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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 33KI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245283**
2.STATE VENDOR OR MEDICAID NO.
(L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/17/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (L17)

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **A5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 06/07/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/07/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(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
05/04/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245283

June 8, 2018

Ms. Cheryl High, Administrator
St Michaels Health & Rehab Center
1201 8th Street South
Virginia, MN 55792

Dear Ms. High:

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 June 1, 2018 the above facility is recommended for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K163. K252, K331, and K521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiencies or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
May 24, 2018

Ms Cheryl High, Administrator
St Michaels Health & Rehab Center
1201 8th Street South
Virginia, MN 55792

RE: Project Number S5283028 and H5283021

Dear Ms. High:

On April 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018 that included an investigation of complaint number H5283021. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 17, 2018, the Minnesota Department of Health 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 March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2018. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on March 22, 2018.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the March 22, 2018 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard extended survey were found 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.

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 June 22, 2018. (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 June 22, 2018. They will also notify the State Medicaid Agency that they must

also deny payment for new Medicaid admissions effective June 22, 2018. 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 Michaels Health & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 22, 2018. 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 September 22, 2018 (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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 8, 2018

Ms. Cheryl High, Administrator
St Michaels Health & Rehab Center
1201 8th Street South
Virginia, MN 55792

RE: Project Number S5283028 and H5283021

Dear Ms. High:

On May 24, 2018, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 22, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of May 24, 2018, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 22, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on March 22, 2018, that included an investigation of complaint number H5283021which was unsubstantiated. , and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our May 24, 2018 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 June 7, 2018, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2018, as of June 1, 2018.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of May 24, 2018. 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 June 22,

2018, 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 June 22, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 22, 2018, is to be rescinded.

In our letter of May 24, 2018, 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 June 22, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 1, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency(ies) cited under K163, K252, K331, and K521 at the time of the March 22, 2018 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 33KI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245283**
2.STATE VENDOR OR MEDICAID NO.
(L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

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 **03/22/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** 5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR - Social Worker 04/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specilaist 05/03/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(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

CCN: 245283

Documentation supporting the facility's request for a continuing waiver of the following life safety code deficiencies have been forwarded to the CMS Region V Office for their determination

K163 42 CFR 483.70(a) NFPA Life Safety Code Standard
K252 42 CFR 483.70(a) NFPA Life Safety Code Standard
K331 42 CFR 483.70(a) NFPA Life Safety Code Standard
K521 42 CFR 483.70(a) NFPA Life Safety Code Standard

Refer to the CMS 2786 Provision justification page. Post Certification Revisit (PCR) to follow.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 2, 2018

Ms. Cheryl High, Administrator
St. Michaels Health & Rehab Center
1201 8th Street South
Virginia, MN 55792

RE: Project Number S5283028 and H5283021

Dear Ms. High:

On March 22, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the March 22, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5283021 that was found to be unsubstantiated.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and
Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 1, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 1, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- 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 June 22, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 22, 2018 (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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	C 03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	**1201 8TH STREET SOUTH VIRGINIA, MN 55792**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 3/19/18 through 3/22/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/19/18, through 3/22/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. During this survey, H complaint H5283021 was investigated and not substantiated.	F 000		
F 571 SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).	F 571		5/1/18

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

Electronically Signed | 04/11/2018

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F 571	Continued From page 1 The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services: (A) Nursing services as required at §483.35. (B) Food and Nutrition services as required at §483.60. (C) An activities program as required at §483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at §483.40(d).	F 571		

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F 571	Continued From page 2 (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.	F 571		

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F 571	Continued From page 3 (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60. (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population. (iii) Requests for items and services. (A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident. (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide denture adhesive and denture cleanser for 2 of 2 residents (R31, R40) reviewed for supplies. Findings include: R31's Face Sheet printed 3/22/18, indicated R31 had diagnoses that included dementia. R31's annual Minimum Data Set (MDS) dated 2/8/18, indicated R31 had no natural teeth. R31's care plan dated 2/7/18, indicated R31	F 571	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. The facility provides denture cleaner and denture adhesive as stock items. R31 and R40 will be offered facility stock denture cleaner and denture adhesive and	

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F 571	Continued From page 4 required extensive assistance with activities of daily living (ADLs). R31's Kardex dated 12/13/10, indicated R31 had upper and lower dentures. On 3/19/18, at 6:11 p.m. family member (FM)-A stated the facility will not supply denture adhesive to the residents, family must purchase this. R40's Face Sheet printed 3/22/18, indicated R40 had diagnoses that included dementia. R40's quarterly MDS dated 2/15/18, indicated R40 required extensive assistance with ADLs and had no oral/dental concerns. On 3/20/18, at 10:42 a.m. FM-C stated they had asked the facility if denture cleanser was available. FM-C stated the facility responded by informing them they would not provide denture cleanser, toothpaste was good enough for denture cleaning. On 3/22/18, at 1:15 p.m. the director of nursing (DON) stated the facility's corporate consultant had informed her that toothpaste would suffice to clean dentures. The facility was unable to provide a policy on denture adhesive and denture cleanser.	F 571	it will be documented as to whether the resident or representative have accepted the stock supplies. All other residents who have dentures will be offered denture cleaner and denture adhesive and it will be documented as to whether they have accepted the stock supplies. Adequate supplies of oral care supplies will be kept in stock. The Denture Care and Replacement Policy and Procedure was reviewed and revised. Nursing Staff will be educated on the new procedure. The Infection Preventionist or designee will complete weekly audits to assure that residents with dentures are being supplied with oral care products. Monitoring will be completed at a consistent level (weekly) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council. The Infection Preventionist is responsible. Completion Date: 05/01/2018	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		5/1/18

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F 641	Continued From page 5 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify behaviors on the Minimum Data Set for 1 of 4 residents reviewed for accurate MDS. Findings include: R11's Resident Face Sheet printed on 3/22/18, identified diagnosis that included dementia with behavioral disturbances. R11's annual Minimum Data Set (MDS), dated 10/23/17, indicated R11 had severely impaired cognition, and had other behaviors not directed towards others on 1-3 days of the assessment period, and rejected cares 1-3 days in the assessment period, which would be seven days back from 1/10/18. R11's quarterly MDS, with an assessment review date of 1/10/18, indicated R11 had severely impaired cognition, did not reject cares and had no behaviors not directed towards others (such as hitting or scratching self, verbal/vocal symptoms likes creaming or disruptive sounds). R11's progress note dated 1/6/18, indicated R11 had loud disruptive yelling in the dining room, refused lunch, spit out her food, and was combative during toileting. On 3/22/18, at approximately 2:00 p.m. registered nurse (RN)-D stated the facility social worker	F 641	R11□s MDS was modified on 3/23/18 and submitted on 3/28/18. All residents will have their most recent MDS reviewed for accuracy of Section E. If the MDS is not accurate, the MDS will be modified and re-submitted. The Comprehensive Assessments Policy was reviewed and remains appropriate. A back-up plan has been developed that includes review of Section E by the Director of Social Services or the MDS Coordinator for accuracy in the absence of the Social Work Designee. An audit of two Quarterly or Annual MDS Assessments per week with ARD□s in the week will be completed on Section E by the Director of Social Services or MDS Coordinator to assure that the MDS is accurate prior to submission. Monitoring will be completed at a consistent level (weekly) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council. The MDS Coordinator is responsible.	

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F 641	Continued From page 6 completed the behavior sections of the MDS. RN-D stated the social worker reviewed progress notes to see if there were any behaviors noted during the assessment period. RN-D stated the facility social worker looked through R11's progress notes on 1/5/18, even though the assessment review date wasn't until 1/10/18. RN-D confirmed this left five days of data out of the MDS, and resulted in an inaccurate MDS. The facility policy on the accuracy of the MDS was not provided.	F 641	Completion Date: 05/01/2018	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure shoes were clean for 1 of 1 dependent residents (R11) who was reviewed for activities of daily living. Findings include: R11's Face Sheet printed 3/22/18, identified diagnosis that included dementia with behavioral disturbances. R11's quarterly Minimum Data Set (MDS) dated 1/10/18, indicated R11 had severely impaired cognition, required extensive assistance for dressing, and was totally dependent upon staff for personal hygiene.	F 677	R11□s shoes have been cleaned. R11 will be monitored daily for clean appearance. An audit of all long-term care residents who are dependent in dressing and grooming shall have a review for clean appearances. The Dignity and Respect Policy was reviewed and remains appropriate. Training will be completed with staff on the Dignity and Respect Policy and expectations that residents who are dependent in dressing and grooming are provided with assistance including	5/1/18

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F 677	Continued From page 7 R11's care plan dated 2/20/13, indicated R11 required assistance with dressing and grooming. On 3/20/18, at 8:54 a.m. R11 was observed in her room, with black tennis shoes on that appeared soiled with milk splatters and old food droppings on them. On 3/21/18, R11 was observed periodically throughout the morning, from 7:24 a.m. until 11:56 a.m. in her room during personal cares, in the dining room, and in front of the bird aviary. Throughout these observations, R11 wore the soiled black tennis shoes. On 3/22/18, at 10:20 a.m. R11 was observed in her bedroom wearing the soiled black tennis shoes. On 3/22/18, at 9:33 a.m. nursing assistant (NA)-E was interviewed and stated either nursing assistants or housekeeping would clean a resident's shoes. On 3/22/18, at 10:20 a.m. registered nurse (RN)-C stated shoes should be cleaned by who ever noted they were soiled. RN-C confirmed R11's shoes were dirty, and stated it looked as if milk had been spilled on them. On 3/22/18, at 1:58 p.m. the director of nursing (DON) confirmed shoes should be cleaned by who ever sees that they are dirty. The facility's Dignity and Respect policy dated 8/17/05, indicated resident's dignity shall be promoted by assuring appropriate attire.	F 677	appropriate and clean footwear and have a clean appearance. Random Dignity Audits will be completed daily by the Clinical Manager or designee. Monitoring will be completed at a consistent level (daily) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council. The Director of Nursing is responsible. Completion Date: 05/01/2018	
F 693	Tube Feeding Mgmt/Restore Eating Skills	F 693		5/1/18

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F 693 SS=D	Continued From page 8 CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the proper placement of the gastrostomy tube (g-tube) prior to the administration of medications for 1 of 1 residents (R32) reviewed for medication administration through a gastrostomy tube. Findings include: R32's Face Sheet undated, indicated R32's diagnoses included gastro-esophageal reflux disease with esophagitis and gastrostomy tube (g-tube, a tube inserted through the abdomen that	F 693	R32 has had an order entered into the electronic medical record (EMR) to check placement prior to administration of anything via G-tube. All residents with tube feedings will have an order placed in the EMR to check for G-tube placement prior to administration of anything via G-tube. The Feedings, Medications, & Care of the Gastric and Naso-Gastric Policy has been reviewed and revised.	

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F 693	Continued From page 9 delivers nutrition directly to the stomach). R32's annual Minimum Data Set (MDS) dated 2/5/18, indicated R32 received nutrition through a feeding tube. R32's Physician's Orders with a start date of 11/28/17, indicated R32's diet was nothing by mouth (NPO) and she was on aspiration precautions. R32's care plan dated 2/9/18, indicated R32 had impaired swallowing related to a stroke, and required 100% of her nutrition and hydration through a g-tube. The care plan further indicated R32 was NPO and required all medications and nourishment through the g-tube. On 3/21/18, at 7:11 a.m. licensed practical nurse (LPN)-A was observed during R32's medication administration. LPN-A crushed the following medications and dissolved them in water: aspirin 81 milligrams (mg), immodium (an antidiarrheal) 2 mg, lasix (a diuretic) 20 mg, metoprolol (for high blood pressure) 50 mg and zoloft (an antidepressant) 50 mg. LPN-A then measured keppra (used for seizures) 5 milliliters (ml) and poured it into the mixture. LPN-A drew up 60 ml of water into a large barrel syringe, and pushed the water with the syringe barrel into R32's g-tube followed by 15 ml of water, drawn up and administrated it in the same way. LPN-A then drew up the water and medication mixture, and administered the medication through the g-tube pushing the mixture in with the barrel of the syringe. LPN-A did this two times until the mixture was gone. LPN-A then flushed R32's g-tube with 60 ml of water into the barrel syringe and pushed the water with the syringe barrel into	F 693	Licensed Nurses will have competency training and testing completed regarding tube-feeding competency. Audits will be completed twice a week on each resident receiving anything via G-tube by the Staff Development Director or designee to assure that licensed nurses are completing tube feedings competently. Monitoring will be completed at a consistent level (Twice Weekly) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council. The Staff Development Director is responsible. Completion Date: 05/01/2018	

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F 693	Continued From page 10 R32's g-tube followed by 15 ml of water, drawn up and pushed in the same way. LPN-A then closed the g-tube port. LPN-A stated he would check placement of the g-tube if it appeared the tube had moved, the tube had numbers on it, and R32's tube stayed at the number 4. LPN-A further stated in the past, some residents have had orders to check g-tube placement with a stethoscope prior to administering the medications, but R32 did not have orders to check placement prior to administering medications. On 3/22/18, at 8:52 a.m. the director of nursing (DON) stated she would expect staff to check placement of a g-tube prior to the administration of medications. The facility's Administering Medications through an Enteral Tube policy dated 12/31/13, directed to check tube placement with two of the following methods: observe for a change in the external tube length marked at the time of the initial insertion x-ray, auscultate the abdomen by injecting 10 ml of air from the syringe into the tubing, listen with a stethoscope for a "whooshing" sound in the stomach, and aspirate a small amount of stomach content. If the syringe does not aspirate any feeding or gastric content, do not insert anything into the tube.	F 693		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726		5/1/18

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F 726	Continued From page 11 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure licensed nursing staff demonstrated competency skills to ensure placement of a gastrostomy tube prior to the administration of medications for 1 of 1 residents (R32) reviewed for medication administration through a gastrostomy tube. Findings include: R32's Face Sheet undated indicated R32's diagnoses included gastro esophageal reflux	F 726	Current Licensed Nurses will have competency training on the instillation of medications via G/J Tube, and Enteral Therapy Nutrition including continuous, intermittent, and bolus feedings. There will be a written and skills testing completed regarding tube-feeding competency on April 23, 2018. All new licensed nurses will be trained in Enteral Therapy, medications and nutrition within two weeks of hire. This includes	

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F 726	Continued From page 12 disease with esophagitis and gastrostomy tube (g-tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach). R32's annual Minimum Data Set dated 2/5/18, indicated R32 received nutrition through a feeding tube. R32's physician's orders with a start date of 11/28/17, indicated R32's diet was NPO (nothing by mouth) and aspiration precautions. R32's care plan dated 2/9/18, indicated R32 had impaired swallowing related to a stroke, and required 100% of her nutrition and hydration through a g-tube. The care plan further indicated R32 was NPO and required all medications and nourishment through the g-tube. On 3/21/18, at 7:11 a.m. licensed practical nurse (LPN)-A was observed during R32's medication administration. LPN-A crushed R32's medications and dissolved them in water. LPN-A drew up 60 ml of water into a large barrel syringe, and pushed the water with the syringe barrel into R32's g-tube followed by 15 ml of water, drawn up, and administrated it in the same way. LPN-A then drew up the water and medication mixture, and administered the medication through the g-tube pushing the mixture in with the barrel of the syringe. LPN-A did this two times until the mixture was gone. LPN-A then flushed R32's g-tube with 60 ml of water into the barrel syringe and pushed the water with the syringe barrel into R32's g-tube followed by 15 ml of water, drawn up and pushed in the same way. LPN-A then closed the g-tube port. LPN-A stated he would check placement of the g-tube if it appeared the tube had moved, the g-tube had numbers on it,	F 726	both a written and skills test out. Licensed Nurses will be trained annually in Enteral Therapy including medications and nutrition. Trainings will be tracked by employee education transcripts. The Director of Staff Development or designee will complete an audit at two weeks for any new licensed nurse hires to assure that the competency training has been completed. The Director of Staff Development or designee will conduct quarterly audits of employee transcripts to assure that required training for the quarter has been completed. Monitoring will be completed at a consistent level (Two weeks/quarterly) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council. The Staff Development Director is responsible. Completion Date: 05/01/2018	

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F 726	Continued From page 13 and R32's tube stayed at the number 4. LPN-A further stated in the past, some residents have had orders to check g-tube placement with a stethoscope prior to administering the medications, but R32 did not have orders to check placement prior to administering medications. On 3/22/18, at 1:10 p.m. registered nurse (RN)-A stated she was the staff development director, and nurses had not had competency evaluations on tube feedings. RN-A stated she had been the staff development director since April, and had not done training or competency on tube feeding medications. On 3/22/18, at 1:23 p.m. LPN-A stated he could not recall having any training or testing on the administration of medications via feeding tubes. LPN-A had worked at the facility since 12/09. The facility was unable to provide a policy on staff competencies.	F 726		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		5/1/18

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F 880	Continued From page 14 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 15 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure injectable insulin pens were stored in a manner to prevent cross contamination of blood-borne pathogens for 12 of 12 residents (R23, R22, R55, R32, R25, R12, R45, R60, R18, R119, R59, and R172) who had insulin pens in the medication cart on all three units. In addition, the facility failed to ensure proper hand hygiene was maintained during personal cares for 1 of 3 residents (R31) observed during personal cares. Findings include: On 3/20/18, from 1:37 p.m. through 2:03 p.m. medication carts on each unit were observed to contain insulin pens, for a total of 12 residents that were stored together in the same compartment or area of the cart, without separation from each other. In the Gardens unit medication cart the following was observed:	F 880	R23, R22, R55, R32, R25, R12, R45, R60, R18, R119, R59, and R172 have had their insulin pens separated with dividers in the medication carts. The medication cart will be reviewed to assure that any other resident insulin pens are stored properly. The Storage of Medications Policy was reviewed and remains appropriate. The Licensed Nurses will be re-trained on the Storage of Medications Policy. An audit of each medication cart will be completed weekly by the Infection Preventionist or designee to assure that medications are stored properly. Monitoring will be completed at a consistent level (weekly) until compliance is achieved.	

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F 880	Continued From page 16 R23's Physician Orders dated 3/1/18 - 3/31/18, indicated R23 had orders for Novolog Flexpen insulin. R22's Physician Orders dated 3/1/18 - 3/31/18, indicated R23 had orders for Novolog Flexpen insulin and Lantus Solostar insulin pen. R55's Physician Orders dated 3/1/18 - 3/31/18, indicated R23 had orders for Novolog Flexpen insulin and Lantus Solostar insulin pen. R32's medication administration history dated 3/1/18 - 3/22/18, indicated R32 had orders for Humulin N insulin. R23's, R22's, R55's, and R32's insulin pens were all stored together in the same medication compartment. On 3/20/18, at 1:46 p.m. licensed practical nurse (LPN)-A stated they always kept the insulin pens stored together in one compartment. In the Meadows unit medication cart the following was observed: R25's Physician Orders dated 3/1/18 - 3/31/18, indicated R25 had orders for Humalog KwikPen insulin and Tresiba insulin pen. R12's Physician Orders dated 3/1/18 - 3/31/18, indicated R12 had orders for Novolog Flexpen insulin, Lantus Flexpen insulin. R45's Physician Orders dated 3/1/18 - 3/31/18, indicated R45 had orders for Novolog Flexpen insulin and Lantus Solostar insulin pen.	F 880	Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council . The Infection Preventionist is responsible. Completion Date: 05/01/2018 R31 did not have any ill effects from the lack of hand washing. No other residents have had any ill effects from lack of hand washing. The Infection Preventionist or designee will complete daily audits on each shift for compliance with proper hand washing. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council. The Infection Preventionist is responsible. Completion Date: 05/01/2018	

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F 880	Continued From page 17	F 880		

R60's Physician Orders dated 3/1/18 - 3/31/18, indicated R60 had orders for Novolog Flexpen insulin and Lantus Solostar insulin pen.

R18's Physician Orders dated 3/1/18 - 3/31/18, indicated R18 had orders for Novolog Flexpen insulin and Lantus Solostar insulin pen.

R25's, R12's, R45's, R60's and R18's insulin pens were all stored together in the same medication compartment.

On 3/20/18, at 2:00 p.m. LPN-B stated that was the way the insulin had been stored for a long time.

In the Waters unit medication cart the following was observed:

R119's Physician Orders dated 3/1/18 - 3/31/18, indicated R119 had orders for Novolog Flexpen insulin and Lantus Solostar insulin pen.

R59's order history dated 3/1/18 - 3/20/18, indicated R59 had orders for Aprida Solostar insulin pen.

R172's Physician Orders dated 3/1/18 - 3/31/18, indicated R172 had orders for Novolog Flexpen insulin and Lantus Solostar insulin pen.

R119'a, R59's, and R172's insulin pens were all stored together in the same medication compartment.

On 3/20/18, at 2:07 p.m. LPN-C stated once the insulin was opened that was how it was stored.

On 3/20/18, at 2:17 p.m. the director of nursing

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F 880	Continued From page 18	F 880		

(DON) stated she was unaware the insulin pens were not to be stored together. The DON further stated the pharmacist periodically checked the medication carts, and they had never said anything about that.

The facility's Storage of Medications policy dated 6/27/17, indicated each resident's external and internal medication would be separated from other resident's internal and external medications.

R31'S Face Sheet printed 3/22/18, indicated diagnoses that included dementia with behavioral disturbances, muscle weakness, and a history of urinary tract infections.

R31's annual Minimum Data Set (MDS), dated 2/8/18, indicated R31 required extensive assistance with dressing, transfers, toileting and personal hygiene. R31's MDS further indicated she had severely impaired cognition and was always incontinent of bladder and bowel.

R31's care plan dated 2/7/18, indicated R31 required extensive assistance with activities of daily living.

R31's Kardex dated 6/14/12, indicated R31 was incontinent of bladder and bowel.

On 3/22/18, at 9:00 a.m. nursing assistant (NA)-B was observed to enter R31's room to perform morning cares. NA-B assisted R31 out of bed, to the bathroom and onto the toilet. NA-E assist with the transfer out of bed and left the room. Family member (FM)-B was present throughout the

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F 880	Continued From page 19 observation. While R31 was on the toilet. NA-B donned gloves and brushed R31's dentures and placed them in her mouth. NA-B handed a warm, wet washcloth to R31, and encouraged her to wash her face. NA-B assisted R31 into a sweatshirt, and proceeded to stand R31. NA-B used a warm, soapy washcloth to wash R31's perineal area, another warm washcloth to rinse the area, and a hand towel to dry R31's the area. NA-B pulled up R31's incontinent product and pants, straightened her sweatshirt, and assisted her to sit in her wheelchair. NA-B removed her soiled gloves, and without performing hand hygiene, used a pick to comb R31's hair. NA-B tied up a plastic bag with used linen, picked up her transfer belt and left the room to put the bag in the soiled utility room. NA-B washed her hands in the soiled utility room and returned to R31's room to make the bed. On 3/22/18, at 9:28 a.m. NA-B confirmed she did not perform hand hygiene after glove removal after performing peri-cares. On 3/22/18, at 10:20 a.m. registered nurse (RN)-C stated hands are to be washed after glove removal and before continuing cares.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident	F 921	R18□s catheter has been changed from a 2-in-1 catheter back to a standard leg	5/1/18

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F 921	Continued From page 20 room was free from urine odors for 1 of 20 residents (R18, R15) whose rooms were reviewed for odors. Findings include: From 3/19/18, at 7:10 p.m. through 3/22/18, at 2:00 p.m. a strong odor of urine was noted in R18 and R15's shared room that permeated into the hallway. R18's Face Sheet undated, indicated R18's diagnoses included chronic kidney disease, bladder spasms, cancer within the prostate, and suprapubic catheter (a drain from the bladder to the outside of the abdomen). R18's annual Minimum Data Set (MDS) dated 1/9/18, indicated R18 had moderately impaired cognition, and required extensive assistance of one staff with toilet use and personal hygiene. The MDS also indicated R18 had an indwelling catheter. R18's care plan dated 1/12/18, indicated R18 require a suprapubic catheter due to incomplete bladder emptying due to urethral calculi and a history of prostrate cancer. The care plan directed staff to observe for leakage and provide assistance for catheter care per facility protocol. R15's Face Sheet undated, indicated R15's diagnoses included legal blindness. R15's quarterly MDS dated 2/5/18, indicated R15 was cognitively intact, and was independent with locomotion. The MDS also indicated R15 was always continent of bladder.	F 921	and night bag. This is being changed every other day. The facility staff will encourage more frequent bathing for R18, keeping in mind that he may refuse. Organic charcoal bags have been placed in R18□s room. The filter in the ozone machine that is in R18□s room will have the filter cleaned monthly. The carpet on R18□s side of the room will be cleaned every two weeks using an Enzyme cleaner. R18□s bed will be cleaned with an enzyme cleaner every week. R18□s recliner will be cleaned with an enzyme cleaner ever week. R18□s wheelchair cushion cover will be changed out and washed weekly. R15 was interviewed by the Administrator on 4/6/18 and was notified that we will interview him weekly to determine if improvements in odors are noted. All residents with catheters will be observed for odors by the Clinical Managers or designee. Roommates, if any, will be interviewed for any odor concerns. Education will be provided to	

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F 921	Continued From page 21 On 3/19/18, at 7:08 p.m. R18 was interviewed. R18 stated he has had a catheter for about a year, and could not smell any urine in the room. On 3/21/18, at 9:15 a.m. R15 was interviewed. R15 stated the room smelled like urine, and he was not happy about it. R15 stated he was in the room first, and if he would have been warned there may be a urine smell when R18 was admitted, it wouldn't have been so bad. R15 stated he has told staff, the social worker, "Everyone" about the strong urine odor, and how it bothered him. R15 stated the facility put in an air freshener, but that did not do anything to clear the odor. R15 stated he was told they would clean the carpet in the room more often. R15 stated he gets up for six hours a day and leaves his room because of the odor. R15 stated he does not get many visitors, but when he does they mention the odor, and he visits with them outside the room. "Everyone, anyone, comments about the odor in the room" R15 stated, and continued, "Why should I have to move?" R15 stated he was angry and frustrated because nothing had been done. On 3/22/18, at 10:26 a.m. nursing assistants (NA)-K and NA-J were interviewed and NA-K stated the room and the hallway had a strong odor since R18 was admitted. NA-J stated she thought the urine odors were in the carpet, and housekeeping washed the carpet daily almost, and it probably needed to be washed again. NA-K stated an air freshener was also put in the room. NA-K stated R15 had never said anything about the urine smell. NA-K stated R18's urine odor was strong, they washed him really good, but he still had an odor. On 3/22/18, at 10:37 a.m. housekeeper (H)-A	F 921	housekeeping staff and nursing on the expectations of cleaning carpet, general cleaning, bed cleaning, filter cleaning. Daily Audits will be completed by the Housekeeping Director or designee to assure that the interventions are being completed by staff and odors are not present in the hallways of those with catheters. An audit will be completed by interviewing R15 weekly to see if odors continue to improve. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the Quality Council. The Housekeeping Director is responsible. Completion Date: 05/01/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	C 03/22/2018

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ST MICHAELS HEALTH & REHAB CENTER	**1201 8TH STREET SOUTH VIRGINIA, MN 55792**

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F 921	Continued From page 22	F 921		

stated he was aware of the urine odor, and maintenance had installed an air freshener about a month ago. H-A stated he did routine cleaning in R18 and R15's room, and cleaned the bathroom with bleach. H-A stated the afternoon housekeeping staff did the carpet cleaning.

On 3/22/18, at 11:19 a.m. the housekeeping director (HD)-A stated she was aware of R18 and R15's room urine odor, and maintenance had put in air freshener before she took over last April. HD-A stated the carpet was cleaned every two weeks.

On 3/22/18, at 2:04 p.m. the director of nursing (DON) and the administrator were interviewed. The DON stated R18's urinary drainage leg bag was changed every other day. The DON further stated a wall deodorizer was installed, but the best thing would be to move R18 to a private room with a tile floor. The administrator stated recliner covers were ordered to prevent the urine from going through to the recliner. The administrator also stated there were not any private rooms available. The administrator stated R15 had been offered to be moved twice, and he did not want to be moved.

A policy on room odors was requested and not received.

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K 000	INITIAL COMMENTS FIRE SAFETY	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

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

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

EPOC

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/11/2018

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

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and 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 Thsi facility was inspected as one building. St Michael's Health and Rehab Center's is a one-story building constructed in 1967, that was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this inspection the building was inspected as a Type V(000), which meets the standard. The facility to include the original 1967 building and the two additions have a full basement.	K 000		

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K 000	Continued From page 2 The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors. The facility has a capacity of 83 beds. At the time of the survey the census was 76. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 163 SS=F	Interior Nonbearing Wall Construction CFR(s): NFPA 101 Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install non-combustible framing, above the ceiling, in two locations in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3. This deficient practice could effect 30 of the 83 residents as well as an undetermined number of staff, and visitors.	K 163	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements.	5/1/18

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K 163	Continued From page 3 Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 03/20/2018, it was observed that in two areas above the ceiling in tub rooms of "A & B" wings limited combustible framing material has been used. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on 03/19/2013, and during the state agency inspections. This deficient practice was confirmed by the Maintenance Supervisor.	K 163	Annual Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division) Completion Date: 05/01/2018	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition. This deficient practice could affect 83 of 83 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable.	K 211	All fire doors will be inspected and the inspection shall be documented for each door. Inspection of the fire doors will be added to the LSC Book annual tasks that need to be completed. The Director of Plant Operations is responsible for completion of the annual inspection.	5/1/18

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K 211	Continued From page 4 Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 03/20/2018, during a records review and an interview with the Maintenance Supervisor, the facility did not completed the fire door inspection or inspection documentation for all of the fire rated doors located throughout the facility. This deficient practice was confirmed by the Maintenance Supervisor.	K 211	When complete, the Director of Plant Operations will present the documentation to the Administrator for review and sign-off. Completion Date: 05/01/2018	
K 252 SS=D	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to provided proper means of egress from the basement storage area under the "A" wing, in accordance with the NFPA Life Safety Code 101 2012 edition section 19.2.1. This deficient practice could effect residents as well as an undetermined number of staff, and visitors that would need to evacuate this area in an emergency. Note: residents are not allowed in this area.	K 252	Annual Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division) Completion Date: 05/01/2018	5/1/18

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K 252	Continued From page 5 Findings include:	K 252		
	On facility tour between 11:30 a.m. and 3:30 p.m. on 03/20/2018, it was observed that the storage area in the basement, under the "A" wing, only has one exit. This area is approximately 7, 290 square feet in size. Rooms over 2,500 square feet require two remote exits. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on 03/19/2013, and during the state agency inspections. This deficient practice was confirmed by the Maintenance Supervisor.			
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K 321		6/1/18

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K 321	Continued From page 6 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 20 of 83 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 03/20/2018, observations revealed the following deficient conditions: 1. The door to the central elevator equipment located that is located on the lower level does not have a fire rated label attached to the door at the time of the inspection. 2. In the A-Wing clean linen/storage room that is greater than 50 square feet there was a	K 321	A new door was ordered for the central elevator equipment room because of the absence of the fire rated label. The door was ordered March 22, 2018 but may not arrive until after May 1, 2018. A Temporary Waiver is being requested (CMS-2786R to be mailed to MN State Fire Marshall Division) When doors are inspected as indicated in K211, they will be inspected to assure that the fire rated label is in place. The Director of Plant Operations is responsible. Completion Date: 06/01/2018 The unapproved door hold open device on the A-Wing clean linen/storage room was removed on 3/21/18. An audit of other doors was completed and all unapproved door hold open devices have been removed. Upon annual inspection of fire doors they	

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K 321	Continued From page 7 unapproved door hold open device holding the door open.	K 321	will be checked for unapproved door hold devices.	
K 331 SS=F	This deficient practice was confirmed by the Maintenance Supervisor. Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient practice could effect all 40 of 83 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 03/20/2018, it was observed that the facility has carpet applied to the corridor walls on both levels, within 12 inches of the floor. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on	K 331	Completion Date: 05/01/2018 Annual Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division) Completion Date: 05/01/2018	5/1/18

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K 331	Continued From page 8 03/19/2013, and during the state agency inspection. At the time of the inspection the facility had corrected this condition throughout the "C" wing. This deficient practice was confirmed by the Maintenance Supervisor.	K 331		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the facility has failed to install the facility's heating and ventilation in accordance with the NFPA Life Safety Code 101 2012 edition section 19.5.2.1 and NFPA 90A 19.5.2.2. This deficient practice could effect 83 of 83 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 03/20/2018, observations revealed the following deficient conditions: 1. Wings A and B are using the corridors as a	K 521	Annual Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division) Completion Date: 05/01/2018	5/1/18

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K 521	Continued From page 9 return air plenums. 2. The facility had an inspection of all fire and smoke dampers located through out the facility but failed to fix or replace 36 dampers and 6 damper motors that were annotated on the third party fire door inspection report. This deficient practice was confirmed by the Maintenance Supervisor.	K 521		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 83 of 83 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 901	A Room Category Risk Assessment will be completed by the Director of Plant Operations or designee. Upon completion of the Room Category Risk Assessment the Director of Plant Operations will present the Assessment to the Administrator for review and sign-off. The Director of Plant Operations is responsible.	5/1/18

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K 901	Continued From page 10 On facility tour between 11:30 a.m. and 3:30 p.m. on 03/20/2018, during the documentation review and an interview with a Maintenance Supervisor it was revealed that the facility did not have the systems chapters 6 and 9 annotated for all rooms located within the facility to include room category and the room category risk assessment associated with it at the time of the inspection This deficient practice was confirmed by the Maintenance Supervisor.	K 901	Completion Date: 05/01/2018	

Name of Facility St. Michael's Health & Rehab Center **2012 LIFE SAFETY CODE**

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
~~K406~~ K163	An annual/continuing waiver is being requested for K163.

A. Compliance with this provision will cause an unreasonable hardship because:
1. The cost of removing the wood framing and replacing the ceilings at the Garden-Wing and Meadows-Wing tub rooms is estimated at roughly $12,000.
2. NFPA 101(00), Sec. 4.6.3 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical. St. Michael's Health & Rehab Center feels that it would be impractical to remove/replace the combustible wood framing at the ceilings because while not in literal compliance with the Code, the combustible wood framing at the ceilings does not represent a significant threat to the safety of the staff and residents and correction of this deficiency would cause the need for disproportionate effort, expense and disruption of services with little or no increase in life safety.

B. There would be no adverse effect on the building occupants safety because:
1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13.
2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system.
3. The Building is equipped with corridor smoke detection.
4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors.
5. The facility is smoke free and signs to that effect are prominently posted at all major entrances.
6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers).
7. The building fire alarm system is monitored to provide automatic fire department notification.
8. Fire Safety Training is provided for all employees annually and during orientation for all new hires.
9. Fire Drills are conducted at least quarterly on each shift.

4-11-18

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal	Date 04-19-2018

Name of Facility ST MICHAEL'S HEALTH + REHAB CENTER

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
~~K400~~ K252	An annual/continuing waiver is being requested for K252

A. Compliance with this provision will cause an unreasonable hardship because:

1. The most recent cost estimate dated 4-8-13 for complying with a second means of egress from this wing is over $113,000.00. Due to past years financial losses and Fiscal Year to Date losses, the facility has no reserves.
2. There are concerns that penetrations of load bearing walls to install a second means of egress could adversely affect the structural integrity of the building.

B. There would be no adverse effect on the building occupants safety because:

1. Residents do not have access to this area.
2. Not more than two staff members occupy the area at any given time and then only for short periods of time (less than 15 minutes) to stock or retrieve supplies.
3. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13.
4. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system.
5. The Building is equipped with corridor smoke detection.
6. This area is equipped with smoke detection.
7. The facility is smoke free and signs to that effect are prominently posted at all major entrances.
8. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers).
9. The building fire alarm system is monitored to provide automatic fire department notification.
10. Fire Safety Training is provided for all employees annually and during orientation for all new hires.
11. Fire Drills are conducted at least quarterly on each shift.
12. The facility continues to monitor the area to keep combustible load reasonable for the storage space.

4-11-18

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	**Title**	**Office**	**Date**
Thomas Linhoff 12424	Fire Safety Supervisor	State Fire Marshal	04-19-2018

Name of Facility St Michael's Health + Rehab Center

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400	

K331

An annual/continuing waiver is being requested for K331

A. Compliance with this provision will cause an unreasonable hardship because:

1. The most recent cost estimate dated 4-19-13 for removing and replacing the carpet cove on the upper and lower floors is approximately $14000. Due to past years financial losses and current fiscal year to date losses, the facility has limited reserves and the original plan of correction was to correct the carpet on the walls as flooring was replaced.
2. Removal of the carpeting without replacement of some type of wall covering would make it aesthetically unappealing and could cause injury to residents due to rough surfaces.
3. **The flooring in the Large Dining Room and Lobby was replaced in February, 2017 at a cost of approximately $68000 and the carpet on the walls in this area was replaced with tile. This is consistent with original plan.**
4. Gardens and Meadows wings and lower level is older and we are hoping to replace before the end of Fiscal year 2019.
5. The Minnesota Department of Public Safety, State Fire Marshall's Division has allowed installation of carpeting on walls up to a height of 12 inches when the building is fully sprinkled and the carpeting has a Class I rating, based on the Radiant Panel Test for carpeting. These conditions are met at this facility.

B. There would be no adverse effect on the building occupants safety because:

1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13.
2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system.
3. The Building is equipped with corridor smoke detection.
4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors.
5. The facility is smoke free and signs to that effect are prominently posted at all major entrances.
6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers).
7. The building fire alarm system is monitored to provide automatic fire department notification.
8. Fire Safety Training is provided for all employees annually and during orientation for all new hires.
9. Fire Drills are conducted at least quarterly on each shift.
10. This annual/continuing waiver has been approved in the past.

4-11-18

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Sire Safety Supervisor	State Fire Marshal	04-19-2018

Name of Facility St Michael's Health & Rehab Center **2012 LIFE SAFETY CODE**

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
~~K400~~ K521	An annual/continuing waiver is being requested for K521 A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 4-10-13 for a complying ducted HVAC system is over $130000.00 excluding the required wiring. Due to past years financial losses and current year to date losses, the facility has no reserves. 2. The most recent cost estimate date 2017 to replace the smoke dampers was approximately $31000.00. 3. There are concerns that penetrations of load bearing walls to install required duct work could adversely affect the structural integrity of the building. 4. Installation of a ducted system may require asbestos abatement which would increase the costs. 5. LSC (00), Sec. 9.2.1 gives AHJ the authority to allow existing HVAC systems that do not comply with NFPA 90A to be continued in service. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. 10. This annual/continuing waiver regarding the HVAC has been approved in the past.

4-11-18

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	State Fire Marshal	04-19-2018