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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3N4L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/21/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Kathie Killoran, HFE NE II — 01/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/05/2016 (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
04/01/1985
(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
Posted 02/17/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/10/2015
(L33)

DETERMINATION APPROVAL

CCN: 24 5277

On January 21, 2016, the Minnesota Department of Health 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 October 23, 2015, and deficiencies remaining uncorrected as of the PCR completed December 22, 2016. Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b)) has been rescinded. Please refer to the CMS 2567B. Effective January 19, 2016 the facility is certified for 76 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245277
February 5, 2016

Mr. Michael Schultz, Administrator
St. Raphael's Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

Dear Mr. Schultz:

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 January 19, 2016 the above facility is certified for or recommended for:

76 Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 5, 2016

Mr. Michael Schultz, Administrator
St. Raphael's Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number S5277025

Dear Mr. Schultz:

On December 31, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 10, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on October 23, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on December 16, 2015. The most serious deficiencies at the time of the revisit 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 January 21, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 19, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 16, 2015, as of January 19, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 19, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 31, 2015. The CMS Region V Office has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 23, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 23, 2016, is

to be rescinded.

In our letter of December 31, 2015, 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 January 23, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 19, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245277 Y1	A. Building B. Wing Y2	1/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0248	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.15(f)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	01/19/2016	LSC	01/19/2016	LSC	01/19/2016
ID Prefix F0314	Correction	ID Prefix F0329	Correction	ID Prefix F0465	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.70(h)	Completed
LSC	01/19/2016	LSC	01/19/2016	LSC	01/19/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	LB/KJ	02/05/2016	29625	01/21/2016`
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/23/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3N4L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**
2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 SW 01/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/13/2016 (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
04/01/1985
(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
12/10/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5277

On December 16, 2015, 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 October 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 6, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on October 23, 2015. However, compliance with the health deficiencies issued pursuant to the October 23, 2015 standard survey has not yet been verified. The most serious health 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 December 22, 2015 a health PCR was completed to verify correcton of the health deficiencies. Based on our revisit we have determined the facility had not corrected all the deficiencies. The most serious 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 require.

As a result that the facility has not achieve substantial compliance, this Department is imposing the Category 1 rememdy.

In addition, we are recommending the following action to the CMS RO related to the remedy imposed in our letter of December 22, 2105 adn January 4, 2016:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

If the facility goes into DPNA, the facility would be subject to a two year loss of NATCEP beginning 01/23/2016.

Health Post Certification Revisit (PCR) to follow. Refer to the CMS 2567, along with the facilitys plan of corection CMS 2567b.

Minnesota Department of Health

Electronically delivered
January 4, 2016

Mr. Michael Schultz, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number S5277025

Dear Mr. Schultz:

On December 31, 2015, this Department, as authorized by the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

Also, the Department notified you in our letter of December 31, 2015, 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 January 23, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on October 23, 2015, and lack of verification of compliance with the health deficiencies at the time of our December 31, 2015 notice. The most serious deficiencies 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 December 22, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the October 23, 2015 standard survey. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 2, 2015. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 23, 2015. The deficiencies not corrected are as follows:

F0248 -- S/S: D -- 483.15(f)(1) -- Activities Meet Interests/needs Of Each Res
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
F0465 -- S/S: E -- 483.70(h) -- Safe/functional/sanitary/comfortable Environ

In addition, at the time of this revisit, we identified the following deficiency:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan

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

As a result of the revisit findings, this Department is imposing the Category 1 remedy of state monitoring, effective January 9, 2016.

In addition, this Department recommended to the CMS Region V Office the following action related to the imposed remedy our letter of December 31, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 23, 2016, remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of November 6, 2015, 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 January 23, 2016.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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 April 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

Minnesota Department of Health

Electronically delivered
December 31, 2015

Mr Michael Schultz, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number F5277024

Dear Mr. Schultz:

On November 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 16, 2015, 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 October 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 6, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on October 23, 2015.
However, compliance with the health deficiencies issued pursuant to the October 23, 2015 standard survey has not yet been verified. The most serious health 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.

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 January 23, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 23, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 23, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial

of payment. Therefore, St Raphaels Health & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 23, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@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 January 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on December 21-22, 2015 to determine compliance with Federal deficiencies issued during a recertification survey exited on October 23, 2015. During this visit the following regulations were determined to be not corrected. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 248} SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 3 of 3 residents (R3, R56, R11) reviewed for activities.	{F 248}	F248 Resident 32, 56 and 11 will have their daily routine reassessed based on past activity and with family input. Following the reassessment the individual activity	1/19/16

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

Electronically Signed | 01/11/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 248}	Continued From page 1 Findings include: R3 was not provided with meaningful activities. R3's Admission Record identified diagnoses that included dementia. R3's annual Minimum Data Set (MDS) indicated R3 was severely cognitively impaired. The MDS further identified R3 did not ambulate, required extensive assistance of two staff with transfers, and required extensive assistance of one staff for wheelchair mobility. The care plan dated 11/11/15, identified R3 was independent in choice of activity, and preferred to spend most of his time resting. The care plan directed staff to provide 1:1 visits twice a week for socialization, and provide reminders to participate in group activities of interest (mass, rosary, music programs, socials, parties and special events). R3's activity participation calendar indicated R3 participated in a party on 12/10/15, rosary on 12/13/15, and had a spiritual visit on 12/16/15. The calendar also indicated 1:1 visits on 12/5/15, 12/8/15, 12/10/15, 12/18/15, and 12/19/15. The visits documented as 1:1's consisted of the following: 12/5/15: Visited. Helped resident to dayroom for lunch. Chicken was on the menu, and talked about raising them. Resident talked about store he owned. 12/8/15: Visited. He asked where he is and was told. Got him an ice cream, and some for other residents. Later he put his call light on for the nurse. 12/10/15: Visited. Resident said he wanted to go home, explained why he lives here now. Brought to his room and got his slippers and glasses. 12/18/15: Asked where his room was. 12/19/15: Visited with resident at lunch time.	{F 248}	schedule will be revised for each. Update of the care plan will be completed to reflect abilities to make choice of activities, offering activities and transporting if necessary. Please note that the 2567 notes R3, but as per call with MDH Team was clarified to be Resident 32. Audits will be completed initially weekly to evaluate activities are offered, supported and encouraged if declined. Training to staff will be provided January 14, 2016 regarding individual activities and encouragement for participation. Analysis of the facilities compliance to all corrections and improvements will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will ensure identification and implementation of necessary changes to systems as indicated, and determine the need for on-going monitoring/auditing after thorough analysis. Audits results will be reviewed/trended and brought forward to the Quality Council. Audits will be monitored and changes will be implemented the Wellness (Activity) Director. All other residents will be reassessed within one quarter, following RAI schedule, or sooner if needed for implementation of individual activities. Audits will be weekly after each implementation and then to monthly or as needed. Completion date will be January 19, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 248}	Continued From page 2 During the survey from 12/21/15, to 12/22/15, R3 was not observed in activities. On 12/22/15, at 1:26 p.m. activities staff (A)-B was interviewed and stated a 1:1 visit was 15 minutes spent with a resident. A-B stated she visited with R3 on 12/16/15, and spent about 15 minutes with him. On 12/22/15, at 1:12 p.m. the activities director (AD)-A was interviewed and stated R3 has dementia, and didn't remember much. AD-A stated since the weather has been colder, she no longer took R3 on wheelchair rides outside of the facility, but added "he's difficult, he wants to sleep a lot." AD-A further stated a 1:1 visit can last as long as the resident's attention span, with R3 it can be 1-2 minutes or 5-10 minutes, and R3 enjoys conversations about the past, music and the newspaper. The facility undated policy and procedure on 1:1 Visits, directed the purpose of 1:1 visits was to provide socialization and/or sensory/mental stimulation to residents that do not participate much in group activities. Staff had a list of residents that he/she was responsible to see for the designated number of visits per week. R56 was not provided with meaningful activities. R56's Resident Admission Record dated 12/21/15, indicated R56's diagnoses included pressure ulcer of an unspecified site, type two diabetes, morbid (severe) obesity due to excess calories, chronic kidney disease, heart failure, stage four (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling) pressure ulcer of unspecified buttock, third degree burn of the buttocks and exposure to smoke, fire and flames.	{F 248}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 248}	Continued From page 3	{F 248}		

R56's quarterly Minimum Data Set (MDS) dated 11/25/15, indicated R56 had moderate cognitive impairment and did not have any behaviors or rejection of cares. R56 had minimal difficulty hearing and her vision was highly impaired. R56 required the total assistance of two staff with transfers. R56 did not walk, required the total assistance of one staff with locomotion on the unit and did not leave the unit during the assessment period.

An Activity Assessment dated 11/20/15, indicated R56 continued to be independent in choice of activity and had fair activity participation. R56 preferred to spend most of her time resting in her room and watching television. Activity staff provided 1:1 visits two times a week for socialization that included visiting about a variety of topics, bringing her snacks during socials and helping her with her phone and in her room. R56 participated in the following activities during the past quarter: exercise group 18 times, attended rosary and had trick or treaters. R56 also enjoyed sitting in the lobby area. R56's spouse visited regularly.

R56's activity participation calendar from 12/1/15 through 12/20/15, indicated R56 watched television on 12/1, 8, 10, 18, 19, 20/15. R56 attended exercise on 12/2/15, and refused exercise on 12/11/15. R56 had an independent activity on 12/18/15, and a family visit on 12/18,19/15. The calendar indicated R56 was sleeping on 12/1, 2, 3, 9, 10/15.

During the survey from 12/21/15, to 12/22/15, R3 was not observed in activities.

On 12/22/15, at 7:38 a.m. activities director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 248}	Continued From page 4 (AD)-A brought the newspapers to the unit. AD-A asked R56 if she wanted to read the newspaper. R56 stated she could not see it. AD-A asked R56 if she wanted her to read her the headlines. R56 agreed. AD-A read three or four newspaper head lines and then left. The AD was with R56 for one minute, until 7:39 a.m. AD-A had her coat on and had just arrived to the facility. On 12/22/15, at 12:40 p.m. R56 stated she liked to do things but was unable to do much due to her poor vision. R56 stated when she could see she would knit, crochet and do needle work. R56 stated she loved to read books and read the newspaper every day. R56 had books on tape at home and the books on tape were mailed to her home. "It was pretty good" but she was not able to go get them at the facility. R56 stated she had not been asked if she wanted books on tape while at the facility. R56 stated "yesterday someone read me the front page newspaper stories and that was the first time." R56 would like the newspaper read to her on a regular basis as she liked to hear the news of what was going on. R56 stated there was nothing on the activity calendar she would like to go to because she could not see to do it. She was also reluctant to attend because someone had to escort her to and from the activity. R56 liked to listen to the music on the television. On 12/22/15, at 1:12 p.m. AD-A was interviewed and stated activity staff usually saw R56 in the morning. Mid afternoon R56's husband came and he stayed until after supper. R56 attended exercise group in the morning and the activity staff did "a lot" of 1:1s with her. AD-A stated R56's 1:1's depended on what was going on, they would discuss the weather, the news or read the	{F 248}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 248}	Continued From page 5	{F 248}		

newspaper. AD-A stated she read R56 the headlines that morning. AD-A further stated R56 listened to the television and napped. Activity staff documented what activities residents did but did not document the amount of time spent with the resident. The AD stated a 1:1 visit should be a minimum of five minutes but some were longer.

R11 was not provided with meaningful activities, tailored to her diminished cognitive level. R11's diagnosis report indicated diagnoses that included dementia, pain, weakness and palliative care.

R11's quarterly Minimum Data Set (MDS) dated 9/15/15 indicated she had severely impaired cognition, and required extensive assistance or was totally dependent upon others for her activities of daily living (ADL's).

R11's 12/11/15 Activities Care Plan indicated R11 was independent in choice of activity and enjoyed being around others.

On 12/21/15, at 10:58 a.m., R11 was observed sitting in her wheelchair, positioned directly in front of the TV in the second floor day room. R11's back was to the nurse's station and the rest of the area. There were 8 residents in the day room. 3 residents, including R11, were in positioned in their wheelchairs facing the TV. All three were sleeping. There was an exercise activity going on in the second floor dining room at this time.

On 12/21/15, from 1:34 p.m. until 1:44 p.m., R11 was in her wheelchair, which was positioned in front of the second floor birdcage, alone. R11 was leaning forward in her wheelchair fidgeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 248}	Continued From page 6	{F 248}		

with her hands and pants; she was not watching the birds. During this time, several staff walked by however, no one acknowledged R11.

On 12/21/15, at 1:44 p.m., Family Member (FM)-A came to visit R11, talking, singing and complimenting her. R11 responded with positive verbal noises, but not intelligible words. FM-A continued to interact with R11.

In an interview on 12/21/15, at 2:06 p.m., FM-A stated he visited R11 daily during the week. FM-A stated R11 is invited to activities, but there are not enough activities. When asked, FM-A stated they do not have any activities specific for someone with dementia. FM-A also stated activity staff are excellent but are not able to spend much one-on-one time with R11.

On 12/21/15 at 2:14 p.m., a hospice volunteer arrived and was still with R11 and FM-A when observations ended at 2:50 p.m.

On 12/22/15, at 7:10 a.m., R11 was dressed, in her wheelchair and positioned facing the second floor birdcage, alone. R11 was in the same area at 7:30 a.m.

On 12/22/15, at 9:19 a.m., R11 was in her wheelchair, positioned directly in front of the TV. R11 was not attending the program, but had her head down facing her lap.

In a telephone interview on 12/22/15, at 1:12 p.m., the Activity Director (AD)-A stated that R11's family came almost daily. AD-A stated that if R11 comes to activities, she was usually sleeping. AD-A also stated R11 loved to be around other people and music, stating, "that's important to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 248}	Continued From page 7 her."	{F 248}		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed ensure the care plan was followed for pressure ulcer interventions for 1 of 3 residents (R56) reviewed for pressure ulcers. Findings include: R56's Resident Admission Record dated 12/21/15, indicated R56's diagnoses included a stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling), type two diabetes, and morbid (severe) obesity. R56's Pressure Ulcer care plan edited 10/28/15, indicated R56 was at risk for pressure ulcers. The care plan directed R56 was to have a pressure reducing mattress on the bed and a pressure relieving cushion in the wheelchair. The care plan further directed staff to elevate bilateral lower extremities on a pillow with no pressure to the heels. No blue boots on when in bed but was to have the blue boots on when in the wheelchair. On 12/21/15, the following was observed: At 10:40 a.m. R56 was observed lying on the bed on her back. R56 did not have any pillows under	F 282	F282 Resident 56 skin integrity has been re-assessed. The kardex and care plan have been reviewed and updated based on the assessment. OT completed an evaluation 1/7/16. Recommendations are being implemented, and care plan is updated. IDT reviewed all residents and identified residents to be at high risk for wound development. These residents will be reassessed and care plans and kardex by 1-19-16 All residents with a wound will have their care plan reviewed and updated as indicated. An audit will be completed 5 x/week rotating shifts. Staff will remain current on care plan changes through the Care Plan Change Process The impaired Skin/Tissue Integrity Policy was reviewed and meets current standards. The DON is responsible for the audits. Analysis of the facilities compliance to all	1/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8 her legs and her heels were on the mattress. At 11:30 a.m. R56 was observed to have stockings on her feet with her heels on the mattress. R56 did not have any pillows under her legs. At 1:55 p.m. R56 was observed to have stockings on her feet with her heels on the mattress. R56 did not have any pillows under her legs. At 2:00 p.m. nursing assistant (NA)-Stated R56 got up for lunch at about 12:10 p.m. and then went back to bed about 1:30 p.m. During constant observations from 2:15 p.m. to 3:52 p.m. R56 was observed lying in her bed with a pillow under her left side near the shoulder. R56 had stockings on her feet with her heels on the mattress. R56 did not have any pillows under her legs. On 12/21/15, at 3:52 p.m. two NA's entered R56's room. NA-L moved the pillow under R56's left side to the right side. R56 was observed to have a large foam dressing on the left hip. NA-L stated she had the pillow under her legs only at night because she kicked them out during the day. On 12/21/15, at 4:00 p.m. registered nurse (RN)-C stated R56's legs should be up on pillows to float the heels. The RN placed a pillow under each leg to float the heels. On 12/21/15, at 3:56 p.m. R56 stated she liked having the pillows under her legs during the day because they kept her heels from hurting. R56 stated her heels hurt "just a little now." R56 also stated no one had offered to put her legs up on a pillow to float her heels. A pressure ulcer policy was requested and not	F 282	corrections and improvements will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will ensure identification and implementation of necessary changes to systems as indicated, and determine the need for on-going monitoring/auditing after thorough analysis. Compliance will be achieved by 1-19-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 9 received.	F 282		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure new occurrences of bruising were documented and monitored for 3 of 3 residents (R7, R20, R17) reviewed with bruises. Findings include: R7 was observed on 12/21/15, at 10:51 a.m. with bruising below the right eye and around the left eye, the left forehead and left upper arm above the elbow and above the geri sleeves. Geri sleeves were covering both lower arms. R7's Admission Record identified diagnoses that included dementia, diabetes, and spontaneous ecchymosis (pinhead size skin discoloration due to hemorrhage; pinpoint, flat, round red spots under the skin caused by bleeding, pinpoint, unraised, round red spots under the skin caused by bleeding, or purple or red pinpoint spots in the skin or mucous membranes caused by minor hemorrhage).	{F 309}	309 Resident 7 continues to have bruising due to her condition of spontaneous ecchymosis. The care plan has been revised to include the type of bruise that is of concern and potentially reportable. The hairline scratch to eye lid has resolved. Resident 7 has had an OT evaluation to determine additional options for bruise prevention. Resident 20's care plan was reviewed and updated and the care plan change process followed to assure staff awareness. Resident 17 care plan was reviewed and updated and the care plan change process followed to assure staff awareness. A Bruise Protocol has been developed and addresses what bruises are to be monitored and staff trained on January 14, 2016. The Weekly Skin Rounding tool will be	1/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 10 R7's annual comprehensive Minimum Data Set (MDS) assessment dated 11/6/15, indicated R7 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), required total staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating, and had displayed physical behaviors and behaviors directed at others 1-3 days during the 7-day assessment period. R7's care plan edited 12/18/15, identified R7 was at risk for bruising related to long-term steroid use, scratching secondary to itching, thinning skin, history of pemphigoid (a rare skin condition that causes large, fluid-filled blisters on areas of skin that often flex - such as the lower abdomen, upper thighs or armpits), and aging capillaries. The care plan further identified R7 had a history of being resistive and combative during cares which may lead to bruising, and directed staff to lotion skin daily and as needed, ensure arm protectors were on at all times, hoyer lift sling to be padded with sheepskin, if combative, ensure her safety and reapproach later, and monitor bruising prn (as needed). The care plan further directed staff to report bruising that was of unusual nature for resident, such as a hardened area below, open skin, and swelling to the area. The care plan lacked identification of the current significant bruising. The undated care sheets direct staff to report bruising that is of unusual nature for resident such as hardened area below, open skin, swelling to area. R7's physician orders dated 11/2/15, indicated R7	{F 309}	utilized to determine other residents that require bruises be monitored per the new policy. Weekly audits will be completed to assure compliance with Skin Rounding and the new Bruise Policy. Nursing administration is responsible for the audit completion. The DON will monitor bruise data and bring the outcomes to the Quality Council. Analysis of the facilities compliance to all corrections and improvements will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will ensure identification and implementation of necessary changes to systems as indicated, and determine the need for on-going monitoring/auditing after thorough analysis. Compliance will be achieved by 1-19-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 11 had an order for prednisone 7.5 milligrams (mg) every bedtime. The medication administration record (MAR) and treatment administration record (TAR) for 12/1/15-12/22/15, indicated R7's skin tears were being monitored, but lacked monitoring of R7's bruises. The progress notes dated 12/2/15, identified a new skin tear on top of R7's left forearm. The interdisciplinary team (IDT) note dated 12/3/15, to review the skin tear, indicated R7's skin is very fragile and does bruise or tear very easily. R7's progress note dated 12/14/15, indicated R7 had bruises to the inner aspect of bilateral elbows and posterior calves, and they were documented weekly until resolved. The documentation lacked measurements, characteristics, and causes of the bruises. The progress notes dated 12/16/15, identified a new skin tear on R7's eye lid that occurred during morning cares. the progress notes indicated this was reviewed on 12/18/15 with the IDT. The progress notes lacked a weekly skin note, until 12/20/15, which indicated R7 had many bruises, but no new skin issues or bruises that week. The documentation lacked measurements and characteristics of R7's bruises. R7's annual Skin Risk Assessment with Braden Scale dated 10/31/15, R7 had discoloration to the face that looked like bruising, but was very faint gray in color. R7 had bruises to the upper arms and abdomen that was likely due to insulin injections, in various stages of healing. The	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 12	{F 309}		

assessment further indicated R7's bruising/discoloration to the forearms were in various stages of healing. The documentation lacked measurements of the bruises.

R7's routine nurse practitioner (NP) visit note dated 11/2/15, indicated R7 had a a history of bruising very easily and family was aware of that. The NP identified several areas of faint ecchymosis to her face, multiple areas of dark ecchymosis to her arms, legs, and abdomen, and indicated there was no evidence of trauma or injury to underlying skin. The NP noted a contributing factor is chronic steroid use and the plan included wearing arm protector sleeves and staff to report to NP any skin breakdown or breaks in skin integrity.

R7 was observed on 12/22/15, at 9:44 a.m. with additional dark bruising on the right upper arm above the geri sleeves. The dark discoloration from bruising was visible through the geri sleeve on the left arm that extended from above the left elbow approximately half way down the left arm and also on top of the left hand. There was a darker bruise on the right side of her face, in front of her ear, that was not raised, swollen, or reddened around it.

During an interview on 12/22/15, at 9:54 a.m. the director of nursing (DON) verified all the bruises on R7's face and arms. The DON stated they are not new because they are not hard underneath. The DON stated R7 bruises even with light washing of the face. The DON stated they are not measuring and tracking each one and stated they would know if it was new if it was hard underneath and swollen. If it were new, they would report it, but it would be a full time job to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 13	{F 309}		

keep track of each one. The DON stated stated her skin is so fragile, she got a skin tear form wiping away crust in the corner of the eye.

During interview on 12/22/15, at 12:52 p.m. licensed practical nurse (LPN)-C stated R7 bruised easily and they don't dissipate; the bruising color stays. LPN-C stated if the bruises are new, they are more purple. LPN-C stated they implemented a form on bath day. The nursing assistant (NAR) will look at the skin and if there is something new, they will go over the skin with the LPN, and it would be reported to the RN. The RN would take it from there. LPN-C stated they look at R7's skin weekly. LPN-C stated the staff know R7, so if there is something new, they would know it.

During an interview on 12/22/15, at 1:11 p.m. the DON stated staff would know if R7 had a new bruise, as it would look fresher and redder. The DON stated they put new bruises on the MAR for monitoring. The DON again stated they do not measure R7's bruises and stated they would get bigger before they got smaller. The RN decided how often they are monitored, but for R7 they would be monitored daily. The DON stated only the reportable ones are put on the medication administration record (MAR) and monitored, and they would be the ones that are hard and swollen.

R20's progress notes dated 12/14/15, identified a bruise on the left inner thigh that was purplish-black in color that caused R20 mild discomfort. The potential cause of the bruise was identified. No measurements were included in the documentation. Further notes indicated the IDT discussed the bruise and interventions were implemented. R20 was able to communicate her needs.

R20's admission record identified diagnoses that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 14 included peripheral vascular disease (circulation problems in the extremities), rash and other nonspecific skin eruption, other skin changes-red skin. R20's quarterly MDS dated 9/25/15, indicated R20 was cognitively intact, had not displayed physical behaviors, and required extensive assistance from staff for bed mobility, transfers, dressing, and toilet use. R20's care plan edited 6/9/15, directed staff to observe skin with cares and report any changes to a licensed nurse. The care plan lacked identification of bruises and the potential for bruising. R20's undated care sheet lacked directives regarding bruising. A Skin Integrity Event regarding R20's bruise on the left inner thigh dated 12/14/15, indicated R20 would be monitored for changes in skin and current bruise would be documented until completely resolved. The progress notes lacked further monitoring or documentation regarding the bruise. R20's progress notes dated 12/17/15, indicated there were no skin issues except the bruise which had been noted previously. No measurements or characteristics of the bruise were documented. R20's quarterly Braden Scale (an assessment to help determine resident's risk for skin breakdown) dated 9/22/15, indicated staff were to observe skin with cares and report any changes to the licensed nurse and the licensed nurse was to observe R20's skin weekly per protocol. R20's MAR and TAR from 12/1/15-12/22/15, lacked monitoring of bruise on left upper thigh. During an interview on 12/22/15, at 7:28 a.m. R20 stated she had bruised easily all her life and identified the current bruise on the left upper thigh. R20 was able to identify the cause of the	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 15 bruise. During an interview on 12/22/15, at 12:50 p.m. LPN-C verified there were no measurements recorded of the bruise on the left upper thigh. LPN-C stated the protocol is to measure the bruise and put it on the TAR to document weekly and monitor until resolved. LPN-C verified the protocol was not followed for R20's bruise. R17's progress notes dated 12/19/15, identified bruising to bilateral forearms. The note indicated measurements and locations were documented on the event. R17's admission record identified diagnoses that included diabetes, iron deficiency anemia, adult failure to thrive (decreased nutritional intake), and dementia. R17's quarterly MDS dated 11/25/15, indicated R17 had a severe cognitive impairment (memory loss), required extensive staff assistance with bed mobility, dressing, toilet use and personal hygiene, and total assistance with transfers. The MDS further indicated R17 displayed physical behaviors 1 to 3 days of the 7 day assessment period for the MDS. R17's care plan edited 11/13/15, directed staff to observe skin with cares and report any changes to the licensed nurse. R17's care plan edited 10/27/15, indicated R17 displayed physical behaviors toward staff and rejected care at times. The care plan lacked identification of R17's bruise and potential for bruising. R17's care sheet lacked identification of bruising. A weekly progress note dated 12/21/15, indicated R17 had some bruises on arms. The progress note lacked measurements of bruises.	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 16 In progress notes dated 12/21/15, the IDT noted bruises to bilateral arms. The cause was potentially identified and change in medical status was discussed. A Skin Integrity Event regarding bruises dated 12/19/15, identified bruises on R17's bilateral arms with measurements as follows: -Right lower forearm by wrist 1 centimeter (cm) x 1 cm -Right top of hand 0.5 cm x 0.5 cm -Left lower forearm by wrist 1.5 cm x 1 cm -Left inner forearm 2 x 1 cm -Left inner forearm next to previous 0.8 x 0.8 cm The Braden Scale skin assessment dated 12/13/15, indicated R17 had no areas of skin concerns at that time. The hospital return Skin Risk Assessment dated 12/8/15, indicated R17 had bruises on the top of both hands and wrist area, and a bruise on the top of the left calf. The MAR and TAR lacked monitoring of bruises. During an interview on 12/22/15, at 12:39 p.m. LPN-C, stated all bruises should be put on the MAR for monitoring. LPN-C verified R17's bruises were not entered on the MAR per their protocol. LPN-C stated bruises should be put on the MAR and documented on weekly. LPN-C observed R17's bruises and verified they were fading bruises. A policy and procedure for bruising was requested and not provided. The facility provided an undated Weekly Skin Observation Tool, which indicated each week the NAR will complete the form above and report all bruises, skin conditions, concerns to the LPN. The LPN will document weekly on skin based on this report and the RN will be updated accordingly.	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services to reduce the risk of pressure ulcers for 1 of 3 residents (R56) reviewed for pressure ulcers. Findings include: R56's Resident Admission Record dated 12/21/15, indicated R56's diagnoses included a stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling), diabetes, morbid (severe) obesity and chronic kidney disease. R56's quarterly Minimum Data Set (MDS) dated 11/25/15, indicated R56 had moderate cognitive impairment and did not have any behaviors or rejection of cares. R56 required the extensive assistance of two staff with bed mobility, total assistance of two staff with transfers. R56 did not walk, was at risk for pressure ulcers, did not have any unhealed pressure ulcers. R56 had pressure reducing devices in the chair and on the bed and	{F 314}	F314 Resident 56 skin integrity has been re-assessed. The kardex and care plan have been reviewed and updated based on the assessment. OT completed an evaluation 1/7/16. Recommendations are being implemented, and care plan is updated. IDT reviewed all residents and identified residents to be at high risk for wound development. These residents will be reassessed and care plans and kardex by 1-19-16. All residents with a wound will have their care plan reviewed and updated as indicated. LNs and managerial staff will audit for skin care plan compliance 5x/week rotating shifts. Results will be reviewed by Quality Council. The impaired Skin/Tissue Integrity Policy was reviewed and meets standards. The DON is responsible. Analysis of the facilities compliance to all	1/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 18 was on a turning and repositioning program. The Care Area Assessment (CAA) dated 8/24/15, indicated R56 had a post surgical graft with open wounds from a burn. Staff assisted with bed mobility and to turn and reposition R56 every two hours and as needed. R56 had a pressure redistribution mattress on the bed and a cushion in the wheelchair to aid in the healing and prevention of pressure ulcers. R56's Pressure Ulcer care plan edited 10/28/15, indicated R56 was at risk for pressure ulcers. The care plan directed R56 was to have a pressure reducing mattress on the bed and a pressure relieving cushion in the wheelchair. The care plan further directed staff to elevate bilateral lower extremities on a pillow with no pressure to the heels. No blue boots on when in bed but was to have the blue boots on when in the wheelchair. The Kardex (not dated) indicated R56 had wounds on her right and left buttocks hip area, and a surgical wound to the right posterior buttock hip area, not to have the blue boots on when in bed but to float the heels with pillows. R56 was in the hospital from 12/11/15, through 12/15/15. The Hospital Discharge Summary dated 12/15/15, indicated R56's hospital course included admission for cellulitis of bilateral hip pressure ulcers. Wound cultures were obtained and IV antibiotics were provided. R56's confusion improved and physical therapy made recommendations for wound treatment. A Hospital Return Skin Assessment dated 12/18/15, R56's legs continued to have edema. R56 had an slit on the coccyx that was now healed. A Braden Scale (a tool used for determining pressure ulcer risk) indicated R56 was at moderate risk for skin breakdown. R56's risk factors included the diagnoses of hypertension, type two diabetes, atrial fibrillation,	{F 314}	corrections and improvements will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will ensure identification and implementation of necessary changes to systems as indicated, and determine the need for on-going monitoring/auditing after thorough analysis. Compliance will be achieved by 1-19-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 19 anemia, congestive heart failure, neuropathy, osteoarthritis, chronic kidney disease and impaired vision. The assessment further indicated R56 was also at risk due to a decline in functional status, the need for assist from staff for all cares, transfers, bed mobility, lower extremity edema, obesity, third degree burn and a history of pressure ulcers. R56 had a pressure redistribution mattress on the bed and cushion in the wheelchair. The assessment further indicated to elevate bilateral lower extremities on pillows and no pressure to the heels. A Progress note dated 12/21/15, at 4:17 p.m. indicated R56's heels were on the bed. Blanching to the left heel was noted with no blanching to the right heel. Pillows were used to float R56's heels. Staff reported the care plan was not followed and staff was reeducated. On 12/21/15, the following was observed: At 10:40 a.m. R56 was observed lying on the bed on her back. R56 did not have any pillows under her legs and her heels were on the mattress. At 11:30 a.m. R56 was observed to have stockings on her feet with her heels on the mattress. R56 did not have any pillows under her legs. At 1:55 p.m. R56 was observed to have stockings on her feet with her heels on the mattress. R56 did not have any pillows under her legs. At 2:00 p.m. nursing assistant (NA)-Stated R56 got up for lunch at about 12:10 p.m. and then went back to bed about 1:30 p.m. During constant observations from 2:15 p.m. to 3:52 p.m. R56 was observed lying in her bed with a pillow under her left side near the shoulder. R56 had stockings on her feet with her heels on the mattress. R56 did not have any pillows under her legs.	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 20 On 12/21/15, at 3:52 p.m. two NAs entered R56's room. NA-L moved the pillow under R56's left side to the right side. R56 was observed to have a large foam dressing on the left hip. The NA stated she had the pillow under her legs only at night because she kicks them out during the day. On 12/21/15, at 4:00 p.m. R56's heels were observed with registered nurse (RN)-C. The RN stated the left heel was red and blanched and the right heel was red but did not blanch. R56 denied pain. The RN stated R56's legs should be up on pillows to float the heels. The RN placed a pillow under each leg to float the heels. On 12/21/15, at 3:56 p.m. R56 stated she liked having the pillows under her legs during the day because it kept her heels from hurting. R56 stated her heels hurt "just a little now." On 12/22/15, at 7:10 a.m. R56 was observed up in the wheelchair. R56 had stockings on her feet. No heel boots were observed on. At 9:25 a.m. R56 was put back in bed on her back with a pillow under each leg and her heels floated off the mattress. At 9:55 a.m. wound care was observed with licensed practical nurse (LPN)-B. R56's right hip graft site was observed to have one large and three smaller open areas. On the left hip R56 had an open area that extended down the leg approximately six inches. The wound bed was black. The dressing LPN-B removed from the left hip had dark dried drainage on it. LPN-B stated the area on the left hip was just a bruise prior to going to the hospital. R56's heels were observed with LPN-B and had no redness. A pressure ulcer policy was requested and not	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 21 received.	{F 314}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor for side effects and efficacy, obtain appropriate diagnoses for justification for use of, and provide informed consent for psychotropic medications for 3 of 3 residents (R3, R18, R40) reviewed for	{F 329}	F329 Resident 3 Risperidone use was reviewed by the Consultant Pharmacist; the Nurse Practitioner and the Clinical Managers on 1-4-16. Side Effect monitoring was completed on 12-21-15.	1/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 22 unnecessary medications. Findings include: R3 was not monitored for side effects for use of risperidone (an antipsychotic medication). R3's Admission Record identified diagnoses that included dementia and major depressive disorder. The Physician Order Report for 12/1/15-12/31/15, ordered risperidone 0.25 milligrams (mg) by mouth at bedtime for a diagnosis of frontotemporal dementia. The quarterly Minimum Data Set (MDS) dated 10/5/15, indicated R3 was cognitively intact. The care plan dated 10/11/12, identified R3 was at risk for side effects of psychotropic medication use, and to refer to Medication Administration Record (MAR) for specifics. It further indicated R3 would not develop side effects of psychotropic medication use, and to monitor for side effects per protocol. Review of the MAR for 12/15, lacked indication of monitoring for side effects of risperidone. R18 was not monitored for side effects of risperidone and olanzapine (antipsychotic medications). R18's Admission Record identified diagnoses that included dementia, anxiety, delusions, depression, and psychosis. The Physician Order Report for 12/1/15-12/31/15, ordered risperidone 1 mg every morning, and 2 mg at noon and bedtime, and olanzapine 5 mg in the morning, and 10 mg at noon and at bedtime. The annual MDS dated 11/11/15, indicated R18 was cognitively intact. The care plan dated 8/15/07, identified R18 was at risk for side effects of	{F 329}	Consent including the black box warning was obtained. Resident 18 has a primary diagnosis of Schizophrenia. Risperidone use was reviewed by the Consultant Pharmacist; the Nurse Practitioner and the Clinical Managers on 1-4-16. The care plan has been reviewed and updated. Side effect monitoring was completed on 11/9/15 but lacked orthostatic hypotension measurements. These measurements were obtained on 1/6/16. Resident 40 P has had Risperidone use reviewed by the Consultant Pharmacist; the Nurse Practitioner and the Clinical Managers on 1-4-16. Consent for use of Risperidone has been signed by the resident and her sister (who is seeking guardianship) and this includes the black box warning. Side effect monitoring was completed on 12-28-16. Resident 3, 18 and 40 have had an IDT Assessment and the Behavior Management care plan updated. All residents on an antipsychotic have been reviewed for side effect monitoring, consents to specifically include the black box warning and for the diagnosis for use. Also an order has been entered into the MAR for those residents on an antipsychotic to obtain glucose level and for lay/sit/stand blood pressures (as appropriate) to review for orthostatic hypotension quarterly. All residents on an antipsychotic will have a Behavior Management Observation completed by the IDT; the team will complete 3 observations per week. Others on a Behavior Management Program will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 23 psychotropic medication use, and to refer to the MAR for specifics. The care plan further indicated R18 would not develop side effects of psychotropic medication use, and to monitor for side effects per protocol. Review of the MAR for 12/15, lacked indication of monitoring for side effects. On 12/22/15, at 9:01 a.m. licensed practical nurse (LPN)-C was interviewed, and stated the facility did not monitor for side effects of medication on the MAR. On 12/22/15, at 9:43 a.m. registered nurse (RN)-C was interviewed and stated the facility monitors for side effects of psychotropic medication quarterly, or when the resident has a change in their medication. On 12/22/15, at 12:08 p.m. the director of nursing (DON) was interviewed and verified the facility did not monitor for side effects of antipsychotic medication on the MAR or in the care plan. The DON stated she would expect the licensed nurses and the nursing assistants to report any changes in a resident to the RNs. The DON further stated side effect monitoring was done quarterly. R40 received risperidone (antipsychotic medication for which the listed indicated use is for schizophrenia and bipolar disease in adults) for diagnoses of restlessness, agitation, and unspecified mood disorder. On 12/7/15, R40's risperidone dosage was increased for grief and agitation. R40's face sheet printed 12/21/15, indicated diagnoses included unspecified mood disorder,	{F 329}	have the observation completed following the RAI schedule. The Behavior Management Policy has been reviewed and revised. The Behavior Monitoring Tool has been revised and staff trained on 1-14-16. These tools will be reviewed monthly by the Clinical Manager and a summary provided in the Behavior Management Observation. Staff was trained on the new policy and tool on 1-14-16. LPNs and NARs have received training on potential side effects of antipsychotic medications on 1-14-16. Additionally this list is placed in each medication room and each RN station for ready reference of staff. The Social Service Designee will audit all those requiring a Behavior Observation monthly for policy compliance and to review for effectiveness of plans and report concerns to the Quality Council for a minimum of one quarter and then as determined by the Quality Council. The Consultant Pharmacist will monitor and report quarterly to the Quality Council. Analysis of the facilities compliance to all corrections and improvements will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will ensure identification and implementation of necessary changes to systems as indicated, and determine the need for on-going monitoring/auditing after thorough analysis. Compliance will be achieved by 1-19-16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 24 Alzheimer's disease, dementia without behavioral disturbance, anxiety disorder, obsessive-compulsive disorder, restlessness and agitation, major depressive disorder, conduct disorder/aggression, and dementia with delusions. R40's quarterly Minimum Data Set (MDS) completed 10/28/15, indicated R40 had a severe cognitive impairment, and had no symptoms of delirium or mood symptoms. The MDS indicated behaviors included rejection of cares, verbal behaviors and other behaviors 1-3 days during the assessment period for the MDS. The MDS indicated there were no physical behaviors at that time. R40 had received an antipsychotic and antidepressant medication at least daily during the assessment period. R40's care plan dated 10/28/15, indicated R40 was at risk for side effects of psychotropic medication use. It directed the staff to: monitor for medication side effects per protocol, review medication use for potential side effects and actual side effects with the resident and family per the facility protocol, review medication use with the physician, pharmacy consults per protocol, daily behavior observations to be completed and the Abnormal Involuntary Movement Scale (AIMS - assessment for a neurological side effects) to be done per protocol. R40's undated signed physician orders for 12/1/15 - 12/31/15, included orders for risperidone 0.25 milligrams (mg) twice daily for restlessness and agitation and risperidone 0.5 mg at bedtime for restlessness and agitation. In addition, the physician orders included an order for risperidone 0.25 mg every 4 hours as needed	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 25 (PRN) for diagnosis of unspecified mood (affective) disorder. On 12/7/15, R40 was seen by the primary care physician for a routine follow-up visit, and was accompanied by a sister. R40 had experienced the death of a close family member and had been more agitated and was starting to act out. Grieving, memory, and other things were discussed with R40's sister. The physician's assessment included documentation of assumption of grieving, and the plan was to increase the risperidone to 0.5 mg three times daily. R40's medication administration record (MAR) indicated the risperidone prn was to be given for paranoia/agitation for a maximum of 3 PRN's in a 24 hour period, and staff was to attempt 1:1, snack/beverage, activity, and toileting prior to administration of the PRN. The MAR indicated R40 received the risperidone prn dose on 12/1/15, at 7:40 a.m. and 12/6/15, at 7:39 a.m. for behavioral issues (swearing and yelling out), and 1:1 interventions had been attempted. The documentation indicated the medication was somewhat effective. The Daily Behavior Observation documentation dated 12/1/15 and 12/6/15, on the night shift indicated there were no behaviors, and on the day shift documentation indicated R40 was obsessing over things, sarcastic and rude to other residents. Staff attempted redirection and 1:1's on 12/1/15 and 12/6/15, but did not attempt the 9 other suggested interventions. The Daily Behavior Observation for 12/15, indicated R40 had almost daily behaviors of obsessing, sarcasm and rudeness. The Daily Behavior Observation for 11/15, indicated R40 displayed the same	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 26 behaviors almost daily, prior to the increase in risperidone on 12/7/15. The progress notes dated 12/2/15, indicated behaviors had increased after the death of the close family member and the sister spoke to staff about the behaviors and possibility of needing a medication adjustment. The sister noted the increased flushing of R40's face recently and requested R40's BP be checked daily until the appointment on 12/7/15. R40's blood pressures were checked each morning and ranged from 140-148/90-92. The progress notes prior to 12/7/15, indicated R40 had incidents of striking out or kicking out at other residents on 12/2/15, and frequent sarcasm, swearing, or hollering back at other residents. The progress notes following the increase in risperidone on 12/7/15, indicated R40 kicked out at another resident on 12/19/15, and had some episodes of sarcasm. The progress notes dated 12/6/15, at 9:27 a.m. indicated R40 had not been transferring well that shift. The MAR indicated R40 had received risperidone at 7:39 a.m. The progress notes did not indicate the change in transfers were assessed and the risperidone and other medications were not considered as a contributing factor. The progress notes following the increase in risperidone, dated 12/16/15, 12/19/15, and 12/21/15, indicated R40 was having more difficulty transferring and was not bearing weight. Orders for physical therapy were requested. The progress note dated 12/15/15, indicated the weekly side effect monitoring for the increase in	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 27 risperidone indicated there were no negative effects noted with the increase in medication and R40 continued to be impulsive and easily agitated. The Medication Side Effect Flow Sheet dated 12/15/15, indicated R40 had restlessness, confusion, and agitation that did not hinder functioning. The Side Effect Flow Sheet documentation indicated there were no changes form baseline in confusion or agitation. The orthostatic hypotension and blood sugars were not addressed on the form, though they were listed as part of the monitoring. The electronic Treatment Administration Record (TAR) and MAR did not have side effect monitoring. R40's Mood Interview (PHQ-9), dated 12/7/15 indicated R40 had no symptoms of depression, per resident interview. During an interview on 12/21/15, at 3:08, the director of nursing (DON) stated she did not agree with the Mood Interview, and verified the social work designee should have documented the discrepancies between the interview and the symptoms observed. The facility did fax the physician on 12/18/15, to request an appropriate diagnosis for the use of risperidone. The facility requested a diagnosis of unspecified mood disorder with psychotic episodes from the physician. The updated consent form for risperidone was not in the medical record. The package insert for Risperidone included a boxed warning indicating, "elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death."	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 28 During an observation on 12/21/15, at 11:29 a.m. R40 became agitated and sarcastic with staff when they had to move her wheelchair out of the way, but calmed when settled again. During an interview on 12/21/15, at 11:28 a.m. RN-B verified the consent in R40's medical record was dated 2/15, and stated they need a new consent for the risperidone signed, since the increased dosage. RN-B stated R40's responsible party had recently passed away, so they needed to have someone else sign it. RN-B stated there was side effect monitoring done weekly x 4 weeks with a change in psychotropic medication, and then quarterly. RN-B verified R40 does not see a psychiatric practitioner, but did receive mental health care at another facility within the past year. During an interview on 12/21/15, at 3:08 p.m. the director of nursing (DON) verified the consent for R40's Risperidone was not completed and stated they were waiting for R40's sister to get the legal stuff done and they would address the consent with her. The DON verified the physician could have looked at increasing the antidepressant rather than the antipsychotic for R40's grief and was not sure why the risperidone was increased instead. The DON stated they would ask for the physician's documentation and rationale, but had not done so yet. The DON verified the medication won't change R40's response to grief due to her dementia; R40 will grieve, become upset, forget the loss, and re-experience that grief again when she realized the loss of the close family member, again. The DON stated the increase in risperidone would help with R40's outbursts. The DON was not sure if the behaviors R40 displayed were upsetting to her, but assumed they were.	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 29 The consent form was provided. The black box warning information was not on the consent form and the new increase in risperidone was not noted on the consent form. There was a notation to review the black box warning information with the family on the consent form. During an interview on 12/22/15 at 1:00 p.m. licensed practical nurse (LPN)-C stated the registered nurse (RN) handled all of the medication side effect monitoring and did the AIMS. LPN-C stated she had been a nurse so long, she knew the side effects of the medications. LPN-C also stated she knew the residents very well and would report if they were having symptoms or were over-medicated, but does not do an actual assessment. During an interview on 12/22/15,at 1:05 p.m. the DON stated the side effect monitoring was done quarterly and the staff were to report changes in condition. The DON stated the staff are consistent and they would notice changes in the resident and would report immediately. The DON stated the orthostatic blood pressures are done by an RN quarterly, and with falls and reports of dizziness. The DON stated orthostatic blood pressures were done at the RN's discretion. The DON stated if orthostatic blood pressures are not done, the RN should document why. The DON verified they were not done for R40's side effect monitoring on 12/15/15 and the RN did not document reason it was not done. On 12/22/15, at 1:39 p.m. the DON stated that Abnormal Involuntary Movement Scale (AIMS) is done every six months and psychotropic medication side effect monitoring is done quarterly. The DON stated they are allowing 90	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 30 days for the responsible staff person to inform residents or their responsible party of black box warnings. The DON stated residents have been on these medications for a long time and they are "tip toeing" around how to inform them of the risks. The facility policy and procedure for Psychopharmalogical (sic) medications dated 12/29/14, directed antipsychotic medication should only be used for organic mental syndromes with associated psychotic and agitated behaviors when ALL 4 criteria are met, including: objective documentation that indicated frequency of behaviors to enable assessment for determination of interventions, whether behaviors are permanent or short term, or related to other situations or conditions. behaviors are persistent behaviors are not caused by a preventable reason behaviors affect the resident's functional ability, have psychotic symptoms that are not dangerous, behaviors behaviors that cause the resident distress, or are for short term treatment of symptoms such as hiccups, nausea, vomiting, or itching The policy and procedure further directed a gradual dose reduction should be attempted at least twice a year and side effect monitoring was to include monitoring for postoral (sic) hypotension (low blood pressure related to position changes). The policy and procedure lacked direction for informed consents for psychotropic medications.	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 465}	Continued From page 31	{F 465}		
{F 465} SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 maintain a safe and homelike environment. Findings include: During initial observations on 12/21/15, at approximately 9:00 a.m., the following rooms were observed to be not corrected: Room 206 still had loose carpeting Room 209 still had loose carpeting Room 235 had gouges on the edges of the door and entryway wall. Room 237 had gouges on the built in closet and dresser. In addition, the small chest of drawers had worn areas and there was a gouge exposing the wood Room 140 had a section of loose carpeting Room 137 still had loose carpeting Room 139 still had loose carpeting In an interview on 12/22/15, at 8:45 a.m., the administrator confirmed rooms 235 and 237 still had gouges. Specifically, Room 235 had gouges on the edges of the door and the entryway wall. Room 237 had gouges in the built in closet, on the dresser and the small chest of drawers had	{F 465}	F 465 Audits of all resident rooms regarding carpets were completed prior to re-survey. All rooms identified in the survey will be re carpeted. Rooms 237 And 235 will have final work completed regarding gouges, edges of doors and entry way walls repaired. Environment audits of areas in the Care Center will be completed and reviewed weekly. Analysis of the facilities compliance to all corrections and improvements will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will ensure identification and implementation of necessary changes to systems as indicated, and determine the need for on-going monitoring/auditing after thorough analysis. All Audit results will continue to be monitored by the Plant Operations Supervisor and reviewed with the Administrator. Audits and Plans will be submitted to the Quality Council. Completion date January 19, 2016	1/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 465}	Continued From page 32 worn areas and a gouge exposing wood. The administrator stated the contractor had made it better, "it's not done yet." In an interview on 12/22/15, at 8:45 a.m., the Administrator confirmed that the facility had not yet fixed the rumpled, loose carpets in all of the rooms, specifically rooms 137, 139, 140, 206, 209, and 235. The administrator stated the facility had used carpet tiles to repair one room's flooring (207) and a laminate product in another (136) and they were waiting to see which product held up best. R16's room was not one of those corrected. During the observation on 12/22/15 at 8:45 a.m., there continued to be a small section where the carpet was rumpled. R16's latest admission record, dated 1/6/15, indicated diagnoses that included osteoarthritis, dementia, difficulty in walking, visual field defects and vertigo. R16's quarterly Minimum Data Set (MDS), dated 11/23/15 indicated R16 was cognitively intact, independent with walking and used a walker. R16's 11/9/15, care plan indicated she was at risk for falls. On 12/22/15, at approximately 12:45 p.m., R16 was observed walking independently using a walker out of the bathroom to the bedroom. In an interview on 12/22/15, at 12:51 p.m., the administrator stated the facility has seven rooms that still need carpet repaired or replaced based on the original survey, however the facility felt that additional rooms needed upgraded flooring as	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	R 12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 465}	Continued From page 33 well.	{F 465}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245277	A. Building B. Wing	12/22/2015

Name of Facility	Street Address, City, State, Zip Code
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/02/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **12/02/2015**
ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/02/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **12/02/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	01/04/2016	34983	12/22/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/23/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245277	A. Building B. Wing **01 - MAIN BUILDING 01**	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **11/01/2015**	ID Prefix	Correction Completed **10/28/2015**	ID Prefix	Correction Completed **11/30/2015**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0046		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **11/30/2015**	ID Prefix	Correction Completed **11/30/2015**	ID Prefix	Correction Completed **11/11/2015**
Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **11/30/2015**	ID Prefix	Correction Completed **12/06/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0067		Reg. # **NFPA 101** LSC K0076		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	12/31/2015	27200	12/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/22/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3N4L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **10/23/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Kathie Killoran, HFE NEII — 12/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 6, 2015

Mr. Michael Schultz, Administrator
St Raphaels Health & Rehab Center
601 Grant Avenue
Eveleth, MN 55734

RE: Project Number S5277025

Dear Mr. Schultz:

On October 23, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
lyla.burkman@state.mn.us
Telephone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 2, 2015, 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 December 2, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 January 23, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2016 (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:

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
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		12/2/15

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

Electronically Signed | 11/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal privacy for 1 of 5 residents (R18) observed nude while in bed without privacy provided. In addition, the facility failed to administer insulin injections in a private area for 2 of 3 residents (R56, R23) observed to receive insulin in a public area. Findings include: R18 was not provided privacy while lying nude in bed, which exposed his body to others. On 10/21/15, from 7:09 a.m. until 7:49 a.m. R18 was observed lying nude in bed without covers or the privacy curtain pulled. R18's incontinent brief was on the floor and could be observed from all angles of the doorway. R18 repositioned himself from from front to back during this time. R18's nude body could easily be observed by anyone walking by the room or peering into the room. On 10/21/15, at 7:58 p.m. nursing assistant (NA)-B reported R18 frequently removed the incontinent brief and was nude in bed.	F 164	F 164 St. Raphael's honors privacy and confidentiality of resident information. Res. 18 has had a bowel and bladder tracking completed to determine what signs he displays with regards to his elimination needs and the care plan has been updated. Due to Resident 18's schizophrenia and fear triggered when he cannot see out of his room the facility has not forced his curtain or room door to be shut. The plan will be to try to ease the resident to allow the curtain to be pulled to attempt to prevent the line of vision to the resident and to gradually close the door to maintain the resident's privacy. The combination of the pulled privacy curtain and the partially closed door blocks the view of other residents in to the room protecting them from the potential exposure to nudity. Nursing will attempt to teach the resident to place his brief in a garbage receptacle, which has been relocated out of line of site of open door to hallway in order to protect other residents from being exposed to resident's nudity. Resident 18 has been reassessed for bowel and bladder and his disrobing and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 On 10/22/15, at 2:09 p.m. NA-F reported it was common for R18 to be in bed nude with the incontinent brief on the floor. NA-F also reported staff had not been instructed on ways to maintain R18's privacy. On 10/23/15, at 1:27 p.m. the director of nursing (DON) verified lying nude in bed was a privacy issue for R18 and reported the facility intervened the best they could. The DON also verified the facility did not have a care plan for staff to follow regarding maintaining R18's privacy when R18 disrobed. R56 was observed to receive an insulin injection while in the dining room. R56's Diagnoses Report active from 10/1/15, through 10/31/15, identified diagnoses that included type two diabetes. A annual Minimum Data Set (MDS) dated 8/29/15, indicated R56 had no cognitive impairment. On 10/21/15, at 8:04 a.m. licensed practical nurse (LPN)-B approached R56 while in the first floor dining room and asked R56 if she could give R56 the insulin in the dining room. R56 stated, "yes." Present in the dining room were several other residents including two residents at R56's table. LPN-B did not ask any of the other residents in the dining room if it bothered them to see R56	F 164	the care plan was updated on 11-12-15. Social worker will obtain alternative clothing for this resident to hinder his ability to disrobe All staff will intervene as best able when res. 18 begins to disrobe or comes in nude to common areas and utilize robe provided and redirect resident to room for appropriate cares. Common areas will be monitored by all departments for signs of R18's disrobing so that they may intervene with residents inappropriate disrobing, and staff will advise other residents to respectfully turn their attention away from this. Residents in proximity will be assessed by the social service designee if they are bothered by the resident's nakedness and will establish a plan for them to be protected Social service will ask residents that have witnessed this nudity "how does this affect you?" All staff will intervene to pull privacy curtain and partially shut door to R18's room while resident is in room to obstruct view from hallway in to the room, protecting other residents from being exposed to R18's potential episodes of nudity. Additionally a bathrobe will be kept in the lobby to allow for quick covering on the resident should he disrobe in common areas, and staff will redirect or escort to room to redress Resident 56 and 23 will be corrected for privacy relating to medication administration as the policy MEDICATION ADMINISTRATION BY ROUTE has been revised for delivery of care and service to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 3 receive an injection. LPN-B lifted R56's shirt exposing the left abdomen and injected the insulin into the left abdomen. LPN-B stated "I just want you to know I gave R56 her insulin in the dining room because that's where she wants it." On 10/22/15, at 10:00 a.m. LPN-B stated she had never asked the other residents in the dining room if they minded if she gave R56 her insulin in their presence. R23 was administered an insulin injection in a public area. R23's Admission Record identified diagnoses that included diabetes. The quarterly MDS indicated R23 was cognitively intact and required staff assistance with bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing. The physician's orders dated 5/18/15, directed Novolog insulin 4 units subcutaneous three times a day before meals. On 10/21/15, at 7:53 a.m. LPN-A was observed administering R23's insulin while R23 was in the hallway by the elevator. LPN-A stated R23 always got his insulin in the hallway as R23 ate breakfast on another floor and she tried to get medications to as many residents as she could before they went to breakfast. On 10/22/15, at 2:33 p.m. the DON stated she was unaware residents should have privacy during insulin administration.	F 164	be completed in an area where others cannot observe, unless per resident request, such as a family member may be present. This will also assure all are residents' privacy is being respected. The Dignity Policy was revised and nursing staff received training on the policy on 11-23-15. Audits for compliance with the new policy will be completed daily until compliance is achieved. Audits for compliance include auditing for attire, toileting, personal care, injections, conversations, hygiene, privacy or personal items. Staff will be reeducated upon occurrence. Once compliance will then be completed weekly to assure compliance is maintained. Daily shift audits, while R18 is in his room, to ensure the privacy curtain is pulled and the door is partially shut obstructing the view from the hallway into the room will be conducted to honor the rights of the other residents to not be exposed to potential episodes of nudity, until placement of curtain and door is habitual. Monthly IDT meetings will be held to review audits relating to this plan of correction to assure educations are being provided as needed, and solutions are being sustained. The Clinical Managers are responsible to audit. Findings will be presented to Quality Council. Date certain is 12-2-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 4 The facility policy and procedure on Dignity and Respect dated 8/17/05, directed the following: Privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident's safety. Resident's dignity shall be promoted by assuring appropriate attire, personal hygiene, grooming, and utilization of name preferences. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passer-by.	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide evaluation for the use of a restraint device to ensure the least restrictive device/intervention for 1 of 1 resident (R37) reviewed for physical restraints. Findings include: On 10/20/15, at 8:00 a.m. R37 was observed	F 221	221 Resident 37 has had a Restraint assessment completed and the Care plan has been updated on 11-10-15. Two others in facility utilize a w/c belt. Both have had a restraint assessment completed including ability to remove the restraint per self and the care plans and nursing assistant reference sheets updated. Care Plan Change forms now have a designated area to be placed so the Clinical Managers are assured to be	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 5 seated in the wheelchair in the dining room with a belt secured across his chest. The belt was secured to each side of the wheelchair on the bars between the seat and the handles. -At 8:09 a.m. the director of nursing (DON) discussed with R37 about cutting up his grapes. The chest belt remained across R37's chest. -At 8:18 a.m. R37 received breakfast from nursing assistant (NA)-D. NA-D did not release the chest belt. -At 8:35 a.m. NA-D sat at the same table as R37 and assisted the tablemate with breakfast. NA-C was seated at the next table assisting another resident with eating. -At 8:38 a.m. NA-D cut R37's toast. NA-D did not release the chest belt. -At 8:48 a.m. R37 was removed from the dining room. R37's Resident Admission Record (undated) indicated R37's diagnoses included Parkinson's disease, disorientation, dementia with Lewy bodies, other mental disorders due to known physiological condition, increased confusion, abnormal posture and depression. R37's quarterly Minimum Data Set (MDS) dated 8/6/15, indicated R37 had no cognitive impairment and had hallucinations. R37 needed total assistance of two staff with bed mobility, transferring and toilet use. R37 did not walk. R37 had two or more falls since the prior assessment and received an antipsychotic medication on seven of seven days during the assessment period.	F 221	made aware. The CARE PLAN CHANGE FORM policy was reviewed and is appropriate. An assessment audit tool will be used to assure compliance with assessments and accuracy with care plans. Audits will be completed for all residents for one quarter until compliance achieved and then randomly to assure compliance is maintained. The RAI Coordinator is responsible for audits. Care plan interventions will be audited daily until compliance is achieved and then weekly to assure compliance is sustained. DON is responsible for these audits. Date certain is 12-2-15. Findings will be presented to Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 6	F 221		

R37's care plan dated 10/2/15, indicated R37 was at risk for falls related to short term memory with impaired decision making skills, incontinence, balance problems, the use of psychotropic medications and weakness. The care plan dated 6/14/10, indicated R37's mobility deficits included transfers, walking, bed mobility and wheelchair mobility. R37 could be variable with some mobility related to Parkinson's disease. Approaches included allow R37 to wear the chest strap.

R37's A Care Plan Change Sheet dated 7/9/15, indicated a care plan change included a directive to allow R37 to wear the chest strap when up in the wheelchair as tolerated. The Change Sheet directed staff read this change in care plan in report every shift for one week.

R37's Occupational Therapy (OT) Treatment Notes consisted of the following:
7/8/15: Applied the chest strap.
7/21/15: R37 was happy with the chest strap.
7/30/15: R37 continued to use the chest strap.
7/31/15: R37 was upright in the wheelchair with the chest strap on.
8/3/15: R37 was observed in wheelchair at breakfast. R37 had no complaints of pain or discomfort from the use of the chest strap.
OT Therapist Progress notes dated 7/31/15, indicated R37's forward trunk flexion had decreased with the use of the chest strap. R37 continued to require the use the chest strap for proper upright positioning when in the wheelchair. Staff was educated on the use of the chest strap.

On 10/22/15, at 10:35 a.m. NA-A stated R37's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 7	F 221		

chest belt was fastened with a snap and Velcro. NA-A stated staff were to open the chest belt before he ate "we just know to do it, he has had it a long time. I think he got the belt because he was leaning forward." NA-A stated R37 transferred with the ceiling lift.

On 10/22/15, at 10:44 a.m. R37 stated the only time staff open the chest belt was when they were going to transfer him from the wheelchair. Staff did not open the chest belt at meals.

On 10/22/15, at 10:48 a.m. registered nurse (RN)-B stated she was unaware of R37's chest belt.

On 10/22/15, at 3:22 p.m. RN-C verified the medical record lacked an assessment or monitoring for the safe use of the chest strap or an evaluation of the use of a restraint device to ensure the least restrictive device was used. RN-C was not sure who initiated the chest strap, and stated the NAs said they released the belt at meals.

On 10/22/15, at 3:30 p.m. the DON stated she did not know about the chest belt until today. The DON verified there was not an assessment or an order for the use of the strap. The DON thought occupational therapist (OT) may have put the chest belt in place. The DON stated licensed practical nurse (LPN)-B told her she knew about the chest belt but did not tell anyone and R37 received the chest belt about a month ago.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 8 On 10/23/15, at 11:30 a.m. OT-G stated the previous OT evaluated R37 and when she started in July and started seeing R37 on 7/8/15, the chest strap was already on the chair. OT-G stated she told R37 he could wear the chest strap if he wanted. OT-G checked with R37 a few times and the NAs said it helped because he was not falling out of the chair anymore. OT-G stated it was at that time when she added the chest strap to the care plan on 7/9/15. OT-G stated she brought a copy of the Care Plan Change Sheet to the nurse's station, put a copy of it the desk or chair where they could clearly see it. OT-G does not normally speak to nursing and could not remember if she verbally told staff. OT-G stated she does not direct staff when to release the chest strap as she was letting R37 decide when he wanted it on or not. OT-G further stated she does not assess for the safe use or if R37 was able to open the chest strap when asked. A policy was requested but not provided.	F 221		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 9 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report potential abuse/mistreatment to the State Agency (SA) and thoroughly investigate incidences of potential abuse / mistreatment for 4 of 5 residents (R7, R15, R25, R38) reviewed for potential mistreatment. Findings include:	F 225	225 Resident 7 has a chronic bruising condition and the facility is certain no maltreatment has caused these bruised. Resident 7 has had a consultation with nursing and the CNP and the care plan now reflects the type of bruise that is to be investigated and potentially submitted as a VA. This information is also included on the RESIDENT CARE REFERENCE SHEET (Kardex). During consultation minocycline was also discontinued as this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10 R7 had bruising of unknown origin around both eyes, the left shin, the right inner groin and both arms which were not immediately reported to the SA and lacked a thorough investigation to determine if abuse/mistreatment occurred, as required. On 10/23/15, at 9:08 a.m. registered nurse (RN)-B and nurse practitioner (NP)-F measured the following bruises on R7: -3.5 centimeters (cm) to the left shin -2.0 x 2.0 cm and 1.0 x 8.0 cm to the right inner groin area -15.0 x 1.0 cm to the back of the left upper arm -12.0 x 11.0 cm to the left upper forearm continuing to the top of the left hand -17.0 x 7.0 cm on the right lower forearm continuing to the third and fourth fingers -3.0 x 4.0 cm to the right inner forearm surrounded by four smaller bruises measuring 1.7 x 1.0 cm, 2.0 x 2.2 cm, 2.3 x 2.0 cm and 1.0 x 1.3 cm (NP-F placed her hand over these bruises and they fit indicative of fingerprints) -4.5 x 6.0 cm to the right upper arm above the elbow -3.3 x 5.6 and 2.2 x 2.3 to the right upper arm and bruising around both eyes that extended from the eyebrows to underneath both eyes. R7's Admission Record identified diagnoses that included dementia and spontaneous ecchymosis (pinhead size skin discolorization due to hemorrhage; pinpoint, flat, round red spots under the skin caused by bleeding, pinpoint, unraised, round red spots under the skin caused by bleeding, or purple or red pinpoint spots in the	F 225	also contributes to spontaneous bruising. Staff received training via report on this unit for care plan updates on resident 7. Resident 15's reddened discoloration and slight swelling was reviewed at approximately 11 am on 11-11-14 by the CNP and CM and DON, no noted swelling or redness remained. This was not documented in the chart as it should have been. Res. 15 will sleep in late per her choice and her dependent side of face will sometimes be slightly edematous, such was the case this morning. Staff documented this appropriately and though the chart lacked the documentation of the investigation, the resident was assessed and the facility determined this was not a reportable condition. Resident 37 bruise to outer eye was smaller than a pencil circumference and was observed by the DON and the CM. Investigation determined this was caused by not lowering the ceiling lift bar below chest level as when attaching the bar it can move easily if not steadied. At this time all NARs received additional training on appropriate use of the ceiling lift system. This was determined not to be reportable as a VA at this time and the documentation is included below. 6/15/2015 07:40 AM [Recorded as Late Entry on 07/01/2015 07:42 AM] IDT met to review bruise to R) outer eye during 1st round. Resident is a mechanical lift and bruise does line up with lifting device. Will speak to staff about ensuring that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 11 skin or mucous membranes caused by minor hemorrhage). R7's quarterly Minimum Data Set (MDS) dated 8/11/15, indicated R7 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R7 had mood indicators of being short-tempered, easily annoyed half or more of the days, and physical behavioral symptoms directed towards others 1-3 days, and behavioral symptoms not directed at others 1-3 days. R7's care plan dated 6/19/12, identified R7 was at risk for bruising related to long-term steroid use, scratching secondary to itching, thinning skin, history of pemphigoid (a rare skin condition that causes large, fluid-filled blisters on areas of skin that often flex - such as the lower abdomen, upper thighs or armpits), and aging capillaries. The care plan further identified R7 had a history of being resistive and combative during cares which may lead to bruising, and directed staff to lotion skin daily and as needed, ensure arm protectors were on at all times, if combative, ensure her safety and reproach later, and monitor bruising prn (as needed). The care plan lacked indication of what bruises were considered suspicious, and when staff was to report suspicious bruising. R7's quarterly skin assessment indicated she was at high risk for breakdown, and resident's skin is very sensitive to bruising and discoloration, and directed staff to observe skin changes with cares and report changes to the nurse.	F 225	lift is down below head level when attaching or disconnecting. Care plan was being follow. No maltreatment suspected. Gail A Potter RN View 06/14/2015 12:34 AM Noted bruise (R) outer eye during 1st round. Likely from mechanical lift. Fax prepped for MD. Will monitor til resolved. ng Deborah L Wolff LPN,charge View 06/12/2015 08:27 PM [Recorded as Late Entry on 06/13/2015 06:29 PM] Res. received a bruise to the R) upper eye. Res. was noted to be rubbing at eye this pm shift. Will continue to monitor and doc. bruise to the R) and doc. accordingly. All events occurring in October have been reviewed. The EVENT policy has been updated to include definitions of what constitutes an event and staff received training on 11-23-15 and this included the need for immediate investigation. RNs will now audit progress notes daily to assure all events are opened appropriately, if an event occurred and is only in the progress note the RN will complete an immediate investigation, open the appropriate event and reeducate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12 On 10/22/15, at 10:03 a.m. RN-B was interviewed, and stated R7 has had bruises for years and her bruises were so commonplace the facility had not documented on them. RN-B stated if R7 had bruising in the groin, then the facility would do an investigation. On 10/22/15, at 2:35 p.m. the director of nursing (DON) was interviewed and stated R7 was always bruised, it's normal for her. The DON stated the facility doesn't monitor her bruising because it was a chronic condition and the facility had not viewed R7's bruises as a sign of abuse and they would monitor for a change in her mood or behavior to determine if R7 was being abused. On 10/22/15, at 5:05 p.m. the DON stated an injury of unknown origin was one where if a resident had been hurt and the facility was unable to determine how it occurred. The DON identified suspicious bruising as bruising that occurred in the groin, neck, throat and face. When asked if R7's bruising in the groin and around the eyes fit her definition of suspicious bruising, the DON stated she knew it did, but R7 had been like that forever. The DON verified the bruises had not been reported to the SA, and were not thoroughly investigated. R15 had a bruise to the lower left eye, which was not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/mistreatment occurred.	F 225	the LN who should have completed an event of this error. The IDT will continue to review Events daily at stand up meetings. Additionally events will remain open until compliance has been achieved for the necessary notifications, investigation and IDT review, and reporting of VA's. DON will continue to evaluate event data monthly to monitor for trends, ineffective plans, appropriate reporting, and this data will be submitted to Quality Council. The Quality Council to assure that this problem does not recur and ensure changes made result in adequate investigations are completed. All newly hired staff is educated on the Event Reporting and VA process. Investigative Protocols have been developed and placed on each floor for nursing reference. An IDT checklist has been created to assure required action is not missed. Staff has been re-educated on the event and reporting process on 11-23-15. Compliance will be achieved by 12/2/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 13	F 225		

On 11/11/14, the facility documented R15 had a bruise to the left lower eye, and the bruise was not measured.

R15's Admission Record identified diagnoses that included Alzheimer's disease.

R15's annual MDS dated 9/8/15, identified R15 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), and required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R15 had mood indicators of being short-tempered, easily annoyed half or more of the days, and physical behavioral symptoms directed towards others 4-6 days, and behavioral symptoms not directed at others 1-3 days. R15's care plan lacked any indication of fragile skin/bruising problems.

On 10/23/15, at 7:56 a.m. the DON stated R15's bruised left lower eye should have been investigated. The DON stated she had "missed" it. The DON verified the bruised lower eye had not been reported to the SA and was not thoroughly investigated as required.

R25 had a bruise to the right eye, which was not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/maltreatment occurred.

On 6/12/15, the facility documented R25 had a bruise to the right upper eye, and the bruise was not measured. On 6/14/15, the facility documented R25 had a bruise to the right outer eye, and the bruise was not measured.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 14	F 225		

R25's Admission Record identified diagnoses that included dementia and Parkinson's disease.

R25's quarterly MDS dated 8/11/15, indicated R25 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R7 had physical behavioral symptoms directed towards others 1-3 days.

R25's care plan dated 6/6/12, identified R25 was at risk for bruises and skin tears due to thinning skin, combative with cares at times, and use of coumadin (a blood thinning medication). The care plan directed staff to lotion legs/feet daily, and monitor for bruising/bleeding gums. The care plan lacked indication of what bruises were considered suspicious, and when staff was to report suspicious bruising.

On 10/23/15, at 7:56 a.m. the DON stated the facility believed R25 was hit in the eye by a mechanical lift, however an investigation was not completed. The DON verified the bruised eye had not been reported to the SA, and was not thoroughly investigated as required.

R38 had three bruises to the right arm which were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/maltreatment occurred.

On 4/15/15, the facility documented R38 had three bruises to the right arm, origin unknown, no abuse suspected. The bruises were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 15 measured. The facility documentation contraindicated itself, identifying that the bruises were in an area of high vulnerability, but the bruises were not in a suspicious area. R38 expired 6/19/15. R38's Admission Record identified diagnoses that included anxiety and spontaneous ecchymosis. R38's quarterly MDS dated 5/3/15, indicated R38 had severe cognitive impairment, and required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R38 had mood problems of feeling down, depressed or hopeless 1 day, and physical behavioral symptoms not directed at others 1-3 days. R38's care plan lacked any indication of fragile skin/bruising problems. On 10/23/15, at 7:56 a.m. the DON stated the facility had not "necessarily" needed to document the size of bruises. The DON verified the bruises were not reported to the SA, and the facility had not thoroughly investigated as required. The facility Abuse Prevention Plan (undated), directed facility management to report suspected maltreatment to the SA immediately (within 1 hour), and then begin an internal facility investigation.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement a policy to ensure immediate reporting of potential incidences of abuse/mistreatment to the State Agency (SA) and thoroughly investigate incidences for 4 of 5 residents (R7, R15, R25, R38) reviewed for potential mistreatment. Findings include: The facility Abuse Prevention Plan (undated), directed facility management to report suspected maltreatment to the SA immediately (within 1 hour), and then begin an internal facility investigation. R7 had bruising of unknown origin around both eyes, the left shin, the right inner groin and both arms which were not immediately reported to the SA and lacked a thorough investigation to determine if abuse/mistreatment occurred, as required. On 10/23/15, at 9:08 a.m. registered nurse (RN)-B and nurse practitioner (NP)-F observed and measured the following bruises on R7: -3.5 centimeters (cm) to the left shin -2.0 x 2.0 cm and 1.0 x 8.0 cm to the right inner groin area -15.0 x 1.0 cm to the back of the left upper arm	F 226	226 Resident 7 has a chronic bruising condition and the facility is certain no maltreatment has caused these bruised. Resident 7 has had a consultation with nursing and the CNP and the care plan now reflects the type of bruise that is to be investigated and potentially submitted as a VA. This information is also included on the RESIDENT CARE REFERENCE SHEET (Kardex). During consultation minocycline was also discontinued as this also contributes to spontaneous bruising; staff was educated on unique diagnosis on 11/23/15. Resident 15's reddened discoloration and slight swelling was reviewed at approximately 11 am on 11-11-14 by the CNP and CM and DON, no noted swelling or redness remained. This was not documented in the chart as it should have been. Res. 15 will sleep in late per her choice and her dependent side of face will sometimes be slightly edematous, such was the case this morning. Staff documented this appropriately and though the chart lacked the documentation of the investigation, the resident was assessed and the facility determined this was not a reportable condition. Resident 37 bruise to outer eye was smaller than a pencil circumference and was observed by the DON and the CM. Investigation determined this was caused by not lowering the ceiling lift bar below	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 17 -12.0 x 11.0 cm to the left upper forearm continuing to the top of the left hand -17.0 x 7.0 cm on the right lower forearm continuing to the third and fourth fingers -3.0 x 4.0 cm to the right inner forearm surrounded by four smaller bruises measuring 1.7 x 1.0 cm, 2.0 x 2.2 cm, 2.3 x 2.0 cm and 1.0 x 1.3 cm (NP-F placed her hand over these bruises and they fit indicative of fingerprints) -4.5 x 6.0 cm to the right upper arm above the elbow -3.3 x 5.6 and 2.2 x 2.3 to the right upper arm and bruising around both eyes that extended from the eyebrows to underneath both eyes. R7's Admission Record identified diagnoses that included dementia and spontaneous ecchymosis (pinhead size skin discolorization due to hemorrhage; pinpoint, flat, round red spots under the skin caused by bleeding, pinpoint, unraised, round red spots under the skin caused by bleeding, or purple or red pinpoint spots in the skin or mucous membranes caused by minor hemorrhage). R7's quarterly Minimum Data Set (MDS) dated 8/11/15, indicated R7 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R7 had mood indicators of being short-tempered, easily annoyed half or more of the days, and physical behavioral symptoms directed towards others 1-3 days, and behavioral symptoms not directed at others 1-3 days.	F 226	chest level as when attaching the sling the bar will move easily if not steadied. At this time all NARs received additional training on appropriate use of the ceiling lift system. This was determined not to be reportable as a VA and the documentation is included below. 6/15/2015 07:40 AM [Recorded as Late Entry on 07/01/2015 07:42 AM] IDT met to review bruise to R) outer eye during 1st round. Resident is a mechanical lift and bruise does line up with lifting device. Will speak to staff about ensuring that lift is down below head level when attaching or disconnecting. Care plan was being follow. No maltreatment suspected. Gail A Potter RN View 06/14/2015 12:34 AM Noted bruise (R) outer eye during 1st round. Likely from mechanical lift. Fax prepped for MD. Will monitor til resolved. ng Deborah L Wolff LPN,charge View 06/12/2015 08:27 PM [Recorded as Late Entry on 06/13/2015 06:29 PM] Res. received a bruise to the R) upper eye. Res. was noted to be rubbing at eye this pm shift. Will continue to monitor and doc. bruise to the R) and doc. accordingly. Resident 38 has deceased the meaning of the documentation below is the bruise was not in area that would create suspicion of maltreatment and was in an area that frequently may be bruised due to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 18 R7's care plan dated 6/19/12, identified R7 was at risk for bruising related to long-term steroid use, scratching secondary to itching, thinning skin, history of pemphigoid (a rare skin condition that causes large, fluid-filled blisters on areas of skin that often flex - such as the lower abdomen, upper thighs or armpits), and aging capillaries. The care plan further identified R7 had a history of being resistive and combative during cares which may lead to bruising, and directed staff to lotion skin daily and as needed, ensure arm protectors were on at all times, if combative, ensure her safety and reproach later, and monitor bruising prn (as needed). The care plan lacked indication of what bruises were considered suspicious, and when staff was to report suspicious bruising. R7's quarterly skin assessment indicated she was at high risk for breakdown, and resident's skin is very sensitive to bruising and discoloration, and directed staff to observe skin changes with cares and report changes to the nurse. On 10/22/15, at 10:03 a.m. RN-B was interviewed, and stated R7 has had bruises for years and her bruises were so commonplace the facility had not documented on them. RN-B stated if R7 had bruising in the groin, then the facility would do an investigation. On 10/22/15, at 2:35 p.m. the director of nursing (DON) was interviewed and stated R7 was always bruised, it's normal for her. The DON stated the facility doesn't monitor her bruising because it was a chronic condition and the facility had not viewed R7's bruises as a sign of abuse and they would monitor for a change in her mood	F 226	activities of daily living; documentation is below. 04/15/2015 09:24 AM IDT met to review bruise to R arm, area is in one of high vulnerability, res. attends exercise group, uses walker, independent with upper body movement and may have bumped per self. Bruise not in suspicious area, no maltreatment suspected. View Remove 04/15/2015 06:38 AM Has three new bruises noted to right arm. Denied any pain to area. Residents skin is very thin and fragile. MD has been faxed and family will be notified. Origin of bruise is unknown. No abuse is suspected. Will monitor bruises until gone. Our current Vulnerable Adult Reporting Policy was reviewed and remains appropriate and complies with federal regulations and staff has been educated on the policy. Our facility EVENT policy has been updated to include definitions and staff received training on 11-23-15. All new hired staff is educated on these policies at time of hire. Education was provided on 11-23-15 and included immediate investigation of suspected VAs to determine whether it is a reportable event. And staff will continue	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 19 or behavior to determine if R7 was being abused. On 10/22/15, at 5:05 p.m. the DON stated an injury of unknown origin was one where if a resident had been hurt and the facility was unable to determine how it occurred. The DON identified suspicious bruising as bruising that occurred in the groin, neck, throat and face. When asked if R7's bruising in the groin and around the eyes fit her definition of suspicious bruising, the DON stated she knew it did, but R7 had been like that forever. The DON verified the bruises had not been reported to the SA, and were not thoroughly investigated. R15 had a bruise to the lower left eye, which was not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/mistreatment occurred. On 11/11/14, the facility documented R15 had a bruise to the left lower eye, and the bruise was not measured. R15's Admission Record identified diagnoses that included Alzheimer's disease. R15's annual MDS dated 9/8/15, identified R15 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), and required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R15 had mood indicators of being short-tempered, easily	F 226	to be reeducated on a case by case basis. An investigative flow sheet has been provided to each floor for ready reference on what is needed to complete an immediate investigation and VA reporting determination. The IDT will continue to review progress notes and events daily at stand up meetings to assure immediate investigations have been done, that events are completed and the VA reporting has been completed as necessary. An IDT checklist has been created to assure required action is not missed. VA reports will be trended monthly and reviewed by the Quality Council to assure compliance is being maintained. All events occurring in October have been reviewed for appropriate reporting to SA. RNs will now review progress notes daily to assure all events are opened appropriately, if an event occurred and is only in the progress note the RN will do an immediate investigation to determine if it needs to be reported and will report as needed as a VA, will open the appropriate event if needed and will provided 1:1 education to the LN who should have completed an event of this error. Additionally the Social Service Designee will be responsible to close events and this will serve as an audit to assure compliance with the necessary notifications, IDT review, and reporting of VA has been accomplished as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 20	F 226		

annoyed half or more of the days, and physical behavioral symptoms directed towards others 4-6 days, and behavioral symptoms not directed at others 1-3 days. R15's care plan lacked any indication of fragile skin/bruising problems.

On 10/23/15, at 7:56 a.m. the DON stated R15's bruised left lower eye should have been investigated. The DON stated she had "missed" it. The DON verified the bruised lower eye had not been reported to the SA and was not thoroughly investigated as required.

R25 had a bruise to the right eye, which was not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/maltreatment occurred.

On 6/12/15, the facility documented R25 had a bruise to the right upper eye, and the bruise was not measured. On 6/14/15, the facility documented R25 had a bruise to the right outer eye, and the bruise was not measured.

R25's Admission Record identified diagnoses that included dementia and Parkinson's disease. The quarterly MDS dated 8/11/15, indicated R25 had impaired long and short term memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R7 had physical behavioral symptoms directed towards others 1-3 days.

The care plan dated 6/6/12, identified R25 was at risk for bruises and skin tears due to thinning skin, combative with cares at times, and use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 21	F 226		

coumadin (a blood thinning medication). The care plan directed staff to lotion legs/feet daily, and monitor for bruising/bleeding gums. The care plan lacked indication of what bruises were considered suspicious, and when staff was to report suspicious bruising.

On 10/23/15, at 7:56 a.m. the DON stated the facility believed R25 was hit in the eye by a mechanical lift, however an investigation was not completed. The DON verified the bruised eye had not been reported to the SA, and was not thoroughly investigated.

R38 had three bruises to the right arm which were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/maltreatment occurred.

On 4/15/15, the facility documented R38 had three bruises to the right arm, origin unknown, no abuse suspected. The bruises were not measured. The facility documentation contraindicated itself, identifying that the bruises were in an area of high vulnerability, but the bruises were not in a suspicious area. R38 expired 6/19/15.

R38's Admission Record identified diagnoses that included anxiety and spontaneous ecchymosis.

R38's quarterly MDS dated 5/3/15, indicated R38 had severe cognitive impairment, and required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R38 had mood problems of feeling down, depressed or hopeless 1 day, and physical behavioral symptoms not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 22 directed at others 1-3 days. R38's care plan lacked any indication of fragile skin/bruising problems. On 10/23/15, at 7:56 a.m. the DON stated the facility had not "necessarily" needed to document the size of bruises. The DON verified the bruises were not reported to the SA, and the facility had not thoroughly investigated as required.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide appropriate dress when in a public area for 1 of 4 residents (R65) observed in a public area with underclothes on. The facility also failed to provide appropriate storage of incontinent briefs for 1 of 4 residents (R32) reviewed for dignity. Findings include: R65 was wheeled around the facility by nursing assistant (NA)-C wearing long underwear and a polo shirt. R65's Resident Admission Record (not dated) indicated R65's diagnoses included insomnia, chronic pain, vertigo, osteoarthritis, stage three	F 241	241 The DIGNITY Policy was revised and now includes storing personal items related to dignity such as under garments in resident closets or drawers, and other products not to be left out in resident's room as noted with Res. 32, and nursing staff received training on the policy on 11-23-15. Res. 65 Staff also re-educated for dignity with specifics to covering residents during cares or transport to cares. The Dignity Policy was revised and all staff educated on 11-23-15. The DIGNITY Policy will also be used for instructing all new staff upon hire. Audits for compliance with the new policy will be completed daily until compliance is achieved. Audits for compliance include	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 23 chronic kidney disease, type two diabetes and depression. R65 had a Brief Interview for Mental Status (BIMS) completed on 10/18/15, which identified him as cognitively intact. On 10/21/15, at 7:20 a.m. R65 was observed to be wheeled up and down the East hall on first floor by nursing assistant (NA)-C. While NA-C wheeled R65, she had his pants draped over her arm while she pushed. R65 was wearing his long underwear and a polo shirt. The long underwear were gaping open, with his polo shirt tucked into the waist band covering the opening in the front of the long underwear. After going up and down the East hall, R65 was wheeled to and positioned just outside the tub room door, by the main dining room. R65 remained in the hallway in his long underwear for 10 minutes prior to being brought into the tub room at 7:30 a.m. On 10/21/15, at 1:00 p.m. when R65 was asked about being in the hall in public view with his long underwear on, R65 stated, "No, I didn't like that, I didn't like that at all." R65 went on to state NA-C said he could have his pants after the bath. On 10/21/15, at 1:15 p.m. NA-C was asked about R65 being in the hall in his long underwear. NA-C stated "that was my fault. I shouldn't have done that." NA-C stated she should have placed something over R65's lap.	F 241	auditing for attire, toileting, personal care, injections, conversations, hygiene, privacy or personal items. Staff will be reeducated upon occurrence. Once compliance will then be completed weekly to assure compliance is maintained. The audit tool will also identify other residents at risk for dignity concerns. Monthly IDT meetings will be held to review audits relating to this plan of correction to assure educations are being provided as needed, and solutions are being sustained. The Clinical Managers are responsible to audit. The DON is responsible to report concerns to Quality Council. Compliance will be achieved by 12-2-15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 24	F 241		

On 10/22/15, at 9:55 a.m. registered nurse (RN)-C stated R65 should not have been wheeled down the hall in his long underwear. RN-C said "normally they have like a draw sheet they put across the lap."

R32's incontinent brief was laying on the nightstand next to the door, in physical sight of anyone who walked by the room.

R32's Admission Record identified diagnoses that included chronic kidney disease and dementia. The quarterly Minimum Data Set (MDS) dated 8/25/15, indicated R32 was occasionally incontinent of bladder, frequently incontinent of bowel, and required staff supervision with toileting.

On 10/21/15, at 9:19 a.m. R32 was observed in bed sleeping, with an incontinent brief on the nightstand.
-At 2:17 p.m. R32 was observed in bed sleeping and the incontinent brief remained on the nightstand.

On 10/22/15, at 10:12 a.m. RN-B was interviewed and stated resident's incontinent briefs should be stored in the closet.

On 10/22/15, at 2:43 p.m. the director of nursing (DON) was interviewed and stated incontinent products should be stored in the closet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 25 The facility policy and procedure on Dignity and Respect dated 8/17/05, directed residents' dignity shall be promoted by assuring appropriate attire, personal hygiene, grooming, and utilization of name preferences. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passer-by.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed ensure residents were involved in decision making related to smoking preferences for 1 of 4 residents (R52) reviewed for choices and who was not allowed to smoke when desired. Findings include: R2's quarterly Minimum Data Set (MDS) dated 6/16/15, indicated R2 had a very important desire to go outside when the weather is nice to get fresh air. The quarterly MDS dated 9/8/15, indicated R2 had mild cognitive impairment and needed extensive assistance of one person for	F 242	242 Resident 52 has had a review of his smoking preferences and this has been documented and care planned on 10-30-15. The IDT has identified 8 additional residents that will be interviewed for preference and choices. The information gathered will be documented and care plans adjusted accordingly by the Social Service Designee. The CARE CONFERENCE AGENDA has been revised to include “Are we meeting your preferences in your daily routine and the services we provide? If no, expound, what can we do to make it better for you?” This will be utilized to assure preferences	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 26 locomotion off the unit. The quarterly MDS included diagnoses of multiple sclerosis and depression. On 10/20/15, at 10:13 a.m. licensed practical nurse (LPN)-B stated R2 only smoked in the evening when his friend visited and R2 did not smoke on his own. On 10/21/15, at 7:22 a.m. R2 stated he used to be able to smoke outside on his own, but now can only smoke when a friend comes to bring him to smoke due to safety. R2 further stated staff did not take him outside to smoke and the facility did not include him in decisions to accommodate his desire to smoke more often. R2 stated smoking only one time a day upset him and made him depressed. R2's care plan dated 9/17/15, indicated R2 would be able to smoke as he preferred and would remain safe. Interventions included review smoking habits quarterly and as needed, observe for any unsafe practices and staff or family/friend to accompany resident when smoking. R2's Safe Smoking Evaluation dated 7/9/15, was blank. On 10/21/15, at 3:24 pm. the director of nursing (DON) verified the 7/9/15, Smoking Evaluation was incomplete and stated she had forgotten to save the information prior to completing the assessment. R2's medical record lacked documentation when	F 242	are honored and care planned for. The CARE CONFERENCE AGENDA will be initiated on 11/16/2015, the IDT has been trained. Audits will be completed monthly by the IDT until compliance is achieved and then randomly to assure compliance is maintained. The Social Service Designee is responsible for the audits. Compliance will be achieved by 12-2-15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 27	F 242		

R2's ability to smoke independently had changed to supervised smoking. The medical record also lacked documentation regarding any involvement with R2 about a smoking plan between R2 and the facility.

The undated nursing assistant care plan sheet indicated R2 needed a smoking apron.

On 10/22/15, at 8:26 a.m. nursing assistant (NA)-G stated R2 needed someone with him while smoking, but didn't know if staff took the resident out to smoke. NA-G stated that R2's mother and friend would take him out to smoke when they visited.

On 10/22/15, at 2:13 p.m. licensed practical nurse (LPN)-C said it had been awhile since R2 could smoke on his own, roughly six months, but she could not be sure of the date. LPN-C stated staff could take him out, if they had enough staff and time.

On 10/22/15, at 2:42 p.m. the social service designee (SSD)-A stated she had not been involved in any care plan decisions regarding R2's smoking.

On 10/23/15, at 1:42 p.m. the DON stated she didn't know when R2's smoking plan had changed and to her knowledge there had been no change in his smoking plan. The DON stated she expected staff to involve residents in decisions regarding their care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 28 The facility policy and procedure on Accommodation of Needs dated 7/03, directed the resident has the right to make choices about aspects of his or her life in the facility that is significant to the resident.	F 242		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide sufficient notice of a room change for 1 of 2 residents (R54) reviewed for admission, transfer and discharge. Findings include: R54's quarterly Minimum Data Set dated 7/21/15, indicated R54 was cognitively intact. On 10/20/15, at 8:50 a.m. R54 stated he was only given ten minutes notice before moving from a short term stay room to a long term stay room. R54 stated he asked the facility if he could be moved to another room other than the room he was requested to move to because the new room did not have cable television or a clock and this was upsetting to R54. R54 stated the request was	F 247	247 R 54 was informed about having to move about 2 weeks prior to the move, but was not given an exact date or asked to sign the SEVEN DAY ROOM CHANGE NOTIFICATION. Resident 54 submitted a complaint on this and a SEVEN DAY ROOM CHANGE NOTIFICATION form was developed and implemented on 8-3-15 This form has been in effect since and the IDT is aware. No other room changes have been made since this occurrence. The Health Information staff or designee will audit all room changes for notification. Compliance has been achieved on 8-3-15.	11/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 29	F 247		

denied. R54 was moved to the new room 8/3/15.

R54's medical record lacked documentation regarding conversations about an upcoming room change, prior to R54's room change.

On 10/22/15, at 4:42 p.m. social service designee (SSD)-A was interviewed and produced a document titled Advanced Notice of Potential Room Change. The document was signed and dated by R54 on 1/26/15. The document indicated "Upon admission, you meet the criteria to the Short Term Unit. You will be transitioned out of the Short Term Unit when you no longer meet the criteria for continued stay in the Short Term Unit. This notice will serve as your seven day advanced notice of room change." SSD-A stated R54 was moved to another room on 8/3/15. SSD-A further stated the form served as the seven day notice. SSD-A acknowledged the resident was upset about the short notice to change rooms.

On 10/23/15, at 2:27 p.m. the administrator verified R54 was not given a proper notice prior to a room change. The administrator further stated SSD-A was new and didn't understand the process and had staff apologies to R54.

The facility policy and procedure on Accommodation of Needs dated 7/03, directed a resident has a right to receive notice before the resident's room or roommate in the facility changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 30	F 248		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 2 of 4 residents (R7, R32) reviewed for activities. Findings include: R7 was not provided with meaningful activities. R7's Admission Record identified diagnoses that included dementia. R7's quarterly Minimum Data Set (MDS) dated 8/11/15, indicated R7 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), and required staff assistance for bed mobility, transfers, wheelchair mobility, locomotion on the unit, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R7 had moderate hearing impairment, unclear speech, rarely/never understood others and had moderately impaired vision.	F 248	248 Resident 7 and Resident 32 have been re-assessed for preferred activities and the care plans updated. The IDT identified an additional eight residents that may benefit from an activity assessment. These eight residents have been assessed and care plans updated. A policy on when to complete an Activity Assessment has been developed and includes upon admission and with each comprehensive MDS. Activity and IDT staff trained. Additionally this will be reviewed with the resident and family upon their request and at each care conference. The RAI manager will audit for compliance for completion of the Activity assessment with the comprehensive MDS, and the Social Service Designee will audit this following the Care Conference schedule. NEW Care plan interventions for activities of choice will be audited until compliance is achieved and then weekly to assure compliance is sustained. Residents will be asked if they enjoy the activity or would	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 31 R7's care plan dated 4/24/13, indicated R7 made independent choices of activities, was at ease interacting with others and would engage in the activity of her choice daily. The care plan directed staff to provide 1:1 visits twice a week for socialization. R7's quarterly activity note dated 8/7/15, indicated R7 continued to have poor passive participation. Activity staff provided her with 1:1 visits twice a week for socialization that included talking to her about a variety of topics. R7 participated in the following group activity this quarter: 4th of July parade. She spent most of her time resting on and off during the day. She sat in the lobby area at times observing her surroundings and watching TV. She had not participated in any group activities or outing this quarter, the care plan and activity assessment were reviewed and were current. R7's activity log completed 8/1/15, through 10/22/15, indicated R7 had participated in 4 spiritual visits and 2 1:1 visits 8/15; 2 spiritual visits and 1 1:1 visit 9/15; and 1 spiritual visit from 10/1/15, through 10/22/15. R7 was not observed in individual or group activities during the survey on 10/19/15, 10/20/15, 10/21/15, 10/22/15, and 10/23/15. R32 was not provided with meaningful activities.	F 248	prefer a different activity and this information will be provided to the Activity Director. Activity Director is responsible for these audits. Compliance will be achieved by 12-2-15. Findings will be presented to Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 32	F 248		

R32's Admission Record identified diagnoses that included dementia. On 10/17/15, a readmission Fall Risk assessment was completed and identified R7 had fallen 10/11/15, and sustained a left hip fracture with surgical intervention. The Fall Risk assessment further identified R32 no longer ambulated, was using a wheelchair for mobility, and required staff assistance with all cares. The Fall Risk assessment also indicated R32 was alert with confusion.

R32's care plan dated 10/23/09, indicated R32 was independent in choice of activity and preferred to pursue independent activity and would engage in activity of choice daily. The care plan directed staff to provide 1:1 visits twice weekly for socialization offering conversation, music-polkas, reading materials, etc., The care plan further directed staff to provide R32 reminders to participate in group activities of interest such as mass, rosary, music programs, socials, parties, and special events.

R32 was not observed in individual or group activities during the survey on 10/19/15, 10/20/15, 10/21/15, 10/22/15, and 10/23/15.

R32's activity log completed 8/1/15, through 10/22/15, indicated R32 had participated in 1 van ride and 2 spiritual visits 8/15; 2 music programs and 2 spiritual visits 9/15; and 1 friendly gathering and 1 spiritual visit 10/1/15, through 10/22/15 (R32 was hospitalized 10/11/15, through 10/16/15).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 33 On 10/22/15, at 10:42 a.m. the activity director (AD)-A was interviewed and stated she had not completed an activity assessment on R32 since his return from the hospital because he hadn't changed for her. AD-A stated the only group activity the facility offered residents was exercise and she did not have time to bring residents so they needed to come on their own. AD-D also stated she had no group activities for residents with dementia and she did not know how she could incorporate those residents into the exercise class. AD-D stated she cannot get everything done, that's the way it is. AD-D further stated nursing does not assist with activities. On 10/22/15, at 2:40 p.m. the director of nursing (DON) was interviewed and stated the nursing department does not assist with activities. The facility was unable to provide a policy and procedure on meaningful activities.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 34 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for the 1 of 4 residents (R3) reviewed for pain, and 1 of 2 (R18) residents reviewed for urinary incontinence. Findings include: R3's care plan lacked non-pharmalogical modalities to use to reduce R3's pain. R3's Admission Record identified diagnoses that included generalized osteoarthritis, primary osteoarthritis in the right shoulder, osteoporosis and myositis (inflammation of the skeletal muscles that may result in weakness, swelling and/or pain). R3's quarterly Minumum Data Set (MDS) dated 10/15/15, indicated R3 was cognitively intact and required staff assistance for bed mobility, transfers ambulation, wheelchair mobility, dressing, toileting, personal hygiene and bathing.	F 279	279 Resident 3 has had a pain assessment completed and care plan revised. A medication review was completed and ben gay discontinued. Due to Resident 18's schizophrenia and fear triggered when he cannot see out of his room the facility has not forced his curtain or room door to be shut. The plan will be to try to ease the resident to allow the curtain to be pulled to attempt to prevent the line of vision to the resident and to gradually close the door to maintain the resident's privacy. Nursing will attempt to teach the resident to place his brief in a garbage receptacle. Resident 18 has been reassessed for bowel and bladder and his disrobing and the care plan was updated on 11-12-15. Care plans relating to skin, bowel and bladder, oral, restorative and pain have been audited to assure timely completion and care plans have been updated accordingly. Following the RAI schedule all resident will be audited for one quarter to assure appropriate assessments are completed and the care plans are effective. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 35 The MDS further identified R3 was on a pain medication regimen, did not receive PRN pain medications (medications taken when needed), and received non-medication interventions for pain. The MDS indicated R3 identified his pain as frequent, and rated it 7 on a scale of 1-10, and gave a verbal description of it as being moderate. R3's pain had no effect on his sleep, but did limit his day-to-day activities. R3's pain assessment dated 10/5/15, indicated R3 had pain daily, and rated his worst pain as a 7/10 on the pain scale. R3 stated his pain was in his right shoulder and it never really went away, but was more manageable with medications. R3's care plan dated 8/11/14, indicated R3 had a potential for pain related to neuropathy (weakness, numbness, and pain, usually in the hands and feet), with a goal R3 will state his pain is managed by not affecting his ADLs (activities of daily living). The care plan directed staff to administer medications as ordered, complete a pain assessment per facility protocol, use therapy modalities as needed, and report signs of pain. The care plan lacked non-pharmalogical modalities to use to reduce R3's pain. The physician's orders dated 9/24/15, directed gabapentin 300 milligrams (mg) three times daily; (used to treat nerve pain) methadone (an analgesic) 10 mg every 12 hours; Tylenol 650 mg twice a day; and BenGay ointment to the right shoulder three times daily, and three times daily as needed. The BenGay ointment was not administered on 10/12-10/21/15, as it was	F 279	auditing will continue for not less than 3 months to assure compliance. And will continue for all comprehensive MDS's. The RAI manager is responsible for audits. Compliance will be achieved by 12-2-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 36	F 279		

unavailable.

On 10/22/15, at 10:20 a.m. RN-B was interviewed and verified the facility had not tried any other interventions to relieve R3's pain.

On 10/22/15, at 1:56 p.m. R3 stated he had previously had a cortisone injection to the right shoulder, but it hadn't helped. R3 sated he had tried a heating pad with no relief, but had not tried ice to the shoulder. R3 also stated the BenGay ointment didn't help. R3 said he didn't know what more could be done.
The facility failed to develop care plan interventions related to inappropriate urination for R18.

R18's quarterly MDS dated 8/8/15, indicated R18 had moderate cognitive impairment and required extensive assistance to toilet. The MDS included diagnoses of schizophrenia and dementia.

The Urinary Incontinence Care Area Assessment dated 12/7/14, indicated R18 had behavior issues related to incontinence.

R18's care plan dated 11/30/15, identified R18 was incontinent of bowel and bladder (mostly at night) with little control present. R18 had functional incontinence depending on mood/behavior. Interventions dated 3/29/14, included assist with toileting approximately every two hours and per resident's request, offer cues and reminders, R18 wears an incontinent brief daily, and required assistance of one with total

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 37	F 279		

care with incontinent brief and hygiene. The behavior care plan dated 7/31/14, indicated at times R18 refused incontinent brief change and had bowel movements in inappropriate places. The intervention dated 8/7/13, directed staff to approach the resident in a calm, soothing manner, approach from the front, and explain intentions prior to initiating cares. The care plan and interventions did not include inappropriate urination or interventions to minimize the occurrence or what to do when inappropriate urination occurred.

The undated Kardex lacked interventions for inappropriate urination.

On 10/21/15, at 7:09 a.m. until 7:42 a.m. R18 was observed in bed with a soiled incontinent brief lying on the floor. The room smelled strongly of urine.

On 10/21/15, at 7:58 a.m. nursing assistant (NA)-B stated R18 was incontinent most of the time, inappropriately urinated on the floor and the staff toileted him every two hours. NA-B also verified R18 removed his incontinent brief frequently and threw it on the floor.

On 10/23/15, at 9:37 a.m. registered nurse (RN)-D stated it was up to the floor nurses to put interventions into place on the care plan. RN-B stated interventions related to inappropriate urination needed to be addressed on the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 38 On 10/23/15, at 1:27 p.m. director of nursing (DON) stated the facility did their best regarding inappropriate toileting, R18 was toileted every two hours which was how R18's needs were addressed. The facility policy and procedure on Care Planning Process dated 9/24/10, indicated the purpose of the interdisciplinary care planning conference was to invite, develop, review and update the care plan for each resident through a collaborative effort. The policy also indicated the facility was responsible for addressing the resident needs from the moment of admission.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure coordination of hospice serves was provided for 1 of 1 resident (R11) reviewed for hospice services; failed to identify and assess significant bruising for 1 of 3 residents (R7) observed with bruising and failed to assess for and implement non pharmacological pain interventions for 1 of 4 residents (R3)	F 309	309 Resident 11 will have hospice services coordinated as of 11/20/15. Each Monday the Health Information Manager or designee will contact Hospice for a schedule for care giver services for that week. The Hospice RN will notify the facility the day before coming to complete an RN	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 39 reviewed for pain in order to attain or maintain the highest practicable well being. Findings include: R11 received hospice services and the hospice agency and facility failed to coordinate and inform staff of care services. R11 had a significant change Minimum Data Set (MDS) completed on 7/1/15, following admission to hospice services. The MDS included a diagnosis of Alzheimer's disease. R11's hospice care plan dated 10/19/15, listed the frequency of nurse visits 2-4 times a month and as needed and aid services 1 time a week. On 10/22/15, at 2:02 p.m. nursing assistant (NA)-F stated R11 was on hospice however the aids do not know what days hospice comes. On 10/22/15, at 2:07 p.m. licensed practical nurse (LPN)-C stated she was not sure when hospice nurses and aids were scheduled to come to the facility. On 10/22/15, at 2:16 p.m. the case manager (CM) from the hospice agency stated the hospice nurses charted in Matrix (computerized medical record system) that they would be coming the following week. They do not give a specific day of	F 309	visit. Hospice communication guidelines have been developed and staff trained on 11-23-15. One additional resident is receiving hospice and her care plan has been reviewed. Resident 7 has a chronic bruising condition and the facility is certain no maltreatment has caused these bruises. Resident 7 has had a consultation with nursing and the CNP and the care plan now reflects the type of bruise that will be investigated and potentially submitted as a VA. This information is also included on the RESIDENT CARE REFERENCE SHEET (Kardex). During medication review/consultation minocycline was discontinued as this also contributes to spontaneous bruising. Staff received training via report on this unit and the care plan change process. Resident 3 has had a pain assessment completed and care plan has been revised. Additionally each shift documents on pain and reports if not controlled to the RN. All residents on a narcotic analgesic One other resident is on hospice. She has been reviewed and we have established communication systems with hospice. Bruises are reported immediately if staff cannot determine the cause of the bruise and a VA will be filed accordingly. This process has not changed. NEW: Each week the NAR will complete a skin review during bathing and report all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 40 the week because they were managing 50 plus patients. The CM also stated the hospice aids signed off on a clipboard at the facility desk when they visited. The CM stated the hospice agency faxed over an updated care plan weekly along with hospice notes. On 10/23/15, at 2:09 p.m. the director of nursing (DON) stated the facility and hospice agency had a mutual care plan that described what the facility and the hospice agency was responsible for. The DON also stated the hospice agency faxed over progress notes and care plan updates weekly. The DON verified the hospice agency had not informed which day of the week the facility could expect the hospice nurse or aid to visit just that the next visit would be the following week. R7 was observed on 10/19/15, at 6:26 p.m. with bruising around both eyes, the forehead and both arms/hands and the facility failed to identify, and assess the bruises. On 10/23/15, at 9:08 a.m. registered nurse (RN)-B and nurse practitioner (NP)-F measured the following bruises on R7: -3.5 centimeters (cm) to the left shin -2.0 x 2.0 cm and 1.0 x 8.0 cm to the right inner groin area -15.0 x 1.0 cm to the back of the left upper arm -12.0 x 11.0 cm to the left upper forearm continuing to the top of the left hand -17.0 x 7.0 cm on the right lower forearm continuing to the third and fourth fingers -3.0 x 4.0 cm to the right inner forearm surrounded by four smaller bruises measuring 1.7	F 309	bruises, skin conditions, concerns to the LPN. The LPN will document weekly on skin based on this report; and will update the RN accordingly. A floor meeting on this protocol will be issued on 12-1-15 to educate nursing staff. Care plans relating to skin, bowel and bladder, oral, restorative and pain have been audited to assure timely completion and have been reviewed to assure care plans are effective or the issue is being addressed by the IDT. In accordance with the RAI process each quarter the IDT will review the care plans and outcomes and adjust care plans as needed. Additionally events will be monitored monthly by the IDT to assure plans remain effective. DON will continue to evaluate event data monthly to monitor for trends, ineffective plans, appropriate reporting, resident outcomes and this data will be submitted to Quality Council. The IDT is responsible to assure care plans are updated per RAI process. NEW Care plan interventions will be audited daily until compliance is achieved and then weekly to assure compliance is sustained. DON is responsible for these audits. Compliance will be achieved by 12-2-15. Findings will be presented to Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 41	F 309		

x 1.0 cm, 2.0 x 2.2 cm, 2.3 x 2.0 cm and 1.0 x 1.3 cm (NP-F placed her hand over these bruises and they fit indicative of fingerprints)
-4.5 x 6.0 cm to the right upper arm above the elbow
-3.3 x 5.6 and 2.2 x 2.3 to the right upper arm and bruising around both eyes that extended from the eyebrows to underneath both eyes.

R7's Admission Record identified diagnoses that included dementia and spontaneous ecchymosis (pinhead size skin discolorization due to hemorrhage; pinpoint, flat, round red spots under the skin caused by bleeding, pinpoint, unraised, round red spots under the skin caused by bleeding, or purple or red pinpoint spots in the skin or mucous membranes caused by minor hemorrhage).

R7's quarterly Minimum Data Set (MDS) dated 8/11/15, indicated R7 had impaired memory, severely impaired cognitive skills for daily decision making (never/rarely made decisions), required staff assistance for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. The MDS further identified R7 had mood indicators of being short-tempered, easily annoyed half or more of the days, and physical behavioral symptoms directed towards others 1-3 days, and behavioral symptoms not directed at others 1-3 days.

R7's care plan dated 6/19/12, identified R7 was at risk for bruising related to long-term steroid use, scratching secondary to itching, thinning skin, history of pemphigoid (a rare skin condition that causes large, fluid-filled blisters on areas of skin that often flex - such as the lower abdomen,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 42	F 309		

upper thighs or armpits), and aging capillaries. The care plan further identified R7 had a history of being resistive and combative during cares which may lead to bruising, and directed staff to lotion skin daily and as needed, ensure arm protectors were on at all times, if combative, ensure her safety and reproach later, and monitor bruising prn (as needed). The care plan lacked identification of the current significant bruising.

R7's quarterly skin assessment indicated she was at high risk for breakdown, and resident's skin is very sensitive to bruising and discoloration, and directed staff to observe skin changes with cares and report changes to the nurse.

On 10/22/15, at 10:03 a.m. RN-B was interviewed, and stated R7 has had bruises for years and her bruises were so commonplace the facility had not documented on them.

On 10/22/15, at 2:35 p.m. the director of nursing (DON) was interviewed and stated R7 was always bruised, it's normal for her. The DON stated the facility doesn't monitor her bruising because it was a chronic condition and the facility had not viewed R7's bruises as a sign of abuse and they would monitor for a change in her mood or behavior to determine if R7 was being abused.

The facility policy and procedure on Impaired Skin and Tissue Management dated 3/14/14, directed staff to ensure residents with skin or tissue damage will receive the necessary treatments and services to promote healing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 43	F 309		

R3 verbalized unrelieved pain in his shoulders and the facility failed to assess for and implement non pharmacological interventions in an attempt to decrease pain.

R3's Admission Record identified diagnoses that included generalized osteoarthritis, primary osteoarthritis in the right shoulder, osteoporosis and myositis (inflammation of the skeletal muscles that may result in weakness, swelling and/or pain).

R3's quarterly MDS dated 10/15/15, indicated R3 was cognitively intact and required staff assistance for bed mobility, transfers ambulation, wheelchair mobility, dressing, toileting, personal hygiene and bathing. The MDS further identified R3 was on a pain medication regimen, did not receive PRN pain medications (medications taken when needed), and received non-medication interventions for pain. The MDS indicated R3 identified his pain as frequent, and rated it 7 on a scale of 1-10, and gave a verbal description of it as being moderate. R3's pain had no effect on his sleep, but did limit his day-to-day activities.

R3's pain assessment dated 10/5/15, indicated R3 had pain daily and rated his worst pain as a 7/10 on the pain scale. R3 stated his pain was in his right shoulder, and it never really goes away, but is more manageable with medications.

R3's care plan dated 8/11/14, indicated R3 had a potential for pain related to neuropathy (weakness, numbness, and pain, usually in the hands and feet), with a goal R3 will state his pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 44	F 309		

is managed by not affecting his ADLs (activities of daily living). The care plan directed staff to administer medications as ordered, complete a pain assessment per facility protocol, use therapy modalities as needed, and report signs of pain. The care plan lacked indication of non-pharmalogical modalities to use to reduce R3's pain.

R3's physician's orders dated 9/24/15, directed gabapentin 300 milligrams (mg) three times daily; (used to treat nerve pain) methadone (an analgesic) 10 mg every 12 hours; Tylenol 650 mg twice a day; and BenGay ointment to the right shoulder three times daily, and three times daily as needed. The BenGay ointment was not administered on 10/12-10/21/15, as it was unavailable.

On 10/19/15, at 3:56 p.m. R3 stated he had unrelieved pain in both of his shoulders and he didn't think he received pain medications.

On 10/22/15, at 10:20 a.m. RN-B was interviewed and stated R3 had not had any changes in his pain medications. RN-B verified the facility had not tried any other interventions to relieve R3's pain.

On 10/22/15, at 1:56 p.m. R3 stated he had previously had a cortisone injection to the right shoulder, but it hadn't helped. R3 sated he had tried a heating pad with no relief, but had not tried ice to the shoulder. R3 also stated the BenGay ointment didn't help. R3 said he didn't know what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 45 more could be done. The facility policy and procedure on Pain Management dated 2/11, directed all residents who were experiencing pain, or may have conditions that may result in pain, would have a treatment plan established to treat pain symptoms. Nurses should include residents in the process and encourage residents to be active participants in pain management.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to minimize the risk of pressure ulcers for 1 of 1 resident (R56) reviewed for pressure ulcers. Findings include: The medical record lacked skin monitoring and	F 314	314 Resident 56 has had a Skin Assessment completed and care plan updated. All residents have been audited to assure a skin assessment has been completed per requirements and care plans are effective. All residents have had an audit to review for Skin Assessment and care plans reviewed for effectiveness. The facility assures prevention for	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 46 contained conflicting information regarding open areas on R56's skin. R56's Diagnoses Report active from 10/1/15, through 10/31/15, indicated R56's diagnoses included pressure ulcer of an unspecified site, type two diabetes, morbid (severe) obesity due to excess calories, chronic kidney disease, heart failure, stage four (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling) pressure ulcer of unspecified buttock, third degree burn of the buttocks and exposure to smoke, fire and flames. R56's annual Minimum Data Set (MDS) dated 8/29/15, indicated R56 had no cognitive impairment, did not have any behaviors or rejection of cares and required total assistance of two staff with bed mobility and transfers. The MDS also indicated R56 required extensive assistance of two staff to use the toilet and the extensive assistance of one staff with personal hygiene. R56 did not walk, was at risk for pressure ulcers, did not have any unhealed pressure ulcers, had a surgical wound and moisture associated skin damage. R56 has a pressure relieving device in the chair and on the bed, is on a turning and repositioning program and received the application of ointments to areas other than the feet. The Physician Order Report dated 10/1/15, through 10/31/15, included the following treatment orders: Bacitracin ointment (an antibiotic) with special instructions to apply to sores on the tailbone once a day starting 7/8/15. Right buttock wound special instructions dated	F 314	negative outcomes with regard to skin and tissue by completion of a comprehensive skin assessment, mobility and incontinence, no less than quarterly and prn. The facility has standing orders for skin protocols and MD is informed as needed. Nursing follows MD recommendations. Wound specialist visits facility every 4-6 weeks and reviews current wounds, progression and treatment. Consults are made for wounds based on individual assessment. All staff received reeducation on the stop and watch program on 11-23-15, which included reporting alteration in skin. Following the RAI schedule all resident's skin risk assessments will be audited for one quarter to assure appropriate assessments are completed and the care plans are effective. This auditing will continue for not less than 3 months to assure compliance. And will continue for all comprehensive MDS's. Residents identified with a wound will be reviewed weekly and this review will be documented in the clinical record. NEW: Each week the NAR will complete a skin review during bathing and report all bruises, skin conditions, concerns to the LPN. The LPN will document weekly on skin based on this report; and will update the RN accordingly. A floor meeting on this protocol will be issued on 12-1-15 to educate nursing staff. The nurse managers for each unit will audit all NAR skin reviews daily done per bathing/showering schedule to ensure all noted skin issues are reassessed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 47 9/8/15, directed staff to remove the current dressing, cleanse the wound with dermal wound cleanser and gauze, pat dry, apply a white Mepilex (foam) 6 x 6 dressing, change the dressing every three days and as needed due to soiling. Diagnosis of pressure ulcer of unspecified buttock, stage four. R56's admission Skin Risk Assessment dated 7/10/15, indicated R56 had a third degree burn to the right hip area that had been surgically repaired with a skin graft. Prior to admission, R56 ripped the skin graft and had three open areas. R56's left buttock had a stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer which measured 2.8 centimeters (cm) x 0.5 cm. The right buttock had a 1.0 cm x 1.0 cm stage two pressure ulcer. Foam dressings were applied to the areas. R56 had a pressure redistribution mattress on the bed and a cushion in the wheelchair. R56's lower extremities were to be on a pillow with no pressure on the heels. R56 was to be turned and repositioned every two hours and have weekly skin assessments followed by the registered nurse (RN) with skin meetings. R56's seven day Skin Risk Assessment dated 7/24/15, indicated the burns remained. The left buttock stage two pressure ulcer measured 2.6 cm x 0.5 cm as well as the right buttock stage two pressure ulcer measured 0.5 cm x 0.5 cm. R56's admission Skin Risk Assessment dated 8/19/15, indicated R56 had been hospitalized for an intestinal bleed. The burn remained. On the prior admission to the hospital, R56 had stage two pressure ulcers to her buttocks which had	F 314	addressed timely. Skin events will be utilized in the EHR for all noted skin issues requiring follow up monitoring/documentation. Any treatments for skin issues will be recorded in the MAR/TAR of the EHR. All new admissions will have the skin risk observations completed and appropriate interventions initiated and any resident with any new skin issues or changes in condition will be reassessed for appropriate interventions and will be included in the audits. The DON will audit charts to assure compliance with this plan of correction. Audits of the skin risk assessments will be done per the RAI schedule. Audits of the NAR skin reviews will be done daily for 4 weeks and then weekly for one month and then randomly. Audits of the skin events will be done daily thru the IDT meeting and review for effectiveness of treatment will be done weekly with the skin meeting. Weekly skin rounds conducted by the clinical mangers on treatment interventions will be conducted to ensure interventions remain appropriate. Unit nurses will audit for interventions each shift daily for 3 weeks, then weekly for one month and then random audits. Compliance will be achieved by 12-2-15. Findings will be presented to Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 48	F 314		

healed. R56 had a pressure redistribution mattress on the bed and a cushion in the wheelchair. R56's lower extremities were to be on a pillow with no pressure on the heels and was to have blue boots on when in bed. R56 was to be turned and repositioned every two hours and have weekly skin assessments followed by the RN with skin meetings.

R56's Progress Notes dated 8/28/15, indicated the nursing assistant (NA) notified the nurse R56 had two new open areas on the right buttock and outer left thigh. The area on the right buttock measured 0.6 cm x 1 cm and the left outer thigh area measured 0.6 cm x 1.5 cm. The areas were covered with Mepilex dressings.

R56's progress note dated 9/6/15, indicated R56 had a small open area which looked like a stage two pressure ulcer on the right upper buttock area, and a couple more reddened areas on the right side of the hip.

R56's progress note dated 9/6/15, indicated a small open area was found in the crack of R56's buttock. The area measured 1 cm x 0.3 cm. A Tegaderm AG Mesh (a dressing with antimicrobal properties) dressing was applied to the area.

R56's Pressure Ulcer care plan edited on 7/10/15, indicated R56 was at risk for pressure ulcers. The care plan approaches included a pressure reducing mattress on the bed and a pressure relief cushion in the wheelchair. Elevate R56's bilateral lower extremities on a pillow with no pressure to the heels. Turn and reposition every two hours as she allowed. Hoyer lift for all transfers. Weekly skin assessment and follow by the RN with skin meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 49 On 10/21/15, the following was observed: -At 9:18 a.m. R56 was brought to her to room to lay down. On the bed was a Rescue Air 3000 alternating pressure mattress. On the mattress was a fitted sheet, a bath blanket and a quilted cloth incontinent protection pad. NA-C connected the overhead lift to the sling R56 had been sitting on in the wheelchair, and transferred R56 onto the bed. NA-C removed the lift sling, provided incontinence care and changed R56's incontinent brief. During the incontinence care, NA-C removed a dressing soiled with feces from R56's coccyx area. On the coccyx area, R56 had a small open area that was approximately a half inch long. The right hip had a padded adhesive dressing on it. NA-C applied the blue heel protector boots and placed pillows under the lower legs and feet. R56's wheelchair cushion was observed to be a Keen Journey cushion and the boots applied to R56's feet were Heelmedix Heel Protectors/Standard. -At 9:41 a.m. R56's dressing changes were observed by licensed practical nurse (LPN)-B. LPN-B removed the right hip dressing and stated the dressing covered a burn R56 was admitted with. LPN-B provided treatment to the burn as ordered. LPN-B then washed the open area on the coccyx, applied the Bacitracin ointment and covered the area with a small padded adhesive dressing. On 10/22/15, at 2:26 p.m. R56's heels were observed with RN-C. R56 did not have the heel protector boots on but had a pillow under each leg and heel. The director of nursing (DON) arrived and stated R56 agreed to not have the boots on in bed but wanted the pillows in place.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 50	F 314		

NA-E and RN-C then applied the heel protector boots.

The Keen Journey Elite Cushion manufacture guidelines provided by the facility indicated the wheelchair cushion enveloped bony prominences that provided comfort and pressure relief.

The manufactures guidelines provided by the facility for the bed mattress indicated the mattress provided pressure relief by combining low air loss with pulsation. The guidelines directed the following linens may be utilized: a draw or slide sheet and incontinence barrier pads. The guidelines further directed to keep the amount of padding between the resident and the bed to a minimum for optimum performance.

On 10/22/15, at 1:47 p.m. NA-E stated R56 was repositioned side to side every two hours when in bed but preferred to lay on her back. R56 was up in the wheelchair for two hour and that was part of the reason why she lays down after meals.

On 10/22/15, at 2:05 p.m. the DON stated the redistribution mattress was for back pain and skin, and the heel protector boots could be off when R56 was in bed. The DON was unaware of the pressure ulcer on R56's coccyx. The DON stated R56 had the heel protector boots when she was admitted, and should be wearing them when using the wheelchair. The DON further stated the draw sheet should be the only item between R56 and the mattress. The DON stated R56 did not need the pillows under her legs and feet while using the redistribution mattress. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 51 DON stated she was unsure about the wheelchair cushion and thought the wheelchair was R56's personal wheelchair. On 10/22/15, at 2:34 p.m. RN-C stated RN-B monitored resident's skin. RN-C stated R56 returned from the hospital with some bruises, but there was no evidence or record of pressure ulcers. RN-B stated the open area on R56's coccyx was closed and the nurses were doing the dressing change to the coccyx proactively.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services for 1 of 1 resident (R47) reviewed for range of motion services. Findings include: R47's Admission Record, dated 2/19/14, indicated diagnoses included cerebral infarction (stroke), knee pain, quadriplegia (partial or complete loss of movement of arms and legs), acute respiratory failure and congestive heart	F 318	318 Resident 47 has been assessed and care planned per his preferences on maintaining functional abilities and ROM. All residents have been reviewed for nursing restorative programs and the care plans updated as needed. NARs were trained on restorative/rehabilitative techniques on 11-24-15. All staff received reeducation on the stop and watch program on 11-23-15, which included decline or improvements in ADL	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 52 failure. R47's quarterly Minimum Data Set (MDS) dated 7/22/15, indicated R47 was cognitively intact and required required extensive assistance for transfer, bed mobility, dressing, toilet use and personal hygiene. The MDS indicated R47 received no physical therapy, occupational therapy or restorative services in the last quarter. The MDS also indicated R47 had lower extremity (hip, knee, ankle, foot) impairment to both sides of his body. R47's Activities of Daily Living (ADL) Functional/Rehabilitation Potential care plan dated 3/7/14, indicated R47 needed assistance for the ability to perform ADLs. Interventions included to provide passive range of motion (PROM) to bilateral lower extremities (both legs) during evening (PM) cares and to attend exercise group five times a week. The goal was listed that resident will not further deteriorate in ADL function. R47's care plan dated 8/30/15 indicated R47 has tetrapleqgia (paralysis that results in a partial or total loss of use of all limbs and torso), R47 leaned to the left and had difficulty standing and bearing weight. R47's goal was to maintain an upright position with the wheelchair for one hour and to bear weight for 5 minutes before needing to sit. Approaches included exercise group five times a week for strength and stretching and standing. R47's Kardex directed staff to perform lower extremity range of motion with evening cares	F 318	function and ROM. LNs will audit one resident daily to assure restorative services are provided per care plan to ensure compliance is obtained and that will be completed weekly to assure compliance is maintained. The MDS coordinator will monitor for significant change alert IDT as needed. Changes noted in ADL function and or ROM will have a PT/OT request made. Following the RAI process all Restorative Service plans will be reviewed and updated accordingly. Compliance will be achieved by 12-2-15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 53	F 318		

daily and for R47 to attend exercise group five times a week.

R47's physical therapy plan of care dated 8/4/15, indicated R47 was to start care on this date to determine appropriate transfer program and to upgrade current mobility program. The plan of care indicated R47 was at risk for further decline in mobility. According to the plan of care, R47 was required to have an assist of two for standing mechanical lift transfers, but previously had required only an assist of one when discharged from therapy in February of 2015.

On 10/21/15, at 8:22, the Activities Director (AD)-A stated R47 was a "hit or miss" at attending the exercise group, which was offered daily on Monday through Friday.

On 10/21/15, at 9:59 p.m. R47 stated attended exercise group, "off and on." R47 stated the facility had cut back on staff, so they had not provided provided range of motion services in the evening "much anymore."

In a follow-up interview on 10/22/15, AD-A stated R47 did not really like to come to exercise. AD-A stated R47 should have came and stood, but he just laughed and kept going down the hall.

On 10/22/15, at 9:57 p.m., the physical therapist (PT)-H stated she worked with R47 for several weeks in August in order for him to return to his prior level of function. Prior to that, he had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 54	F 318		

needing two staff to transfer. After therapy, R47 used a standing mechanical lift and an assist of one staff for all transfers. PT-H explained the recommendations and the training she provided to the restorative nurses to perform with R47 upon completion of physical therapy included: standing in the hall using the hand rail and a walker, quad sets, thera-band exercises for lower extremities and trunk strength, and trunk strengthening exercises for wheelchair positioning. PT-H stated the restorative nurse was instructed in this follow-up program.

In a review of documents, restorative nurses last worked with R47 on 9/25/15.

Review of activities attendance records revealed R47 attended exercise group twice in May, three times in June, once in July, once in August, eight times in September and had not yet attended in October.

On 10/22/15, at 10:34 a.m. RN-B stated R47 didn't like to go to exercise, put his feet up, follow his diet or fluid restrictions. The staff try to tell R47 how important it was for his health for him to move around. When asked what the interdisciplinary team had tried for different approaches, RN-B stated they had talked to R47 numerous times.

On 10/22/15, at 12:29 p.m. nursing assistant (NA)-E stated the day shift stood R47 up in the standing mechanical lift when transferring and that was what they did for morning range of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 55	F 318		

motion. NA-E stated the afternoon shift was responsible for doing the upper body exercises.

In a 10/22/15 record review, the "Nursing Range of Motion Program" form for R47 for October 2015 read, PROM to bilateral lower extremity with PM cares. All but 4 days were signed as complete.

On 10/22/15, at 2:04 p.m. NA-E stated the nursing assistants were not trained to do the standing exercises or the thera-band exercises. NA-E stated the nursing assistants performed passive range of motion to R47's lower extremities with his evening cares, but not specific quad exercises.

On 10/22/15, at 2:10 p.m., registered nurse RN-C indicated nursing assistants tried to do upper and lower range of motion exercises for R47. RN-C stated the restorative nurse was doing R47's exercises up until a few weeks ago when the positions ended.

A sheet with lower extremity PROM exercise pictures was provided in the nursing assistants work area. In an interview on 10/22/15, at 3:32 p.m. R47 stated the nursing assistants were not performing the exercises depicted in the pictures. R47 stated that he used to do those exercises with restorative staff including stretch and moving his knee, using the thera-band and him pushing against them to the side. R47 stated they don't do range of motion at night anymore because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 56 there were too busy. On 10/22/15, at 4:30 p.m. PT-H stated R47, "drives his own bus." PT-H stated they can't make him go to exercise group. During an observation of recommended exercises during the interview, PT-H stated R47's functional level continued to be what it was at the time of discharge from services on August.	F 318		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor for side effects and efficacy, obtain appropriate diagnoses for the justication and assessment for the use and provide informed consent for psychotropic medications for 4 of 5 (R3, R37, R45, R40) residents reviewed for unnecessary medications. Findings include: R40 received risperidone (antipsychotic to treat schizophrenia and/or bipolar disease) for agitation and restlessness and the facility failed to provide family with informed consent, lacked indentificaion of use on care plan for psychotropic medications along with a system to monitor for side effects and efficacy. R40's quarterly Minimum Data Set (MDS) dated 8/4/15, indicated R40 was diagnosed with Alzheimer's disease, anxiety and depression. The MDS also indicated R40 had moderate cognitive impairments and minimal depression. The MDS indicated R40 had 1-3 days of verbal behavioral symptoms with no delusions or hallucinations. R40's physician orders dated 9/8/15, directed staff to administer risperidone 0.25 milligrams (mg) twice a day, risperidone 0.5 mg at bedtime and risperidone 0.25 mg every four hours as needed (PRN) up to three times a day. Diagnoses for risperidone listed were agitation and restlessness. The physician orders directed	F 329	329 Resident 40 has been reviewed and physician has agreed with current medication management. Assessments have been completed for side effect monitoring, tardive dyskinesia, and the behavior management care plan, and consents reviewed. Black box warnings will be told to patient or family upon initial consent. Resident 3, 37 and 45 Assessments have been completed for side effect, tardive dyskinesia, and the behavior management care plan reviewed and consents reviewed All residents on psychotropic medications have been reviewed for side effect monitoring, Tardive Dyskinesia, Behavior monitoring, care planning and consent. The MEDICATION/TREATMENT ORDER Policy has been revised to include documentation for interventions tried before given a PRN psychotropic and effectiveness of the medication after administration. The PSYCHOPHARMALOGICAL MEDICATIONS Policy has been updated to assure the “black box” warnings will be included on the consent forms and staff trained on 11-23-15. All residents on psychotropic medications have been reviewed and will continue to be audited monthly, with any change in medication, with any dosage change, or change in condition. All new admissions will be reviewed for use of psychotropic medications and the same monitoring system set up for monitoring of side	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 58 staff to administer the following antidepressants duloxetine 60 mg daily, mirtazapine 15 mg daily and trazodone 50 mg at bedtime. R40's psychotropic medication use Care Area Assessment (CAA) dated 1/7/15, indicated nursing monitored for effectiveness and side effects per protocol for psychotropic medications. The CAA indicated R40 did exhibit numerous behaviors daily that were not redirectable. R40's care plan dated 2/4/15, indicated R40's diangoses included dementia, depression, anxiety, aggression and moods. The care plan interventions included approach resident in a calm soothing manner, approach from the front, explain your intentions prior to initiating care and if R40 became resistive and striking out, ensure resident is safe and reproach later. The care plan lacked any direction for staff to monitor side effects and efficacy of psychotropic medications. The 10/15, behavior monitoring sheet listed R40's target behaviors as obsessing over things, anxious and yelling out. The interventions directed staff to redirect, 1:1 activity, return to room, toilet, give snack/fluid, change position and back rub. The medications trazodone, mirtazapine, duloxetine given together had a major risk of serotonin syndrome (a rare but serious side effect). R40's medical record lacked monitoring for the potential side effect.	F 329	effects, Tardive Dyskinesia, behavior monitoring, consent obtainment and care plan completion. Nurse managers will run the “order reports by category” report weekly for 3 months out of the electronic health record for those on psychotropic medications and audit for completion of monitoring including appropriate diagnosis, use of medication consent assessment, and evidence of side effect monitoring. Additionally, the nurse managers with work with the consultant pharmacist monthly. Monthly pharmacy meetings are held with clinical managers, CNP and pharmacist. These meetings will now include monitoring for antipsychotic medications for diagnosis and or reason for use, assessments, consents and a summarizing note of this meeting will be included in the resident’s medical record. The DON will review for completion of these notes monthly with pharmacy consultation; this auditing will continue for not less than 6 months and then as determined by quality council. The RAI Manger is responsible for audits. Compliance will be achieved by 12-2-15. Findings will be presented to Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 59	F 329		

R40's Medication Administration Record (MAR) from 8/1/15, through 10/20/15, indicated R40 had received PRN risperidone 0.25 mg on 9/30/15, 10/7/15, 10/11/15, and 10/20/15, for behavior issues of yelling. The MAR listed the following interventions to be attempted prior to administering PRN risperidone: attempt 1:1, offer snack, beverage, activity, toileting. The MAR lacked documentation that interventions were attempted prior to the risperidone being administered.

The medical record lacked daily documentation on side effect monitoring and efficacy to formulate a quarterly analysis.

R40 did not have any observed behaviors during the survey period of 10/19/15, 10/20/15, 10/21/15, 10/22/15, and 10/23/15.

On 10/21/15, at 7:52 a.m. R40 stated she had never been depressed and she cannot remember what her medications were for.

On 10/22/15, at 1:41 p.m. member (FM)-C stated R40 was having some behaviors when admitted to the facility and the facility had asked for consent for medications and had also asked for a transfer to a behavior health facility. FM-C also reported that he signed a consent for the medications but was not aware of serious potential side effects of death for taking an antipsychotic for a person with dementia (black box warning). FM-C stated the facility did not involve the resident or himself in any behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 60	F 329		

intervention techniques prior to administrating medications and a transfer to the behavioral health unit.

On 10/29/15, at 1:59 p.m. nursing assistant (NA)-F stated R40 got angry at times and yelled at staff and other residents. NA-F further stated R40 had not hurt herself or others. NA-F reported there were no individualized interventions for R40 as the interventions listed were the same for all residents. NA-F stated R40 was redirected easily.

On 10/22/15, at 2:14 p.m. licensed practical nurse (LPN)-C stated the floor nurses did not collect data for psychotropic medication monitoring for side effects or efficacy of the medications. LPN-C stated the registered nurses did a quarterly summary.

On 10/23/15, at 1:47 p.m., the director of nursing (DON) acknowledged that agitation and restlessness were not appropriate diagnoses for the use of antipsychotic medications and had been trying to get the diagnoses changed. The DON was not aware of the black box warning for the use of antipsychotic medications with persons with dementia. The DON stated the RN's summarize quarterly on psychotropic medications but there was not a process for collecting any side effects or the efficacy of medication daily. The DON further stated the RN's gathered their information by a chart review on behaviors and talking to each other. The DON expected interventions be documented as tried and ineffective prior to administering a PRN antipsychotic medication and that yelling was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 61	F 329		

always an appropriate reason. The DON also stated R40 should have a care plan on psychotropic medication use as that was expected and was policy.

R3 was not monitored for side effects of antipsychotic medication use.

R3's undated Admission Record identified diagnoses that included depression.

R3's quarterly MDS dated 10/15/15, indicated R3 was cognitively intact and required staff assistance for activities of daily living. The MDS also identified R3 had mood indicators of feeling down, depressed or hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy and feeling bad about himself. The MDS further identified the following behavioral symptoms: verbal behavioral symptoms directed towards others, and other behavioral symptoms not directed at others.

R3's physician's orders dated 9/24/15, directed risperidone (an antipsychotic medication) 0.25 milligrams (mg) be administered at bedtime.

R3's care plan dated 10/11/12, indicated R3 was at risk for side effects of psychotropic medication use and would not develop side effects. The care plan directed staff to monitor for medication side effects per protocol, review medication use, potential for side effects, and any actual side effects with resident/family per protocol, and review medication use with MD per protocol. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 62	F 329		

care plan lacked indication of what side effects staff were to be monitoring for.

R3's medical record lacked indication of side effect monitoring.

On 10/22/15, at 1:49 p.m. RN-B verified the facility had not completed side effect monitoring related to R3's resperidone use.

R37 received Risperdal (an antipsychotic medication) for dementia with Lewy bodies and the medical record lacked a system to monitor for side effects and also lacked an assessment of behaviors prior to the initiation of the medication.

R37's Resident Admission Record (undated) indicated R37's diagnoses included Parkinson's disease, disorientation, dementia with Lewy bodies, other mental disorders due to known physiological condition, increased confusion and depression.

R37's quarterly MDS dated 8/6/15, indicated R37 had no cognitive impairment. R37 had hallucinations. R37 needed the total assistance of two staff with bed mobility, transferring and toilet use. R37 did not walk. R37 had two or more falls since the prior assessment and received an antipsychotic medication on seven of seven days during the assessment period.

R37's Psychotropic Medication Use Care Area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 63	F 329		

Assessment (CAA) dated 5/27/15, indicated R37 was showing a decline in health and cognition due to the disease process. R36 remained alert but was confused and had times of delusional thinking. R36 was at risk for falls and had a fall without injury since the previous assessment. R37 received antipsychotic medication daily which remained appropriate.

R37's Physician Orders dated 10/1/15, through 10/31/15, directed staff to administer Risperdal 0.25 milligrams (mg) by mouth two times a day for the diagnosis of Lewy bodies dementia. The Risperdal had a start date of 2/2/15.

R37's Psychotropic Medication care plan dated 6/14/10, indicated R37 was at risk for side effects of psychotropic medication use and to refer to the Medication Administration Record (MAR) for specifics. Approaches included monitor for side effects. Review medication use for potential side effects with resident and family. Review medication use with the physician. Review of the MAR lacked side effect specifics.

The Daily Behavior Observation Sheets done every shift indicated R37's behaviors consisted of inappropriate sexual comments, attention seeking, complaints about wheelchair, attention with regard to health related issues, complaints of caregivers/staff and yelling/aggressiveness toward staff. The Observation Sheets lacked monitoring for hallucinations.

R37's medical record lacked descriptive behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 64	F 329		

documentation that included onset, duration, possible precipitating events and or environmental triggers.

R37 did not have any observed behaviors during the survey period of 10/19/15, 10/20/15, 10/21/15, 10/22/15, and 10/23/15.

On 10/19/15, at 6:41 p.m. R37 stated he seen water leaking through the ceiling. "The water comes out of the lamp and sprays on the curtain."

On 10/23/15, at 10:54 a.m. the director of nursing (DON) stated there was no monitoring of R37's hallucinations because the hallucinations were constant and were never going away. The DON stated charting was done by exception. The DON verified R37's medical record lacked a risk vs benefit statement and clinical rational for continuation. The DON stated monitoring side effects was done quarterly and was done last in 5/15.

On 10/23/15, at 9:38 a.m. nursing assistant (NA)-A stated R37 saw sand come out of the ceiling and feels water dripping on him. NA-A tried to redirect R37. NA-A stated the hallucinations were mainly on midnight shift. NA-A reassures R37 everything will be okay and will stay in the room with him or take him out of his room to the lobby to talk to the nurse. Sometimes R37 went back to sleep or you would have to take him out and he's better. "It's real to him."
R45 was not monitored for side effects from psychotropic medications nor for abnormal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 65	F 329		

involuntary movement (AIMS) according to facility policy or best practices.

R45's quarterly MDS, dated 8/18/15, indicated R45 was cognitively intact, suffered from severe depression and required extensive assistance with bed mobility, transfers, dressing and personal hygiene. The MDS also identified R45 as receiving antipsychotic, antianxiety, antidepressant, hypnotic, anticoagulant and diuretic medications each of the 7 days of the review period.

R45's 9/16/15, admission record identified diagnoses including major depressive disorder (recurrent, severe with psychotic symptoms), anxiety, insomnia, suicidal ideations, sleep apnea and chronic obstructive pulmonary disease (COPD). R45's 7/25/15, care plan identified left side weakness related to a stroke.

R45's Vulnerable Adult care plan, dated 7/25/15, indicated R45 was at risk for side effects of psychotropic medication use with a goal R45 would develop none to minimal side effects of psychotropic medication use. The approaches, with a start date of 7/25/15, directed staff to use the following approaches: monitor for medication side effects per protocol, review medical use, potential for side effects and any actual side effects with resident/family per protocol, review medication use with MD per protocol.

R45's AIMS (an assessment to monitor movements)observation, dated 7/26/15, indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 66	F 329		

R45 did not exhibit any AIMS movements at that time. AIMS were requested back to R45's original admission on 2/20/15, but were not received.

R45's current physician orders, dated 9/16/15, included the following medications:
-Lexapro (escitalopram oxalate), 20 mg once a day, an antidepressant
-risperidone tab, 0.5 mg tablet at bedtime, an antipsychotic.
-zolpidem, 5 mg tab at bedtime as needed for insomnia, a hypnotic
-lorazepam, 0.5 mg three times a day as needed, for breakthrough anxiety or agitation

On 10/21/15, at 8:43 a.m. and 10/23/15, at 8:43 a.m. R45 was observed in the dining room, making repetitive mouth movements-open and close-when sitting and not while eating or talking.

Review of R45's undated medication side effect flow sheet revealed three observation dates: 8/15/15, 8/26/15, and 9/1/15. The following side effects and frequency were noted:

8/15/15:
-Insomnia (present but does not hinder function)
-Agitation (present and produces some impairment)
-Akathisia (inability to sit/inner restlessness) (present and produces some impairment)

8/26/15:
Akathisia: (present and produces some impairment)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 67 Agitation: (present and produces some impairment). 9/1/15: Akathisia: (present and produces some impairment) Agitation: (present and produces some impairment) All side effect monitoring was requested. No other side effect monitoring was provided by the facility. On 10/23/15, at 9:26 a.m. RN-C stated side effect monitoring forms were put out if the staff seen any signs of side effects. RN-C stated the updated medication side effect flow sheet for R45 was begun when clonazepam (an antiseizure medication) was discontinued. RN-C thought the standard timeframe was to do these flow sheets with the quarterly reviews. On 10/23/15, at 9:26 a.m. when asked about R45's mouth movements, RN-C stated she had not known R45 before and guessed "she's always done that." RN-C stated she had asked R45 about repetitive leg rubbing, but not about the mouth smacking. When asked to clarify if a movement was to be documented if it had been ongoing, RN-C replied, "I would think so." On 10/23/15, at 10:45 a.m. the DON stated AIMS assessments were done on admission, usually in the first week, and every six months. The DON also stated side effect monitoring was to be done quarterly by the RNs.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 68 The facility Abnormal Involuntary Movement Policy, date July 2013, indicated individual prescribed antipsychotics would be assessed at least every three months. The facility policy Psychotropic Medications dated 7/08, directed staff that all psychotropic medications would have the appropriate diagnosis for prescribed medications, side effect monitoring in place, AIMS assessment completed on admission and bi-annually for residents on antipsychotic medications.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334		12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 69 the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 70 refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to determine and document the pneumococcal vaccination status for 2 of 5 residents (R56, R3) reviewed for immunizations. Findings include: R3's admission documentation was dated 9/21/12. There is no evidence to indicate R3's pneumococcal vaccination status was determined upon admission. R56's admission documentation was dated 8/17/15. There is no evidence to indicate R56's pneumococcal vaccination status was determined upon admission. On 10/22/15, at 5:30 p.m. the Health Unit Coordinator (HUC)-E stated when a resident was admitted and she found immunization history in the hospital paperwork she would record the immunization status in the medical record. HUC-E stated if she didn't find the immunization information, she ensured that a blank Pneumococcal Vaccination consent form was passed on to the nurses in their admission paperwork so they knew to gather this information. HUC-E stated she could not find any documentation on pneumococcal vaccinations for R3 or R56 in either their electronic or hard copy medical record.	F 334	334 All residents have been audited for influenza and pneumococcal vaccinations. All residents will have their current status reviewed on the MICC site. Residents requiring either vaccination will be offered and consents or declinations signed and the MICC site and resident face sheets will be updated by 12-1-15. Health information has developed an admission checklist and this includes obtaining consent or declinations for both vaccines. Orders for pneumococcal vaccinations for those under the age of 65 will recur in 10 years. The Influenza and Pneumonia Vaccination Process was reviewed and remains appropriate. Health Information will complete an admission audit to assure vaccination status is obtained and offered accordingly. The DON or designee will complete an annual audit for vaccination status every November. The DON is responsible for the audits. Compliance will be achieved by 12-2-15. Findings will be presented to Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 71 The facility policy and procedure on immunizations dated 2/11, directed the facility to ensure residents were offered pneumococcal immunization. The facility policy and procedure on pneumococcal vaccinations dated 6/14 indicated each resident's medical record would reflect the resident's immunization status.	F 334		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address bleeding gums and arrange for annual routine and / or emergency dental appointments for 1 of 3 residents (R51) observed with bleeding gums following oral hygiene. Findings include: R51's Admission Record dated 10/1/14, identified diagnoses that included pain, dementia, chronic kidney disease, atrial fibrillation and heart	F 412	412 Resident 51 has a dental appointment made. All residents have been reviewed for Oral Assessments and care plans updated accordingly and if a dental appointment was needed that has been made. The STOP and WATCH protocol was reviewed and remains appropriate and staff re-educated on 11-23-15. Upon admission the Clinical Manger will assure dental services have been addressed and this information will be	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 72 disease. R51's annual Minimum Data Set (MDS), dated 9/8/15, indicated R51 had severely impaired cognition and required extensive assistance with dressing, toilet use and personal hygiene. R51's MDS also indicated obvious or likely cavities or broken natural teeth. R51's Dental Care Area Assessment (CAA) dated 9/8/15, indicated resident had his own teeth with some missing and likely cavities. The CAA indicated a visual inspection revealed no noted sores, lesions or patches in oral cavity. The CAA further indicated R51's last dental exam was unknown with no dental exam wanted at this time and staff were to set-up and offer cues and supervision with feeding and oral cares. R51's cognition care plan, dated 10/13/14, indicated R51 memory impairment with difficulty making independent decisions. The care plan indicated R51 needed moderate assistance with decision making related to dementia. The short term goal edited on 9/18/15, indicated R51 will make his own decisions with the help of staff and family as needed. Approaches directed staff to establish and maintain a consistent Activity of Daily Living (ADL) routine, observe for confusion and report to licensed nurse, provide reorientation, cues and reminders as needed and assist with decision making as needed. R51's care plan for Anticoagulant Therapy, dated 11/6/14, directed staff to encourage use of soft toothbrush and observe for signs of active	F 412	placed in the medical record and audited by the RAI manager for all admissions until compliance is achieved and then randomly to assure compliance is maintained. Following the RAI schedule all resident will be audited for one quarter to assure appropriate assessments are completed and the care plans are effective and consults made as needed. This auditing will continue for not less than 3 months to assure compliance. And will continue for all comprehensive MDS's. The RAI Manger is responsible for audits. Compliance will be achieved by 12-2-15. Findings will be presented to Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 73	F 412		

bleeding (nosebleeds, bleeding gums, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temp, pain in joints, abdominal pain, epistaxis).

R51's care plan did not address daily dental care, annual exams or emergency care.

R51's Kardex indicated he had his own teeth and required assist of one for oral cares.

On 10/21/15, at 7:09 a.m. R51 was observed during morning cares. Nursing assistant (NA)-H wet R51's toothbrush, applied toothpaste and asked R51 if he'd brush his teeth. R51 initially refused, but did take the toothbrush and independently brushed his teeth. As R51 continued to brush his teeth, spit and rinse the brush, blood was observed on the brush and in the water. NA-H stated R51's gums were sensitive and R51 brushed "so hard." NA-H asked R51 to stop brushing and rinse his mouth with water. NA-H stated, "I've never seen your mouth bleed so bad." R51 replied, "Me either." R51 denied pain. After rinsing, drying and handwashing, NA-H escorted R51 to licensed practical nurse (LPN)-A, and informed her R51's gums were bleeding "more than usual." LPN-A asked R51 to wait for her on the couch in the second floor day room.

Review of R51's medical record on 10/22/15, lacked evidence of LPN-A, or any staff person, acknowledging or addressing R51's bleeding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 74 gums on 10/21/15. On 10/22/15, at 10:29 a.m., LPN-C stated she worked four days per week. LPN-C stated R51's bleeding gums had never been reported to her. LPN-C also stated it was not on the report board, nor was anything verbally reported to her that R51 had bleeding gums the day before. On 10/22/15, at 10:30 a.m. registered nurse (RN)-B stated she had not heard R51's gums were bleeding the day before and no one had talked about his gums bleeding previously. RN-B stated, "It may be so common" and that was why it was not reported. RN-B also stated R51's last care conference was on 9/10/15, and there was no mention in the notes addressing R51's dental needs. The facility's oral hygiene policy dated 2/11, directed staff to report/record the condition of a resident's mouth, including bleeding, swelling, or excessive redness of the gums.	F 412		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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	F 465	F465	12/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 75 review, the facility failed to ensure resident rooms were well maintained for 17 resident rooms (room 111, 128, 133, 137, 140, 204, 206, 207, 209, 213, 231, 235, 237,238, 239,240) and a urine odor was detected in room 202. In addition, the facility failed to provide routine maintenance to the common area carpets, light fixtures, walls, ceilings, elevators, second floor dining room and overhead kitchen vent. This had the potential to affect all 46 residents residing in the facility. Findings include: On 10/22/15, at 10:19 a.m. an environmental tour was conducted with the environmental services director (ED)-D The following common areas were identified in need of repair: The first floor East hallway had multiple gouges in the walls and the handrails lacked varnish in areas. The first floor West hallway had duct tape on the floor outside of RM 130 as well as handrails that lacked varnish and had some rough areas on the handrails. The second floor East hallway smelled of urine. ED-D reported the facility was planning on replacing carpet in a residents room but had not finalized the repairs at this time.	F 465	Routine Rounds are made and maintenance request forms are made available throughout the building. Round are made by various individuals such as the Administrator, Plant Operations supervisor, Housekeepers and the Culinary Director. Routine maintenance to common areas is provided on an ongoing basis. Daily cleaning is completed on schedule and deep cleaning is completed with an identified need in addition it may be identified by rounds/audits/maintenance requests. No maintenance request regarding room 202 was ever presented. The room had been identified during rounds made in September 2015 for various needs. Duct tape in areas of torn carpet was put in place after gluing. This practice was discontinued in February of 2015. Walls, carpets, and other necessary repairs/replacement will be made in rooms 111, 128, 133, 137, 140, 204, 206, 207, 209, 213, 231, 235, 237, 238, 239 and 240 will be made as necessary. Cleaning schedules will be redeveloped for all areas. Hand rails will be repaired or removed as necessary in all areas. Rounds/audit schedules will be developed for all areas of the skilled nursing facility. Rounds/audits will be routinely made by housekeepers, plant operations supervisor, culinary director and the administrator. Areas will be assigned on a routine schedule. These rounds/audits will assist in identifying and scheduling additional actions to take place.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 76 The second floor West hallway had worn carpet that was ripped and had duct tape holding the carpet together. The window at the end of the hallway had worn varnish on the window ledge. The second floor lobby area had worn carpet that was ripped with duct tape holding the carpet together. The ceiling light fixture contained multiple bugs. The ceiling near the East elevator was stained from water damage. The East elevator had a thick coating of dust on the vent. The second floor dining room had multiple gouges in the the flooring. Three holes covering a 2 foot (ft) x 9 inch (in) area. One hole measuring 3.0 in X 2.0 in. Duct tape in the center of the floor measuring 10 in. x 2 in. The lower dining room cabinets had exposed wood on the edge of cabinet. ED-D reported he was in the process of receiving a second bid on the flooring but the repairs had not been finalized. The following resident rooms were identified to need repair: Room (RM) 111 privacy curtain was missing 7 hooks that created a hanging gap at the top of the curtain. RM 128 had a ceiling tile in the bathroom which	F 465	Preventive maintenance is routinely scheduled by the Plant Operations Supervisor. The current scheduling did not include key areas of the skilled nursing facility and will be added to that schedule in addition to the rounds/audits that are being initiated. All areas will be monitored by the Plant Operations Supervisor, Housekeepers, Culinary Director and Administrator. Rounds/Audits will be monitored for completion with the administrator on a routine basis. Completion date will be December 2, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 77	F 465		

was cracked near the ceiling vent.

RM 133 had carpet with large multiple stains and the carpet was loose and did not lay flat in the center of the room.

RM 137's main door to the room did not shut all the way.

RM 140 had loose and rumpled carpet.

RM 204 had multiple scuff marks on the walls.

RM 206 had carpet that was loose and did not lay flat.

RM 207 had carpet that was loose and did not lay flat.

RM 209 had carpet that was loose and did not lay flat. There were gouges in the wall behind the door and behind the head of the bed.

RM 213 had carpet that was loose and did not lay flat.

RM 231 had torn carpet in the center of the room. There were gouges in the wall behind the bed. The caulking around the base of the toilet in the bathroom was dirty and peeling.

RM 235 had carpet that was loose and did not lay flat. There were multiple black markings on the wall behind the door. The main door and door jam had multiple scuffed markings.

RM 237 had a built in closet/dresser which had several gouges in it with the largest being 5.5 in X 2.5 in. The main door had a 7.5 in. x 3/4 in area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 78	F 465		

of separation exposing particle board. The facility small chest of drawers had worn areas exposing wood.

RM 238 the caulking around the bathroom toilet was dirty and peeling up.

RM 239 lacked caulking around the base of the toilet. There were multiple markings on the walls.

RM 240 had carpet stained in multiple areas. The built in dresser/closet had multiple gauges with the largest measuring 1 1/2 in x 0.5 in. There were gauges in the wall being the chair exposing sheet rock.

The blank Safety Rounds Worksheet included areas to address the following concerns:

vents dirty
doors with chips/scrapes
furniture dirty/repair
carpet dirty/repair
wallpaper
ceiling stains
chipped paint
odors

ED-D stated on 10/22/15, at 10:19 a.m. during the environmental tour the environmental audits were not being conducted due to the lack of maintenance staff.

On 10/22/15, at 11:37 a.m. the dietary manager (DM)-C verified the hood vent above the stove was greasy and covered in dust. DM-C stated the vents were cleaned every 6 months and as needed and would put in a maintenance ticket to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 79	F 465		

get the vents cleaned.

On 10/22/15, at 3:10 p.m. the administrator stated the facility planned to contract services for the building repairs as the facility lacked the capacity to hire more staff to help with the repairs needed. The administrator further stated they were trying to prioritize repairs that were safety issues versus aesthetics.

The facility policy and procedure on Cleaning Resident Rooms dated 3/14, directed staff to clean vents, spot clean walls and use carpet cleaner on any noticeable spots.

Room 202 (R18's room) smelled of urine and a soiled incontinent brief on the floor could be observed from the doorway.

R18's quarterly Minimum Data Set (MDS) dated 8/8/15, indicated R18 had moderate cognitive impairment, required extensive assistance to toilet and was frequently incontinent. The MDS included diagnoses of schizophrenia and dementia.

On 10/19/15, at 4:07 p.m. R18's room was observed to smell strongly of urine.

On 10/21/15, at 7:09 a.m. R18's room was again observed to smell strongly of urine, with a soiled incontinent brief on the floor.

On 10/22/15, at 2:09 p.m. nursing assistant (NA)-F verified the room odor and stated staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 80 had been requesting the removal of the carpet due to the strong urine odor in R18's room for over 6 months. On 10/23/15, at 1:27 p.m. the director of nursing (DON) stated the facility was planning on replacing R18's bedroom carpet.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY 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. Raphaels Health & Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/12/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Raphaels Health & Rehabilitation Center is a 2-story building with a full basement. The original building was constructed in 1954 with an addition constructed in 1974. The 1954 building is of type II(111) construction and the 1974 building is type II(111) construction. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 76 beds and had a census of 47 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD 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 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) 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 the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, observation revealed, that the Soiled Utility room 128A on the first floor and 228A on	K 029	K029 Doors to 128A and 228A latches were repaired and operating by October 27, 2015. Doors will be monitored by the Plant Operations Supervisor. Audits and monitoring will be reviewed by the Administrator or designee. Completion date Nov 1, 2015	11/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 the second floor did not positively latch into the frame. This deficient condition was verified by the Maintenance Supervisor.	K 029		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility could not provide any documentation verifying that the annual 90 minute testing of the battery backup emergency lights had been completed. This deficient practices was confirmed by the Maintenance Supervisor.	K 046	K046 Emergency lighting testing will be completed by the plant operations supervisor on an annual basis. The administrator or designee shall monitor for completion. The annual test was completed on October 28, 2015. Completion date October 28, 2015	10/28/15
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		11/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050 SS=D	Continued From page 4 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility failed to vary the times of the fire drills by conducting three of the afternoon shift drills were held in the 3 PM hour and all of the overnight shift drill are in the 5 AM hour. This deficient practices was confirmed by the Maintenance Supervisor.	K 050	K050 Quarterly drills were held but a varying schedule was not complied with. A schedule will be developed by the Plant Operations Supervisor and reviewed with Safety Team. This will be monitored by the administrator or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 5	K 052		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 1-5.6. This deficient condition could adversely affect the functioning of the fire alarm system failing to alert the facility in the event of a fire emergency negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, observations revealed that the fire alarm control panel that is located in the facility's maintenance room did not have a smoke detector located within 5 feet of the fire alarm control unit. This room is not constantly attended and did not have any heating producing equipment located	K 052	K052 A smoke alarm was installed by November 2, 2015. The alarm will be monitored by the Plant Operations Supervisor. The administrator or designee will monitor for compliance.	11/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 6 within the room. The only piece of equipment located in the maintenance room that did produce any heat was the facility's computer server. These observations and conditions do not appear to meet the exception to NFPA 72 National Fire Alarm Code section 1-5.6. This deficient practices was confirmed by the Maintenance Supervisor.	K 052		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system	K 056	K056 Eight escutcheon rings were found missing and will be replaced. The corroded sprinkler head will be replaced in the dish room. The kitchen sprinkler heads will be replaced as to be standard response sprinkler heads. The gauges on the main fire sprinkler riser will be replaced to new. The fire sprinkler riser	11/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 7 capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, observations revealed that the following conditions were found to be affecting the facility's fire sprinkler system: 1. escutcheon rings missing from the 238 storage room, 2nd East nurses station by chart room 201D, 2. there is a corroded sprinkler head located in the kitchen's dish washing room, 3. there are 2 quick response sprinkler heads mixed in with standard response sprinkler heads located in the kitchen, 4. the gauges that are located on the main fire sprinkler riser were last replaced in Feb. 2006 outside of the 5 year replace or recalibrate requirements, 5. The fire sprinkler riser is blocked from full and immediate access by multiple bio-hazard barrels. This deficient practices was confirmed by the Maintenance Supervisor.	K 056	has been made accessible and any items blocking the riser have been relocated.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		11/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 8 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, a review of documentation and interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any documentation for 3 of 4 quarterly fire sprinkler flow test having been completed. This deficient practices was confirmed by the Maintenance Supervisor.	K 062	K062 The quarterly fire sprinkler flow tests will be completed by the plant operations supervisor or designee. This will be monitored by administrator or designee. Completion date November 11, 2015	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		11/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 9 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor, that at the time of the inspection the facility could not provide any documentation verifying that the facility's smoke and fire damper had been tested within the last 4 years. This deficient practices was confirmed by the Maintenance Supervisor.	K 067	K067 Fire and smoke damper testing will be completed by an outside vendor. This will be monitored for compliance by the Plant Operations supervisor. Completion date will be November 30, 2105	
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076		12/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE** **EVELETH, MN 55734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 10 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Observations revealed that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition) section 4-3.1.1.2. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:00 AM to 2:00 PM on 10/22/2015, it was observed that the door to the oxygen storage rooms 134 and 234 open into the exit corridors and are equipped with transfer grills on the top and bottom of the doors. It was also observed that the room that these cylinders are being stored in was not vented to the outside by a dedicated mechanical ventilation system or natural venting means that is in accordance with oxygen storage rooms. This deficient practices was confirmed by the Maintenance Supervisor.	K 076	K076 Oxygen Room doors 134 and 234 will be replaced with solid core doors. The Plant Operations Supervisor will monitor for completion of this change. Completion date December 6, 2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245277	ST RAPHAELS HEALTH & REHAB CTR

Type of Survey (select all that apply):

I					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 29433	10-19-2015	10-23-2015	0.00	2.00	38.50	2.00	2.00	17.75
2. Team Leader 29625	10-19-2015	10-23-2015	2.00	2.00	38.50	2.00	2.00	25.75
3. 34983	10-19-2015	10-23-2015	0.00	2.00	38.50	2.00	2.00	23.50
4. 35575	10-19-2015	10-23-2015	0.00	1.00	39.50	2.00	2.00	20.50
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 25.50

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... Y