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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1NT4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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: **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 **12/13/2016** (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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 12/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/29/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245487

December 28, 2016

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

Dear Mr. Crowley:

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 8, 2016 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 28, 2016

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

RE: Project Number S5487028

Dear Mr. Crowley:

On December 1, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 6, 2016. (42 CFR 488.422)

Also on December 1, 2016, This Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred with our recommendation and authorized this Department to notify you of the following:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 15, 2016.(42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on September 15, 2016 and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on November 17, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 13, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 8, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 17, 2016, as of December 8, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 8, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 1, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 15, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 15, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 15, 2016, is to be rescinded.

In our letter of December 1, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 15, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 8, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245487 (Y1)	A. Building B. Wing (Y2)	12/13/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/08/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** GPN/kfd	**DATE** 12/28/2016	**SIGNATURE OF SURVEYOR** 28651	**DATE** 12/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 9/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1NT4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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: **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 **11/17/2016** (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 :
Marietta Lee, HFE NE II 12/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/28/2016 (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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

December 1, 2016

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

RE: Project Number S5487028

Dear Mr. Crowley:

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.

On October 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 15, 2016. 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 November 17, 2016, the Minnesota Department of Health and on October 17, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 14, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on September 15, 2016. The deficiencies not corrected are as follows:

0309 --Provide Care/Services For Highest Well Being 483.25
0329 --Drug Regimen Is Free From Unnecessary Drugs 483.25(l)

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing

the following category 1 remedy:

- State Monitoring effective December 6, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 15, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 15, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 15, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Elizabeth Medical Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 15, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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.

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 15, 2017 (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

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

November 18, 2016

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

RE: Project Number S5487028

Dear Mr. Crowley:

On October 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 15, 2016. 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 October 17, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 14, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on September 15, 2016.

However, compliance with the health deficiencies issued pursuant to the September 15, 2016 standard survey has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 15, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 15, 2016. They will also notify the State Medicaid Agency that they

must also deny payment for new Medicaid admissions effective December 15, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Elizabeth Medical Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 15, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 15, 2017 (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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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
	245487	A. BUILDING _____ B. WING _____	R 11/17/2016

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 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 11/17/16 to determine compliance with Federal deficiencies issued during a recertification survey exited on 9/15/16. During this visit the following regulations were determined to be not corrected: See F309 and F329.	{F 000}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and monitor bruising for 1 of 3 residents (R13) reviewed for non pressure related skin issues. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 9/16/16, identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. During observation on 11/17/16, at 11:16 a.m. R13 was noted with the following areas of bruising on the left arm/hand: left hand middle finger- measuring 3.2 centimeters (cm) by 2.4	{F 309}	R13's MPOC reviewed and verified that nursing order for weekly skin assessments of all skin concerns was active. Review of R13's medical record documentation for week of November 18th - December 3rd verified that skin observation completed and documented. R13 continues to have extensive bruising present on bilateral arms from elbow to hands in various stages of healing despite interventions; R13 continues to state that bruises "just appear" with no obvious trauma or cause. Facility has entered in each resident's MPOC weekly skin observation, monitoring and documentation for any	12/8/16

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

Electronically Signed | 12/06/2016

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 _____	R 11/17/2016

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 309}	Continued From page 1 cm; left hand index finger-measuring 0.2 cm by 0.1 cm; top of left hand-measuring 6.2 cm by 1.9 cm; left lateral hand-measuring 1.0 cm by 1.4 cm; left wrist bruise-measuring 1.3 cm by 1.7 cm; left lower forearm-measuring 4.5 cm by 1.2 cm; left lateral forearm-measuring 7.4 cm by 5.7 cm and left elbow-two bruises measuring 2.1 cm by 1.7 cm and 1.0 cm by 1.6 cm. The following areas of bruising were noted to the right arm/hand: top of right hand- measuring 1.9 cm by 0.7 cm, two on right wrist-measuring 1.6 cm by 1.5 cm and 2.8 cm by 2.0 cm and right elbow-measuring 5.5 cm by 3.4 cm. When interviewed at this time, R13 stated the bruising was from the blood thinner he takes, and clarified, "I may have bumped them too." Review of the undated medical plan of care, identified R13 received Warfarin (Coumadin) (blood thinning medication), aspirin and prednisone (a steroid medication which when used in conjunction with blood thinners such as Warfarin may interact causing bleeding/bruising) daily. The medical plan of care also identified weekly skin assessment/observation was to be done on bath day with measurements of ALL skin concerns, including bruising to be documented as R13 was at high risk for impaired skin integrity and bruising related to fragility, Coumadin/aspirin/prednisone use. The activity of daily living (ADL) care plan updated 10/18/15, identified R13 at risk for spontaneous bruising due to anticoagulation therapy and prednisone use. The facility care plan dated 9/17/15, identified R13 as at risk for skin breakdown due to the use of prednisone and on Warfarin which can cause unexplained bruising and bleeding. Review of the treatment administration record	{F 309}	impaired skin integrity (including bruising, skin tears, surgical incisions) by 11/30/16. Facility has communicated via internal messaging with all nursing team members the expectation that weekly skin observations/documentation are to be completed. In addition, reviewed expectation with team members that any newly discovered impaired skin integrity concerns are to be documented at time of discovery. DON/designee completing audits daily X3 weeks (11/20-11/26,11/27-12/3, 12/4-12/10) to verify completion of the above expectation; continued audits by DON/designee of 1x week x4 weeks (12/11 - 1/7/17) for identified high risk residents of those that have chronic, recurring bruising. Findings to be reviewed at quarterly QAA meetings.	

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 _____	R 11/17/2016

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 309}	Continued From page 2 (TAR) from 10/10/16 to 11/17/16, identified weekly skin assessment/observation to be done on bath day (Friday) with measurements of all skin concerns being identified due to R13's risk for impaired skin integrity and bruising. Review of the nurses notes from 10/15/16 thru 11/17/16, identified multiple bruising to hands and arms on 10/15/16, 10/22/16 and 10/28/16. No further documentation of skin problems was charted until 11/17/16, at 12:57 p.m. The progress note identified the current bruising (which had been identified by the surveyor and reported to the director of nursing (DON)attention at 11:22 a.m.) When interviewed on 11/17/16, at 1:44 p.m. the DON confirmed the identified bruising was not documented and instructed staff conduct an assessment and subsequent documentation. The DON stated this was omitted/missed with the 11/11/16 bath. She stated the expectation was that the nurse aides would note these areas while providing personal cares. She further explained that staff provide cares twice daily so someone should have reported the bruises and followed up. Review of the policy titled Monitoring of Pressure and Stasis Ulcers and Bruising last reviewed 11/17/16, identified that skin should be assessed upon admission and weekly or as specified for residents with impaired skin integrity and bruises should be measured when identified and weekly thereafter until healed.	{F 309}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	{F 329}		12/8/16

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 _____	R 11/17/2016

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 329}	Continued From page 3 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to attempt a gradual dose reduction (GDR) and/or document physician justification based on clinical evidence for the continued use of an antidepressant medication for 1 of 3 residents (R13) reviewed for unnecessary medications. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 9/30/16, identified diagnosis of depression. Documentation on the MDS	{F 329}	R13's had GDR of antidepressant initiated on 11/18/16, clinical observation/monitoring continues to observe for any adverse response to taper. Facility has reviewed all residents on any psychotropic medication and verified that GDR has been completed within CMS guidelines or medical record contains clinical documentation that supports rational for not initiating a GDR by 12/5/16. Policy "Gradual Dose Reduction (GDR)	

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 _____	R 11/17/2016

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 329}	Continued From page 4 identified a personal health questionnaire (PHQ-9) score of 4, indicating minimal depression and a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition and the daily use of an antidepressant medication. The Care Area Assessment (CAA) psychotropic drug use dated 7/5/16, identified R13 had been receiving Celexa since admission on 4/15/15, and had no dose taper/reduction since admission. R13's care plan dated 9/17/15, identified R13 had some memory loss and was receiving Celexa (antidepressant medication) 10 milligrams (mg) daily for anxiety and depression, monitor for effectiveness and update nurse practitioner as needed. R13's physician orders, print date 11/17/16, included an order for Celexa 10 mg daily for anxiety and depression. A progress note by the nurse practitioner dated 10/26/16, did not address the use of Celexa. R13's pharmacy consultant recommendation, from 4/22/15 to 11/16/16, did not address a GDR/tapering of the medication related to the continued administration of Celexa. During interview on 11/17/16, the director of nursing verified no gradual dose reduction had been attempted nor addressed since admission. She stated her expectation was that a GDR would have been addressed or acknowledged by the pharmacist and the physician. No policy for gradual dose reduction for the use of an antidepressant medication was provided by the facility nor justification for the continued use.	{F 329}	for Psychotropic Medications" has been reviewed and revised 11/29/16. DON/designee to conduct medical record audits for residents on psychotropic medication(s) to verify GDRs are being recommended, initiated or declined with clinical rational by medical provider. Audits to be done monthly x4 months (November - February. Discrepancies to be reviewed at medical director team meetings and with consultant pharmacist.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245487 Y1	A. Building B. Wing Y2	11/17/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 10/14/2016	ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	Correction Completed 10/14/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 12/01/2016	SIGNATURE OF SURVEYOR 15425	DATE 11/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245487	A. Building 01 - MAIN BUILDING 01 B. Wing	10/17/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 10/14/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 10/14/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 11/18/2016	SIGNATURE OF SURVEYOR 37008	DATE 10/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245487	A. Building 02 - ST. ELIZABETHS CARE CENTER B. Wing	10/17/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 10/14/2016	ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 10/14/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 11/18/2016	**SIGNATURE OF SURVEYOR** 37008	**DATE** 10/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1NT4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **09/15/2016** (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 :
Sarah Strenke, HFE NE II 10/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/27/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 5, 2016

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

RE: Project Number S5487028

Dear Mr. Crowley:

On September 15, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> 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 a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 25, 2016, 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 25, 2016 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:

- 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.

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 December 15, 2016 (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 15, 2017 (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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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
	245487	A. BUILDING _____ B. WING _____	09/15/2016

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 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide choices for hour of awake time for 1 of 3 residents (R58) reviewed for choices. Findings include: R58's significant change Minimum Data Set (MDS), dated 7/1/16, indicated R58 was cognitively intact and required physical assist for toileting. R58's care plan, print date 3/3/14, indicated during the night I need to be offered toileting	F 242	Care plan of R58 reviewed and updated to reflect that team does "not offer her to assist with her toileting needs during the nighttime hours, resident will ring for assist when she wants to be assisted to bathroom". Policies: "Resident Care Plans, Development, Implementation and Revision", "Standards for Resident in His/Her Environment" reviewed by 10/7/16.	10/14/16

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

Electronically Signed | 10/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	Continued From page 1 every two hours. R58's record failed to address R58's choice of awake time. On 9/13/16, at 12:57 p.m., R58 stated they (referring to the night shift staff) wake me up at 5:00 a.m., to see if I have to go to the bathroom and I cannot get back to sleep. I am an early riser and I am ok with the time I get up at 6:00 a.m., to get dressed but not at 5:00 a.m. On 9/14/15, at 8:46 a.m., R58 stated she does not like getting up at 5:00 am. R58 stated they wake me up at 5:00 a.m., to go to the bathroom, it is ridiculous. I have had a lot of trouble with the night nurse. There is nobody here (referring to staff available) until 6:00 a.m., to get me dressed and that is the time I would like to get up. R58 stated she had informed staff she did not want to be woken up until 6 a.m. R58 stated she told the night shift staff she did not want to be woken up at 5:00 a.m., but it does not work that way. On 9/14/16, at 8:54 a.m., nursing assistant (NA)-A stated she was aware R58 did not like to get woken up at night. NA-A stated she had told the nurse, but the night shift just do their rounds. NA -A stated R58 was assisted to get up and get dressed around 6:00 a.m. On 9/14/16, at 9:01 a.m., NA-B stated R58 liked to get up at 6:00 a.m. to get dressed and R58 was one of the first resident's dressed. On 9/14/16, at 9:05 a.m., licensed practical nurse (LPN)-A stated she was aware R58 did not like to be woken up at 5:00 a.m. and R58 liked to be one of the first residents dressed in the a.m. LPN-A stated she was not aware of any specific place it would be documented regarding the residents	F 242	Review of policies and expectation to allow residents to make choices regarding their routines reviewed at team meetings, communicated via internal messaging system by 10/17/16. Audits to be completed by IDT/designee to verify residents are given opportunity to choose when to get up in the morning, as well as other choices. Resident interviews/audits to be completed on 4 residents weekly x4 weeks (10/17 - 11/12), 2 residents weekly x4 weeks (11/14 - 12/9) and 1 resident weekly x4 weeks (12/1 - 1/6). Audit results to be reviewed and discrepancies discussed at QA&A meeting and team meetings.	

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F 242	Continued From page 2 preference to awake time. LPN-A reviewed R58's record and stated there was nothing documented in regards to R58's choice of not wanting to be awakened at 5:00 a.m. On 9/15/16, at 10:36 a.m., registered nurse (RN)-A stated the residents' choice for awake time would be documented under sleep pattern. RN-A stated upon admission residents were asked their preference of awake time and review of the choice was done annually or if there was a change in sleep aid. RN-A stated during care conference a resident is able to express a change. RN-A stated she was not aware R58 had requested to not be awakened at 5:00 a.m. for toileting. RN-A stated if R58 had told someone that she did not want to get up at 5:00 a.m., that was R58's choice and right and she would expect staff to communicate R58's choice and R58's choice of awake time could be specially care planned. On 9/15/16, the director of nursing (DON) stated R58 should have the choice of when she prefers to be awakened. The DON reviewed the night shift documentation and stated the night shift was documenting that they were toileting R58 at 5:00 a.m. The DON stated we do recognize resident choices and accommodate choices to the greatest ability we can. The facility policy, Standards for Resident and His/Her Environment, dated last revised 8/7/15, indicated Purpose: to provide quality care to all residents and allow for individualization in each resident's care plan. Policy: 1. Resident should be allowed to make choices and direct the care. 2. c. Rest and sleep promotion: vii. Allow to waken on their own in the mornings.	F 242		

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify broken, carious teeth for an oral assessment for 1 of 3 residents (R58) reviewed for dental services. Findings include:	F 278	Oral assessment completed on R58 and findings documented in clinical record. Policies: "Resident Assessment, Resident Assessment Instrument (RAI), Minimum Data Set (MDS), Care Area Assessment	10/14/16

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F 278	Continued From page 4 R58's significant change Minimum Data Set (MDS) dated 7/1/16, had identified for oral/dental status no oral concerns were present. During observation on 9/13/16, at 1:09 p.m., surveyor viewed R58's teeth and noted broken, carious teeth on R58's bottom gum line. On 9/15/16, at 10:04 a.m., registered nurse (RN)-C stated she had completed R58's oral section for R58's significant change MDS, dated 7/1/16. RN-C confirmed she had checked none of the above present. RN-C stated she had not visually looked in R58's mouth to complete the MDS dated 7/1/16, and she was not aware R58 had broken, carious teeth on her bottom gum line. RN-C stated a visual assessment was completed for an oral assessment upon admission, but after the admission oral assessment a visual oral assessment would only be completed if a resident complained about something orally or if a nursing assistant would notice something when brushing a residents teeth. On 9/15/16, at 11:19 a.m., the director of nursing stated she would expect a visual assessment to be completed for an oral assessment and the assessment to be accurately reflected on the MDS. The facility policy Nursing Assessment, dated last revised 1/1/95, indicated Purpose: To provide comprehensive and ongoing assessments to facilitate establishing an individualized plan of care for each resident. Policy: 7. Assessments are used to complete the Minimum Data Set (MDS) and to develop the individualized resident	F 278	(CAA)" reviewed by 10/17/16. Discrepancy of clinical findings and coding on MDS reviewed at IDT meeting and with MDS coordinators. Review of policy completed at IDT meeting by 10/17/16. Audits to be completed on section L of MDS (oral/dental) for accurate coding compared to oral assessment findings on 6 MDS's completed each month X3 months (11/1/16 - 1/31/17) by DON/designee. Audit results to be reviewed and discrepancies discussed at QA&A meetings and team meetings.	

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F 278	Continued From page 5 care plan.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to do neurological assessment following a head injury according to their policy for 1 of 4 residents (R61) reviewed for accidents and failed to identify and monitor bruises for 2 of 3 residents (R58 & R16) reviewed for non-pressure related skin conditions. Findings include: LACK OF MONITORING NEUROLOGICAL SIGNS AND SYMPTOMS TO DETERMINE DECLINE IN NEUROLOGICAL STATUS: R61's progress note dated 8/11/16, documented at 2:26 p.m., indicated R58 had a fall at 1:45 p.m. and had noted injury of two lumps to the back left side of head and bruising. Vitals obtained at 1:55 p.m. Documented at 4:52 p.m., neuro checks continued and vital signs stable (VSS) at this time. Documented at 9:07 p.m. neuro checks continued and VSS. On 8/12/16, at 6:33 a.m., neuro results were documented.	F 309	"Lack of monitoring neurological signs and symptoms to determine decline in neurological status". Policy "Falls Assessment/Reporting Policy" reviewed with nursing team by 10/17/16 with specific focus on number 7 regarding neuro checks. Worksheet titles "Neuro Checks Post Fall" reviewed with nursing team by 10/17/16 to provide means of gathering required information at time of fall and post fall neuro checks. Form to be completed and data entered into electronic medical record reflecting specific findings. Form to be kept as part of medical record and filed under "nursing" section in paper chart. Chart audits to be completed on all resident falls that require neuro checks to verify neuro checks completed and	10/14/16

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F 309	Continued From page 6 R61's record lacked further documentation of the neuro results or any further neuro checks being completed. On 9/14/16, at 12:49 p.m. registered nurse (RN)-A confirmed the above documented information for neuro checks for R61. RN-A stated neuro checks were completed when a resident falls and hits their head or if it is unknown if the resident has hit their head. RN-A stated neuro checks were to be documented in the computer and were to be done every 15 minutes the first hour, every 30 minutes the second hour, every 4 hours X 3, then every shift for one day. On 9/14/16, at 1:00 p.m., RN-B reviewed R61's record and stated R61's record had no other documented information in regards to neuro checks. On 9/15/2016, at 11:01 a.m., the director of nursing (DON) stated in regards to a resident sustaining a head injury, she would expect the staff to follow our protocol for neuro checks and document the information in the electronic health record. The facility policy Falls Assessment/Reporting, dated last revised 2/1/95, included Policies: 7. If resident hits head during fall (witnessed or unwitnessed), complete a focused assessment: b. Do neuro checks including vital signs, observations of nausea, vomiting and headache, change in mental status: 1. Every 15 minutes x 4 2. Every 30 minutes X 2 3. Every 4 hours X 3 4. Every shift for three shifts.	F 309	documented as expected both on Neuro Checks Post Fall form and in electronic medical record 10/13 - 12/13/16. Audit results to be reviewed and discrepancies discussed at QA&A meetings and team meetings. "Skin Conditions" Policy "Skin Assessment" reviewed and revised by 10/17/16 to reflect continued observation and monitoring of bruising until healed. Staff education provided at team meetings and via internal messaging system by 10/17/16 to reflect expectation that any skin concerns (bruises, tears, open areas) are to be reported to licensed staff upon discovery. Documentation of findings to be included in electronic medical record with a minimum weekly documentation to reflect progress of healing of any impaired skin integrity, including bruising, location and measurement of areas of concern. Care audits to be completed on 4 residents weekly x4 weeks (10/17 - 11/12), 2 residents weekly x4 weeks (11/14 - 12/9) and 1 resident weekly x4 weeks (12/12 - 1/6). Audit results to be reviewed and discrepancies discussed at QA&A meeting and team meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 7 SKIN CONDITIONS R58's diagnosis list, print date 9/15/16, included occlusion and stenosis of unspecified carotid artery and Parkinson's disease. R58's physician orders, print date 9/15/16, included an order for aspirin 81 milligrams (mg) daily. On 9/13/16, at 1:11 p.m., R58 was observed to have a large dark purple bruise on the top of her left hand. R58 stated the bruise was from the nurses helping her out of bed, due to her skin was so soft. R58's care plan, print date 3/3/14, included skin: history of periods of redness to my abdominal and groin region, assist with peri care twice daily and as needed (PRN), make sure to dry skin well and update nurse PRN to evaluate for use of PRN nystatin, continue to receive aspirin daily which increases my risk for bruising. R58's ADL (activities of daily living) care plan, updated 8/31/16, indicated miscellaneous: report any skin concerns to nurse. R58's progress notes, dated 9/1/16 through 9/12/16, indicated on 9/12/16, skin condition: noted to have bruising throughout arms and legs. R58's record failed to include documentation regarding a large bruise on the top of R58's left hand. On 9/14/16, at 9:01 a.m., nursing assistant (NA)-B stated she noticed the bruise on R58's left hand last Tuesday and had reported the bruise to the nurse. NA-B stated R58 reminds us when we are rubbing lotion on her skin to rub lightly as she has sensitive skin. On 9/14/16, at 9:05 a.m., licensed practical nurse	F 309		

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 _____	09/15/2016

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 309	Continued From page 8 (LPN)-A said the facility system was to report bruising to the nurse on the floor, inform the charge nurse and DON, measure the bruising and document. LPN-A stated R58 had very delicate skin, used aspirin and any little bump to the skin caused bruising. LPA-A observed R58's left hand and confirmed R58 had a large dark purple bruise to the top of her left hand. During the observation R58 stated the bruise on the top of her left hand had been there several days. LPN-A reviewed R58's record and stated there was no documentation regarding the bruise on the top of R58's left hand. LPN-A stated the nurses do a weekly skin inspection on the resident's bath day and are responsible for documenting any skin concerns noted. LPN-A stated she would measure the bruise and on 9/14/16, LPN-A had documented the measurements of the bruise as 4 cm (centimeters) by 3.2 cm. On 9/15/16, at 11:22 a.m., director of nursing (DON) stated she would expect upon discovery of bruising the information be documented, investigate accordingly if no identified cause and interventions to be implemented appropriately. The DON stated bruising should be observed weekly with baths, when the nurse completes the resident's skin inspection and the information then documented in the resident's record. The DON verified R58's care plan as above. R16's diagnosis found on the Physician Dictation Report dated 5/3/16, indicates history of coronary artery disease and chronic atrial fibrillation on Coumadin. R16 has orders for Aspirin 81 mg daily with a start date of 2/23/16, Warfarin 2.5 mg on Tuesday, Thursday and Sunday with a start date of 5/24/16 and Warfarin 5 mg on Monday, Wednesday,	F 309		

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 _____	09/15/2016

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F 309	Continued From page 9 Friday and Saturday with a start date of 5/24/16. R16's care plan with a date of 8/31/16, identifies R16 is at high risk for unexplained bruising/bleeding due to Coumadin use. Staff to report bruising, bleeding. ADL care plan (guide direct care staff utilize when assisting residents) dated 8/31/16 indicates R16 is a high risk for bruising and unexplained bleeding related to Coumadin use. Observe for and report to nurse. Observation on 9/12/16, at 5:22 p.m. R16 had multiple bruises noted to bilateral arms and hands. Some bruises were light pink in color and appeared to be present for a while, while others were dark purple and appeared to be recent. Interview on 9/13/16, at 4:23 p.m. with R16 stated that he is taking Coumadin and bruises very easily. R16 stated in a joking manner that he only needs to get close to someone in order to get a new bruise. Observation on 9/14/16, at 7:09 a.m. R16 has a new bruise to the outer left side of his left hand which was dark purple in color. Interview on 9/14/16, at 7:39 a.m. with nursing assistant (NA)-A stated if a bruise is found on a resident it should be reported to the nurse for further assessment. Interview on 9/14/16, at 7:47 a.m. with licensed practical nurse (LPN)-A stated bruises are monitored and documented under skin charting weekly. LPN-A stated R16 receives Coumadin and Aspirin and bruises very easily. LPN- stated nursing assistants should have made nursing aware of the bruises and nursing should have been monitoring and documenting on the bruises. Interview on 9/14/16, at 11:11 a.m. with director of nursing (DON) stated nursing staff should have been monitoring the bruises and documenting the assessment of bruises at least weekly with the weekly skin assessment.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 309	Continued From page 10 A progress note was completed on 9/14/16, at 12:16 p.m. which identified a bruise on the left lateral side of hand that measured 3 centimeters (cm) by 2 cm by 8 cm. Progress note makes no mention of the other multiple bruises found on R16's hands and arms. Policy titled, Skin Assessment, dated 7/2013 indicates nursing assistants during a residents bath should inspect the resident's skin and report any abnormalities to the nurse. Policy does not mention monitoring and documenting of bruises.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		10/14/16

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F 329	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to attempt a tapering reduction or document of a detailed physician justification based on clinical evidence for the continued use of an antidepressant medication for 2 of 5 residents (R92 and R16) reviewed for unnecessary medications. Findings include: R92's significant change Minimum Data Set (MDS), dated 8/1/16, identified diagnoses of Alzheimer's disease and depression, had received an antidepressant medication, feeling down/depressed/hopeless and had no behaviors. R92's care plan dated 8/2/16, included psychotropic: I refuse cares, get angry and feel depressed at times. I am on Zoloft (antidepressant) to treat depression. Staff to monitor for effectiveness and for adverse side effects. I enjoy reading books, newspaper, keeping up with the news, music, small group activities, gong outdoors, attending mass and frequently prefer to stay in my room where it is quiet. Mood: I am at risk for depression due to history of depression. I need for staff to monitor for changes in mood and effectiveness of Zoloft. R92's physician orders, print date 9/15/16, included an order for Zoloft 100 milligrams daily for depression. R92's medication administration record dated 8/15/16 to 9/15/16, revealed R92 was receiving the Zoloft daily as ordered.	F 329	R92 initiated on a gradual dose reduction 10/6/16. R16 initiated on a gradual dose reduction 10/11/16. Clinical observation/monitoring being completed to observe for any adverse response to taper. Review of policy "Gradual Dose Reduction" completed by 10/17/16. Review of findings completed at IDT meeting, involving practitioner and medical director involved in gradual dose reductions. DON/designee to review any declined gradual dose reduction recommendations x3 months to verify clinical rationale is included in provider/practitioner dictation and follow up as indicated. Findings to be reviewed at monthly med director meetings/QA&A meetings.	

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F 329	Continued From page 12 R92's pharmacy consultant recommendation, dated 6/7/16, indicated Zoloft 100 milligrams every hour of sleep, review for medication taper or provide documentation for not reducing medication. The physician response was family member (FM)-A reports increased behaviors will wait to taper. R92's physician progress notes dated 8/19/15 through 8/16/16, identified: 9/10/15, depression, Zoloft 100 mg daily, mood has been stable and affect is normal. 4/19/16, mood has been stable, affect is normal, depression relatively stable, on Zoloft 100 mg daily, has been very pleasant. 8/2/16, depression relatively stable, most of the time is pleasant and easy to get along with, has been on Zoloft 100 mg daily, no increased signs of depression lately. However, the physician progress notes lacked documentation of physician justification at a minimum to include information as to why any attempted dose reduction for the Zoloft would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. On 9/15/16, at 10:14 a.m., registered nurse (RN)-A confirmed the pharmacy consultant recommendation dated 6/7/16. RN-A stated R92's Zoloft had not been decreased since R92 was admitted (8/2015). RN-A reviewed R92's behaviors and stated R92 had increased episodes of crying 1/16. RN-A stated R92's PHQ9 (depression scale) since admission were: 8/24/15, score of 6, 11/15/15, score of 0, 2/12/16, score of 0, 5/3/16, score of 2 and 7/29/16, score of 3. The lower the score reflects less	F 329		

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F 329	Continued From page 13 signs/symptoms of depression noted. On 9/15/16, at 11:03 a.m., the director of nursing stated a titration of antidepressant for R92 was attempted. R16's diagnosis found on Physician Dictation Report dated 7/14/16, indicates Depression/Anxiety disorder. Currently on Zoloft 50 mg orally daily in the morning. Family declined greater dose reduction. R16's care plan dated 8/31/16, indicates R16 is on Zoloft for depression and needs staff to monitor the effectiveness, the side effects and make dosage reductions when appropriate. Activities of daily living care plan (guide staff utilize when assisting residents) dated 8/31/16, had no mention of R16 having depression and had no mood symptoms identified to determine if Zoloft was affective or not. Behavior monitoring/psychotropic medication use assessment completed on 6/7/16, identifies assessment is being completed for the comprehensive review. Assessment identifies R16 receives Zoloft 50 mg for dementia. Assessment identifies R16 occasionally will make sexual comments but has not had any other behaviors in the last 90 days. Reviewed behavior monitoring from March 2016 to August 2016 does not identify specific mood symptoms and indicates no mood symptoms occurred. Depression assessment completed on 8/23/16, indicates R16 scored a 2/27 for a severity score with the previous score of 3/27 on 6/3/16. Pharmacy consultant note dated 3/27/16, indicates recommendation for taper down of Zoloft. On 4/26/16 note indicated general nurse practitioner addressed the request for a Sertraline taper review but the family had declined. On	F 329		

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F 329	Continued From page 14 9/13/16, note indicated the last request for a taper of Zoloft was in April 2016 and was declined by the family. Note indicated taper should be reviewed again in October. Physician Dictation Report dated 4/26/16, indicates R16 is receiving Zoloft 50 milligrams (mg) daily in the morning. Provider indicated the consultant pharmacist had recommended to attempt a gradual dose reduction. Provider discussed gradual dose reduction with R16's family member (FM)-B who expressed not wanting to change any medications since R16 was doing well. Provider indicated she felt this was reasonable as R16 has moderate dementia and is probably unable to address his psychiatric concerns. Note dated 5/3/16 indicated to continue Zoloft 50 mg due to family decline for a gradual dose reduction. Observation on 9/12/16, at 5:22 p.m. R16 eating supper in bedroom. R16 was cheerful and engaged in conversation. Observation on 9/13/16, at 11:59 a.m. R16 eating lunch in bedroom. R16 was cheerful and engaged in conversation. Observation on 9/14/16, at 7:09 a.m. R16 shaving in his bedroom. R16 was cheerful and engaged in conversation. Interview on 9/14/16, at 11:00 a.m. with licensed practical nurse (LPN)-A stated R16 doesn't exhibit any symptoms of depression. LPN-A stated mood symptoms or behaviors are documented by exception so there may not be any documented. Interview on 9/14/16, at 11:01 a.m. with licensed practical nurse (LPN)-B stated she has never seen R16 exhibit any symptoms of depression. Interview on 9/14/16, at 11:11 a.m. with director of nursing (DON) stated the facilities consultant pharmacist recommendations are shared with the	F 329		

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F 329	Continued From page 15 general nurse practitioner (GPN). DON stated the GNP would review the recommendation and then is expected to document either yes or no to the recommendation and then provide the rational for not following the recommendation. DON stated if the provider's justification was due to family decline, more information should have been documented to explain the rational. DON stated the provider would be expected to document why the recommendation is not being followed. Policy titled, Gradual Dose Reduction for Antipsychotic medications dated 6/1/12, identifies the decision to lower, raise or maintain the dose are based upon the target behavior before and after reducing the dose and other documented problems which emerge. Documentation of dosage reduction attempts should be addressed in the physician/physician assistant/nurse practitioner progress notes. If dosage reduction is not possible or attempts of dosage reduction are not appropriate, documentation of the reasons, including the risk-benefit analysis, should be documented by the physician in the progress notes.	F 329		

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 _____	**09/15/2016**

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 Schroeder, Gary A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 9/15/2016, St. Elizabeths Medical Center was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility will be surveyed as four separate buildings, which are located at two different street addresses. St. Elizabeths Medical Center building # 1 is located at 1200 Fifth Grant Boulevard West. This facility is a 2-story building with a full basement. 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 fully sprinklered. The facility has a fire alarm system with full corridor smoke	K 000	EPOC	

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

Electronically Signed — 10/14/2016

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 _____	**09/15/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 detection and spaces open to the corridor that is 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. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 On facility tour between 2:30 PM and 3:30 PM on 9/15/2016, based on observation and interview revealed that a penetraction through smoke barrier above the ceiling on the second floor was found between buildings built in 1919 and 1961.	K 025	Metal sleeves and fire stopping have been added to these penetrations. Completed on 10/6/16. John Fillmore, Facilities Director.	10/14/16

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	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/15/2016**

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 025	Continued From page 2 Findings include: This deficient practice could affect the safety of the (20) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 025		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 On facility tour between 02:30 PM and 03:30 PM on 9/15/2016, based on observation and interview revealed that an extension cord with a two outlet box was found behind refrigerators in room S242.. This deficient practice could affect the safety of the (20) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 147	The extension cord was removed and a double gang 4 outlet receptacle was added to accommodate the refrigerators. Completed on 9/21/16. John Fillmore, Facilities Director	10/14/16

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 _____	**09/15/2016**

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ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981**

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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 dated 9/15/2016, St. Elizabeths Medical Center , Building #2, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 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: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/14/2016

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 **02 - ST. ELIZABETHS CARE CENTER** B. WING _____	**09/15/2016**

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 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Elizabeths Medical Center, Building # 2, is located at 626 Shields Avenue South. 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 building is fully sprinklered. The facility has a fire alarm system with corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 71 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches	K 027		10/14/16

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 _____	**09/15/2016**

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 027	Continued From page 2 from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 On facility tour between 10:30 AM and 02:30 PM on 9/15/2016, based on observation and interview revealed that smoke compartment doors in wings 100 and 200 would not closed with tested.. This deficient practice could affect the safety of the (12) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 027	Door edges were sanded to allow doors to close flush to each door and frame. Completed 9/20/16 John Fillmore, Facilities Director.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Heating, ventilating, and air conditioning comply	K 067	The building codes Life Safety features	10/14/16

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 _____	**09/15/2016**

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 067	Continued From page 3 with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 On facility tour between 10:30 AM and 02:30 PM on 9/15/2016, based on observation and interview revealed that Smoke dampers were found in all smoke compartments duct work and were not wired to alarm system. No documentation was provide to why they were not wired to system. This deficient practice could affect the safety of the (81) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 067	are being reviewed by HGA Architects to reassess the buildings Life Safety compliance. When the fire/smoke dampers were installed the building codes were different and the facility was not sprinkled and fewer smoke detection was present. We are waiting on a determination to see if the dampers are required. Once the plan is identified we will correct with a letter stating the dampers are not required or wire the dampers to the fire alarm system. Tentative correction date 10/25/16. John Fillmore, Facilities Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **03 - CHAPEL ADDITION** B. WING _____	**09/15/2016**

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		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 9/15/2016, St. Elizabeths Medical Center , Building #3 Chapel Addition, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

St. Elizabeths Medical Center, Building # 3 Chapel Addition, is located at 626 Shields Avenue South.

The Chapel is a 1-story addition to Building #2, and has a full basement. The chapel addition was constructed in December 2003 and was determined to be of Type II(111) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification.

The facility has a capacity of 81 beds and had a census of 71 beds at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/14/2016

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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 **04 - 4 SEASON SUN ROOM** B. WING _____	**09/15/2016**

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		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 9/15/2016, St. Elizabeths Medical Center , Building #4 Four Season Sun Room Addition, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

St. Elizabeths Medical Center, Building # 4 - Four Season Sun Room Addition, is located at 626 Shields Avenue South.

The Four Season Sun Room is a 1-story addition to Building #2, 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 facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification.

The facility has a capacity of 81 beds and had a census of 71 beds at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

EPOC

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

Electronically Signed | 10/14/2016

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