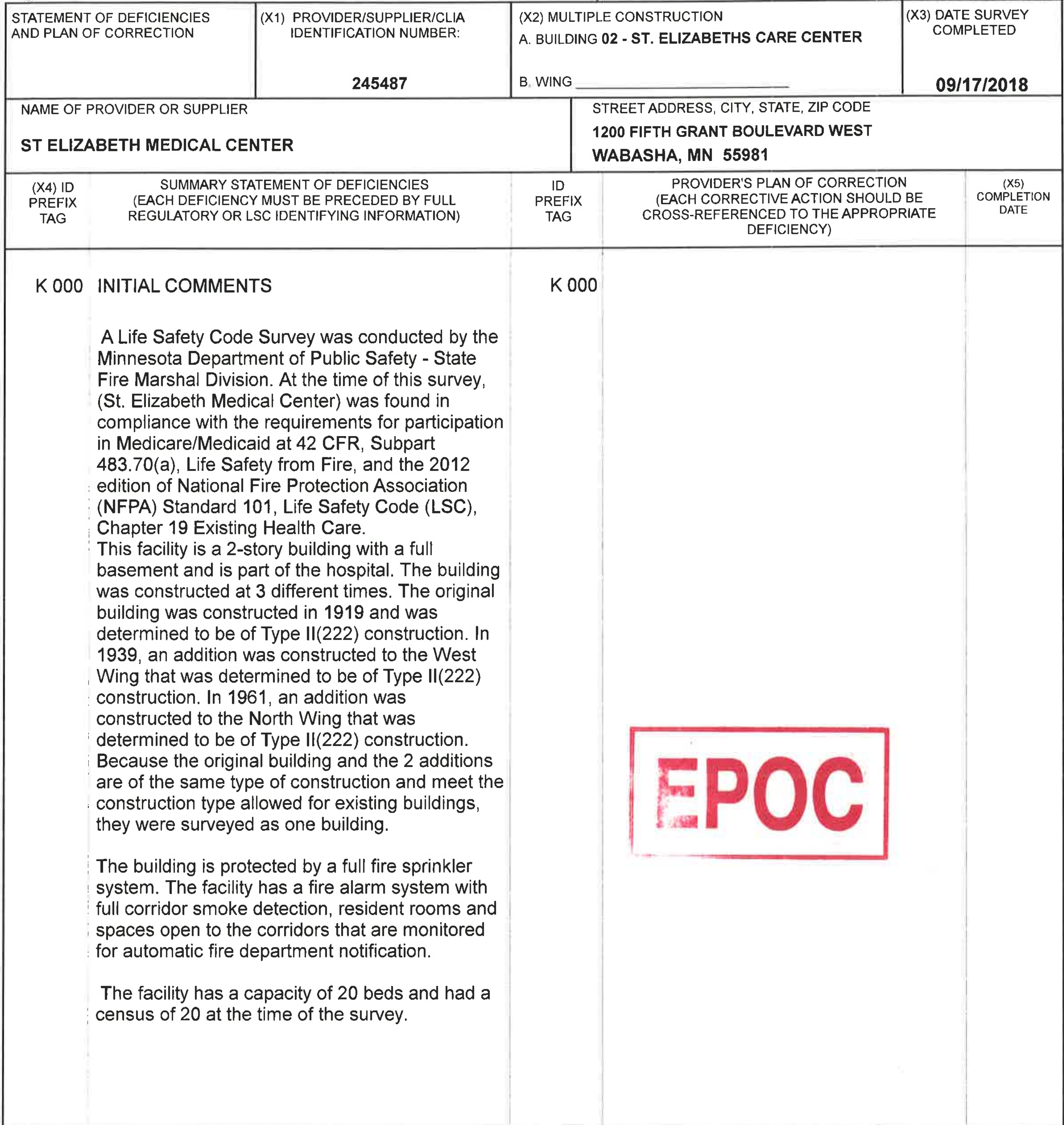

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING ______	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

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K 000	INITIAL COMMENTS	K 000	EPOC	

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. Elizabeth Medical Center) was found 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.
This facility is a 2-story building with a full basement and is part of the hospital. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type II(222) construction. In 1939, an addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1961, an addition was constructed to the North Wing that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification.

The facility has a capacity of 20 beds and had a census of 20 at the time of the survey.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/28/2018

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.