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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4536

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245283**

2.STATE VENDOR OR MEDICAID NO.
(L2) **228663700**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **6/19/2013** (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 **87** (L18)

13.Total Certified Beds **87** (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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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 7/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 7/11/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/31/2013 CO 4536

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/24/2013
(L33)

DETERMINATION APPROVAL

A standard OTC survey was completed at this facility on March 1, 2013. Deficiencies were found, the most serious were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F).

A LSC FMS was completed on March 19, 2013. Deficiencies were found, the most serious at a S/S level of F. As a result of the FMS, CMS informed the facility of the following remedy:

- Mandatory DOPNA, effective June 1, 2013

In addition, CMS also informed the facility that if DOPNA goes into effect, they would be subject to a loss of NATCEP for a two year period beginning June 1, 2013

On April 25, 2013, a PCR was conducted and two deficiencies were found uncorrected, the most serious were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). As a result, we imposed state monitoring effective May 8, 2013.

We also recommended the following to CMS:

- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F431, effective April 25, 2013, for a total penalty of $1,000.00.

- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F441, effective April 25, 2013, for a total penalty of $1,000.00.

- Mandatory DOPNA, effective June 1, 2013 remain in effect

A second health PCR was completed on June 19, 2013, and the LSC and FMS PCR were completed on May 28, 2013. The PCR's found all deficiencies corrected and the facility was in substantial compliance as of June 1, 2013.

As a result, we are recommending the following to the CMS RO:

- Mandatory DOPNA, effective June 1, 2013 be rescinded

Please note NATCEP loss was not triggered since DONPA did not go into effect.

Additionally, on July 8, 2013 the Minnesota Department of Public Safety completed a follow-up of the temporary waiver involving the Life Safety Code deficiency cited at K038. This deficiency was found to be corrected as of July 8, 2013.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K038, K067, & K103.

See attached CMS-2567B's for the results of the May 28, 2013, June 19, 2013 and July 8, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5283

July 11, 2013

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

Dear Ms. High:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 1, 2013 the above facility is recommended for:

87 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 87 skilled nursing facility beds.

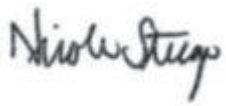
We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K014, K067, & K103.

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 11, 2013

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

RE: Project Number S5283023

Dear Ms. High:

On March 10, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2013. 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.

In addition, on March 19, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. 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 April 1, 2013, CMS forwarded the results of the FMS to you and informed you that the following remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 1, 2013. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 1, 2013, 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 Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 1, 2013.

On April 25, 2013, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 1, 2013. Based the visit, we determined that your facility had not achieved substantial compliance with the deficiencies issued pursuant to the March 1, 2013 survey.

As a result of the April 25, 2013 revisit results, we informed you in our letter dated May 3, 2013 that the following enforcement remedy was being imposed:

- State Monitoring effective May 8, 2013. (42 CFR 488.422)

Also on May 3, 2013, we recommended to the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies be imposed:

- Per instance civil money penalty of $1,000.00 for the deficiency cited at F431, effective April 25, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,000.00 for the deficiency cited at F441, effective April 25, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 1, 2013 remain in effect. (42 CFR 488.417 (b))

On June 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR), and on May 28, 2013, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on March 1, 2013, the April 25, 2013 PCR, and the FMS, completed on March 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 1, 2013. Based on our PCR's, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2013, the April 25, 2013 PCR, and the FMS, completed on March 19, 2013.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 1, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 3, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 1, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 1, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 1, 2013, is to be rescinded.

In the CMS letter dated April 1, 2013 CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was

prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 1, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 1, 2013, 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.

Your request for a continuing waiver involving the deficiencies cited under K014, K067, & K103 at the time of the March 1, 2013 FMS survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Additionally, on July 8, 2013 the Minnesota Department of Public Safety completed a follow-up of the temporary waiver involving the Life Safety Code deficiency cited at K038. This deficiency was found to be corrected as of July 8, 2013.

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.

Enclosed is a copy of the Post Certification Revisit Form (CMS-2567B) from the May 28, 2013, June 19, 2013, and July 8, 2013 revisits

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

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

2nd PCR

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245283	A. Building B. Wing	6/19/2013

Name of Facility	Street Address, City, State, Zip Code
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**06/01/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	**06/01/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PH/NCS	Date: 7/11/13	Signature of Surveyor: 29625	Date: 6/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/1/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245283	A. Building B. Wing **01 - MAIN BUILDING 01**	5/28/2013

Name of Facility	Street Address, City, State, Zip Code
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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 **03/20/2013**	ID Prefix	Correction Completed **05/17/2013**	ID Prefix	Correction Completed **05/17/2013**
Reg. # **NFPA 101** LSC K0017		Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0025	
ID Prefix	Correction Completed **05/27/2013**	ID Prefix	Correction Completed **05/17/2013**	ID Prefix	Correction Completed **05/17/2013**
Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0033	
ID Prefix	Correction Completed **05/17/2013**	ID Prefix	Correction Completed **04/12/2013**	ID Prefix	Correction Completed **05/17/2013**
Reg. # **NFPA 101** LSC K0046		Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0056	
ID Prefix	Correction Completed **04/05/2013**	ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed **04/30/2013**
Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0069		Reg. # **NFPA 101** LSC K0071	
ID Prefix	Correction Completed **04/05/2013**	ID Prefix	Correction Completed **03/20/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0144		Reg. # **NFPA 101** LSC K0147		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/NCS	7/11/13	03005	5/28/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/19/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245283	01 - MAIN BUILDING 01	7/8/2013

Name of Facility	Street Address, City, State, Zip Code
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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 Reg. # NFPA 101 LSC K0038	Correction Completed 07/08/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/NCS	Date: 7/11/13	Signature of Surveyor: 03005	Date: 7/8/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/19/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 11, 2013

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

Re: Enclosed Reinspection Results - Project Number S5283023

Dear Ms. High:

On April 25, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 1, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00582	A. Building B. Wing	4/25/2013

Name of Facility	Street Address, City, State, Zip Code
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**04/10/2013**	ID Prefix **20625** Reg. # **MN Rule 4658.0450 Subp. 1 A-I** LSC	**04/10/2013**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	**04/10/2013**
ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	**04/10/2013**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	**04/10/2013**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	**04/10/2013**
ID Prefix **21400** Reg. # **MN Rule 4658.0810 Subp. 1** LSC	**04/10/2013**	ID Prefix **21405** Reg. # **MN Rule 4658.0810 Subp. 2** LSC	**04/10/2013**	ID Prefix **21410** Reg. # **MN Rule 4658.0815 Subp. 1** LSC	**04/10/2013**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	**04/10/2013**	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed
ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PH/NCS	7/11/13	12831	4/25/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/1/2013

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: 4536

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245283**

2.STATE VENDOR OR MEDICAID NO.
(L2) **228663700**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **4/25/2013** (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 **87** (L18)

13.Total Certified Beds **87** (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
	87			
(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 :
Edith Hasskamp, HFE-NEII 5/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 7/11/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/31/2013 4536

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/24/2013
(L33)

DETERMINATION APPROVAL

A standard OTC survey was completed at this facility on March 1, 2013. Deficiencies were found, the most serious were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F).

On April 25, 2013, a PCR was conducted and two deficiencies were found which were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). As a result, we are imposing state monitoring effective May 8, 2013.

We are also recommending the following to CMS:

- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F431, effective April 25, 2013, for a total penalty of $1,000.00.

- A Per Instance CMP in the amount of $1,000.00 for the deficiency cited at F441, effective April 25, 2013, for a total penalty of $1,000.00.

- Mandatory DOPNA, effective June 1, 2013

Please note that NATCEP loss will be effective June 1, 2013 if DOPNA goes into effect.

See attached CMS-2567 and the CMS-2567B for the results of the April 24, 2013 revisit.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 4788

May 3, 2013

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

RE: Project Number S5283023

Dear Ms. High:

On March 10, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2013. 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 April 25, 2013, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 1, 2013. The deficiencies not corrected are as follows:

F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective May 8, 2013. (42 CFR 488.422)

In addition, this Department has recommended to the CMS Region V Office the following actions:

- Per instance civil money penalty of $1,000.00 for the deficiency cited at F431, effective April 25, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,000.00 for the deficiency cited at F441, effective April 25, 2013, for a total penalty of $1,000.00. (42 CFR 488.430 through 488.444)

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 1, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 1, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 1, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Michaels Health & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective June 1, 2013. 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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 302-6151

Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

Failure to submit an acceptable PoC 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 PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	R 04/25/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS 76	{F 000}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	{F 431}		

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

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

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{F 431}	Continued From page 1 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a system for accurate accountability of controlled medications for 5 of 5 residents (R107, R40, R60, R94, R109) reviewed for control medications. Findings include: The Individual Narcotic Records in the bound narcotic books did not indicate number of pills or date of delivery. Each Individual Narcotic Record had a sticker that read, "Pharmacy delivers a week of medication every Wednesday for a new count of 7." The pharmacy delivery inventory did not include the automatic refills of control drugs so there was no documented accountability of control drugs leaving the pharmacy and arriving at the facility. The facility's Controlled Scheduled Medication Policy dated 3/28/13, directed the "licensed nurse	{F 431}		

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{F 431}	Continued From page 2	{F 431}		

(LN) to sign for receiving all controlled substances. Upon signing for any controlled substances the LN will include the name of the medication, directions for use, prescription number, resident name and medical record number and reconcile the count of medication and document that count into the INDIVIDUAL NARCOTIC RECORD."

The Garden Unit bound narcotic book was reviewed with the licensed practical nurse (LPN) -A, on 4/23/13, at 12 noon. Several residents had routinely scheduled doses of controlled medications. The sheduled control medications were automatically refilled each Wednesday with one week supply. LPN-A stated there is no record or count of the number of doses when they were delivered each Wednesday. The controlled medications were placed in the medication cart and counted at the end of the shift.

The Meadows Unit bound narcotic book was reviewed with LPN-C on 4/23/13, at 1:20 p.m.. LPN-C stated that controlled medications that residents take daily were not counted when they were delivered from the pharmacy. The medications were placed in the medication cart and counted at the end of the shift.

R107's physician's orders included Lortab (narcotic analgesic) 5/325, 1 tablet by mouth every night. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply

R40 had an order for lorazepam (anti-anxiety medication) 2.5 milligrams (mg) 1/2 tablet at bed

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{F 431}	Continued From page 3 time. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply However, they did not record who received the lorazepam or the number of lorazepam they had received, nor did they reconcile the count of medication and document that count into the INDIVIDUAL NARCOTIC RECORD as their policy indicated they would. .R60 had an order for lorazepam (anti-anxiety medication) 0.5mg milligrams (mg) 1/2 tablet three times a day. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply. R94 had an order for Lortab (narcotic analgesic) 5/325, 1 tablet by mouth three times a day. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply. R20 had an order for Lortab (narcotic analgesic) 5/325, 1 tablet by mouth three times a day. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply. On 4/25/13, at 2:15 p.m. the director of nursing (DON) was interviewed and stated they had not been counting the regularly daily scheduled controlled medications that came in on	{F 431}		

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{F 431}	Continued From page 4 Wednesdays. She confirmed they just put them in the medication carts and counted what was left at the end of the shift.	{F 431}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	{F 441}		

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{F 441}	Continued From page 5 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not maintain infection control standards for 2 of 3 residents (R54, R128) observed during provision of care. Findings include: R54 was observed during a dressing changes to the left heel on 4/23/13, at 2:43 p.m.. LPN-A retrieved supplies in a plastic container which included Hydrogel dressings, CovRsite dressings, and other equipment needed to complete the dressing change. LPN-A placed the supplies on the bed side stand, washed hands and donned gloves. The heel boot was removed with gloved hands and LPN-A used scissors from the plastic container to cut the old bandage from R54's foot. The scissors was placed back into the container without being cleaned. The soiled dressing was observed to have a 2 centimeter (cm) area of yellow drainage with serous drainage beyond. LPN-A picked up the Hydrogel packet and removed one piece, touching the inside and outside of the packet with the contaminated gloves. The contaminated packet held 5 more dressings that should be used a later time. LPN-A applied the Hydrogel to the heel ulcer and returned the Hydrogel packet to the plastic container with the other clean supplies. Still wearing the soiled gloves, LPN-A applied another dressing over the Hydrogel. LPN-A replaced	{F 441}		

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{F 441}	Continued From page 6	{F 441}		

R54's socks and heel protector and moved R54 in the wheelchair before going into the bath room to remove the gloves and wash hands.

LPN-A, interviewed on 4/23/13, at approximately 3 p.m., stated that he would have changed his gloves if the resident did not have her own box of supplies.

On 4/25/13, at 1:56 p.m., the the director of nursing (DON) was interviewed and stated staff were expected to wash their hands and change gloves after removing the soiled dressing and before putting on a clean dressing. Residents, supplies or heel protector boot were not to handled with soiled gloves. Staff should have removed gloves and washed hands before going on to touch clean equipment and clean dressings.

The facility's policy for Dressing changes dated 2/13/03 indicated staff should wash hands and don gloves before they begin, remove soiled dressings and dispose of them, remove gloves and wash hands, don new gloves, clean the open area, apply any medication, and new dressing, dispose of what was used and remove gloves and wash hands.

R128 was observed during perineal care on 4/25/13, at 8:27 a.m.. The nursing assistant (NA) -A did not perform hand hygiene or change her gloves after perineal (peri) care.

R128's diagnoses included multiple sclerosis, diverticulosis. renal failure, osteoarthrosis and diabetes.

R128's care plan dated 9/18/12, indicated R128

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 7	{F 441}		

was continent of bowel and bladder but was dependent with toileting. The care plan directed staff to report any loose stools to the nurse as R128 had a history of clostridium difficile (c-diff) in his stools. The Kardex dated 1/15/12, indicated R128 transferred with the mechanical ceiling lift.

On 4/25/13, at 8:10 a.m. NA-A transferred R128 from the wheelchair onto the toilet using the mechanical overhead ceiling lift. At 8:27 a.m. NA-A raised R128 from the toilet with the lift, wiped the rectal area with a moist disposable wipe and threw the wipe in the garbage. Without changing gloves or washing hands, NA-A moved R128 over to his bed with her hands on the lift sling and lowered R128 on top of the bed. NA-A removed and changed R128's wet incontinent brief, turned R128 side to side, pulled his pants back up and reapplied the lift sling. All while wearing the same soiled gloves. NA-A adjusted her own clothing and then removed the gloves and threw them in the trash. NA-A did not wash or sanitize her hands before lifting R128 from the bed and into the wheelchair with the overhead lift. NA-A removed the lift sling from under R128, picked up the trash bag, opened the door by the handle and exited the room, never having washed her hands.

On 4/25/13, at 10:50 a.m. NA-A was interviewed and stated R128 had a bowel movement on the toilet and what she did was her usual procedure for R128. NA-A verified she had used the same gloves during the entire time and should have removed the gloves and washed her hands before leaving the bathroom. NA-A stated she watched the mandatory infection control video, but had not been observed during any of the hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	R 04/25/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 8 washing audits. The DON, interviewed on 4/25/13, at 1:56 p.m., stated gloves should be removed and hands washed or sanitized with Purell (hand sanitizer) after peri care. The DON was informed of the situation and stated, "Absolutely, the gloves should have been removed and the hands should have been washed or sanitized after the peri care and before leaving the room. It's okay to sanitize the hands outside the room and wash them later." The facility's Perineal Care policy and procedure that was reviewed and revised on 6/19/09, indicated the purpose of the policy was to prevent infection and odors. The procedure directed staff to remove the soiled gloves after washing the peri area.	{F 441}		

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{F 000}	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS 76	{F 000}	OK 5/17/13 PLH RECEIVED MAY 13 2013 MN Dept of Health Duluth **F431** R107, R40, R60, R94, and R20's, medications are accounted for. The *Medication Delivery System Policy* was reviewed and revised to include two LN's counting medications upon receipt of controlled medications and documentation in the INDIVIDUAL NARCOTIC RECORD as to who accepted the Pharmacy delivery, the number of doses received and the total available upon receipt of the supply. All LN's have been trained regarding this policy. Continued →	
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	{F 431}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin/CEO — (X6) DATE: 5/10/2013

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

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{F 431}	Continued From page 1 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a system for accurate accountability of controlled medications for 5 of 5 residents (R107, R40, R60, R94, R109) reviewed for control medications. Findings include: The Individual Narcotic Records in the bound narcotic books did not indicate number of pills or date of delivery. Each Individual Narcotic Record had a sticker that read, "Pharmacy delivers a week of medication every Wednesday for a new count of 7." The pharmacy delivery inventory did not include the automatic refills of control drugs so there was no documented accountability of control drugs leaving the pharmacy and arriving at the facility. The facility's Controlled Scheduled Medication Policy dated 3/28/13, directed the "licensed nurse	{F 431}	F431 continued The Consultant Pharmacist will review all MEDICATION DESTRUCTION SHEETS and the INDIVIDUAL NARCOTIC RECORD monthly with the Director of Nursing. Clinical Managers or designee will be responsible to audit their wing's Individual Narcotic Records daily to assure that shiftly counts per policy are being completed and that medications are counted and documented upon receipt. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The DON will complete weekly audits on each wing to assure that all INDIVIDUAL NARCOTIC RECORDS are being counted shiftly per policy and are counted and documented upon receipt. F431 continued →	

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{F 431}	Continued From page 2 (LN) to sign for receiving all controlled substances. Upon signing for any controlled substances the LN will include the name of the medication, directions for use, prescription number, resident name and medical record number and reconcile the count of medication and document that count into the INDIVIDUAL NARCOTIC RECORD." The Garden Unit bound narcotic book was reviewed with the licensed practical nurse (LPN) -A, on 4/23/13, at 12 noon. Several residents had routinely scheduled doses of controlled medications. The sheduled control medications were automatically refilled each Wednesday with one week supply. LPN-A stated there is no record or count of the number of doses when they were delivered each Wednesday. The controlled medications were placed in the medication cart and counted at the end of the shift. The Meadows Unit bound narcotic book was reviewed with LPN-C on 4/23/13, at 1:20 p.m.. LPN-C stated that controlled medications that residents take daily were not counted when they were delivered from the pharmacy. The medications were placed in the medication cart and counted at the end of the shift. R107's physician's orders included Lortab (narcotic analgesic) 5/325, 1 tablet by mouth every night. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply. R40 had an order for lorazepam (anti-anxiety medication) 2.5 milligrams (mg) 1/2 tablet at bed	{F 431}	F431 Continued Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The DON will complete random monthly audits on each wing by physically counting at least one resident per wing to assure reconciliation of count versus records. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The Director of Nursing is responsible. Completion Date is June 1, 2013.	

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{F 431}	Continued From page 3 time. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply However, they did not record who received the lorazepam or the number of lorazepam they had received, nor did they reconcile the count of medication and document that count into the INDIVIDUAL NARCOTIC RECORD as their policy indicated they would. .R60 had an order for lorazepam (anti-anxiety medication) 0.5mg milligrams (mg) 1/2 tablet three times a day. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply. R94 had an order for Lortab (narcotic analgesic) 5/325, 1 tablet by mouth three times a day. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply. R20 had an order for Lortab (narcotic analgesic) 5/325, 1 tablet by mouth three times a day. The Individual Narcotic Record did not indicate who accepted the pharmacy delivery, the number of doses received, or the total available upon receipt of the supply. On 4/25/13, at 2:15 p.m. the director of nursing (DON) was interviewed and stated they had not been counting the regularly daily scheduled controlled medications that came in on	{F 431}		

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{F 431}	Continued From page 4 Wednesdays. She confirmed they just put them in the medication carts and counted what was left at the end of the shift.	{F 431}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	{F 441}	**F441** St. Michael's Health and Rehabilitation Center maintains infection control processes and policies to assure a safe environment and prevent the spread of infection. R54 has not suffered any ill effects due to the break in infection. R128 has not suffered any ill effects due to the break in infection control. The *Dressing Change Policy* was reviewed and remains appropriate. The *Hand Washing Policy* was reviewed and remains appropriate. Continued →	

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{F 441}	Continued From page 5 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not maintain infection control standards for 2 of 3 residents (R54, R128) observed during provision of care. Findings include: R54 was observed during a dressing changes to the left heel on 4/23/13, at 2:43 p.m.. LPN-A retrieved supplies in a plastic container which included Hydrogel dressings, CovRsite dressings, and other equipment needed to complete the dressing change. LPN-A placed the supplies on the bed side stand, washed hands and donned gloves. The heel boot was removed with gloved hands and LPN-A used scissors from the plastic container to cut the old bandage from R54's foot. The scissors was placed back into the container without being cleaned. The soiled dressing was observed to have a 2 centimeter (cm) area of yellow drainage with serous drainage beyond. LPN-A picked up the Hydrogel packet and removed one piece, touching the inside and outside of the packet with the contaminated gloves. The contaminated packet held 5 more dressings that should be used a later time. LPN-A applied the Hydrogel to the heel ulcer and returned the Hydrogel packet to the plastic container with the other clean supplies. Still wearing the soiled gloves, LPN-A applied another dressing over the Hydrogel. LPN-A replaced	{F 441}	F441 Continued All RNs and LPNs will be observed completing a dressing change by the Infection Preventionist or designee for skill competency by May 15, 2013. All housekeeping and NAR staff have attended a training session on PPE and hand washing as of May 15, 2013. The Clinical Manager or designee will complete daily audits of Nursing staff for compliance with infection control policies and procedures including hand-washing and dressing changes. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The Infection Preventionist or designee will complete weekly audits of non-nursing staff for compliance with infection control policies and procedures. Continued →	

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{F 441}	Continued From page 6 R54's socks and heel protector and moved R54 in the wheelchair before going into the bath room to remove the gloves and wash hands. LPN-A, interviewed on 4/23/13, at approximately 3 p.m., stated that he would have changed his gloves if the resident did not have her own box of supplies. On 4/25/13, at 1:56 p.m., the the director of nursing (DON) was interviewed and stated staff were expected to wash their hands and change gloves after removing the soiled dressing and before putting on a clean dressing. Residents, supplies or heel protector boot were not to handled with soiled gloves. Staff should have removed gloves and washed hands before going on to touch clean equipment and clean dressings. The facility's policy for Dressing changes dated 2/13/03 indicated staff should wash hands and don gloves before they begin, remove soiled dressings and dispose of them, remove gloves and wash hands, don new gloves, clean the open area, apply any medication, and new dressing, dispose of what was used and remove gloves and wash hands. R128 was observed during perineal care on 4/25/13, at 8:27 a.m.. The nursing assistant (NA) -A did not perform hand hygiene or change her gloves after perineal (peri) care. R128's diagnoses included multiple sclerosis, diverticulosis. renal failure, osteoarthrosis and diabetes. R128's care plan dated 9/18/12, indicated R128	{F 441}	F441 Continued Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The Infection Preventionist is responsible for monitoring Completion Date: June 1, 2013	

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{F 441}	Continued From page 7 was continent of bowel and bladder but was dependent with toileting. The care plan directed staff to report any loose stools to the nurse as R128 had a history of clostridium difficile (c-diff) in his stools. The Kardex dated 1/15/12, indicated R128 transferred with the mechanical ceiling lift. On 4/25/13, at 8:10 a.m. NA-A transferred R128 from the wheelchair onto the toilet using the mechanical overhead ceiling lift. At 8:27 a.m. NA-A raised R128 from the toilet with the lift, wiped the rectal area with a moist disposable wipe and threw the wipe in the garbage. Without changing gloves or washing hands, NA-A moved R128 over to his bed with her hands on the lift sling and lowered R128 on top of the bed. NA-A removed and changed R128's wet incontinent brief, turned R128 side to side, pulled his pants back up and reapplied the lift sling. All while wearing the same soiled gloves. NA-A adjusted her own clothing and then removed the gloves and threw them in the trash. NA-A did not wash or sanitize her hands before lifting R128 from the bed and into the wheelchair with the overhead lift. NA-A removed the lift sling from under R128, picked up the trash bag, opened the door by the handle and exited the room, never having washed her hands. On 4/25/13, at 10:50 a.m. NA-A was interviewed and stated R128 had a bowel movement on the toilet and what she did was her usual procedure for R128. NA-A verified she had used the same gloves during the entire time and should have removed the gloves and washed her hands before leaving the bathroom. NA-A stated she watched the mandatory infection control video, but had not been observed during any of the hand	{F 441}		

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{F 441}	Continued From page 8 washing audits. The DON, interviewed on 4/25/13, at 1:56 p.m., stated gloves should be removed and hands washed or sanitized with Purell (hand sanitizer) after peri care. The DON was informed of the situation and stated, "Absolutely, the gloves should have been removed and the hands should have been washed or sanitized after the peri care and before leaving the room. It's okay to sanitize the hands outside the room and wash them later." The facility's Perineal Care policy and procedure that was reviewed and revised on 6/19/09, indicated the purpose of the policy was to prevent infection and odors. The procedure directed staff to remove the soiled gloves after washing the peri area.	{F 441}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4536

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/01/2013** (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 **96** (L18)

13.Total Certified Beds **96** (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
	96			
(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):
At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Kathie Killoran, HFE NEII — 03/28/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 04/18/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(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 04/24/2013 CO.
Event ID 4536

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

Certified Mail # 7011 2000 0002 5148 4313

March 10, 2013

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

RE: Project Number S5283023

Dear Ms. High:

On March 1, 2013, 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:

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

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

<u>Remedies</u> - 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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 302-6151

Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2013, 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 April 10, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	03/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE 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	OK 3/28/13 PLH	
F 241 SS=D	Census 76/96 483.15(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 for dignity with an exposed lift sling for 1 of 3 residents (R13) reviewed. Findings included: On 2/25/13, at 5:10 p.m. during the evening meal R13 was observed in the dining room with a bright yellow lift sling over the back of the	F 241	F241 St. Michael's Health and Rehab. Center (SMHRC) promotes the dignity and well-being of all residents. R13 has been interviewed and it is her choice not to have a sling in place while in her wheelchair. The Care Plan was reviewed and remains appropriate. A list of all residents who currently are care planned for to have the sling left in the wheelchair was developed. Social Services interviewed all these residents to determine their preferences in relation to sling placement. Those with the capacity to make their preference known have been noted and care plans updated. Continued →	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
(Laura)	Administrator	3/22/2013

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

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F 241	Continued From page 1 wheelchair. At approximately 5:12 p.m., R13 stated she did not like the bright yellow lift sling to be left under her in the wheelchair, "Would you like it?!" The quarterly Minimum Data Set (MDS) dated 2/18/13, indicated R13 had moderate cognitive impairment and required extensive assistance of one person for transfers with a mechanical lift. The care plan dated 12/12/12, and the nursing assistant care plan indicated the ceiling lift would be used for transfers and did not identify R13's preference regarding the visible sling when she was in public. On 2/26/13, at 1:00 p.m., the nursing assistant (NA)-L, was interviewed and said that all lift slings were to be removed from residents in the chair unless the care plan directed it. NA-L said R13	F 241	F241 continued. The *Dignity and Respect Policy* has been reviewed and remains appropriate. The *Mechanical Lift Policy* has been reviewed and revised to include resident preference. Staff has received training on March 27 and March 28, 2013 on following the care plan and adherence to respect of the residents. Random Audits will be completed by LN's weekly to assure compliance with respect and dignity. Monitoring will be completed at a consistent level (weekly) until	

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F 241	Continued From page 2 was in the wheelchair, in her room, with the bright yellow sling crossed between her legs. At approximately 2 p.m., NA-K was interviewed and stated she left the sling visible under R13 because it was on nursing assistant care plan. NA-K reviewed the care plan and admitted the care plan did not direct the sling be left under R13. The registered nurse (RN)-B, interviewed on 2/28/13, at approximately 3:05 p.m., stated slings are left under residents because they are difficult to remove and replace. RN-B stated residents were not assessed or consulted for their preference regarding the visible lift slings in public. Review of Mechanical Lift policy dated May, 2012, did not address dignity concerns for residents who required use of lift slings. The policy said with the sling mechanical lifts may be left under the resident in their wheel chairs but never to be left under the resident when in bed. The manufacturer's information did not address the slings being left under the residents when not in use, however, indicated the use of slings must be assessed.	F 241		
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:	F 282	F282 SMHRC provides services by qualified persons in accordance with each resident's written plan on care. R167 has had an updated Skin Risk Observation/Assessment completed and the Care Plan has been updated on March 13, 2013. R61 has had an Elimination Assessment completed and care plan revised. continued →	

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F 282	Continued From page 3 Based on observation, interview and document review the facility did not provide care as directed by the plan of care for 1 of 3 residents (R167) reviewed for pressure ulcers and for 1 of 3 residents (R61) reviewed for urinary incontinence. Findings included: R167 was not provided pressure relief and weekly assessment of a left heel pressure ulcer. R167's diagnoses included malignant neoplasm of the lung, chronic obstructive pulmonary disease, fracture of left femoral neck, and status post arthroplasty. R167's temporary care plan and Kardex dated 2/12/13, directed R167's heels were to be floated off pillows due to ulcer on left heel. Review of R167's electronic admission ulcer documentation dated 2/14/13, noted R167 had a stage 3 pressure ulcer on the left heel, measuring 3.0 cm in length by 2.0 in width and no measurements of depth. The assessment further described R167's treatment plan as daily dressing changes, a pressure relieving device on the bed and in the wheelchair, and heels to be floated off pillows while in bed. R167's Skin Risk Assessment dated 2/21/13, noted R167 had an unhealed pressure ulcer at stage 1 or higher, required supervision with bed mobility, and contained no further information on the stage 3 pressure ulcer on R167's left heel. On 2/27/13, at 11:00 a.m. R167 was observed to be laying flat on [his/her] back in bed, with one pillow under R167's left lower leg and with the left heel resting on the mattress.	F 282	F282 Continued All residents who currently have a pressure ulcer have been reviewed to assure compliance with weekly wound assessments. A list of three (3) residents on each wing who are at risk for impaired skin integrity was developed by Clinical Mangers. These residents were reviewed for compliance with facility *Skin Risk Assessments and Observations Policy*, and appropriate interventions are care planned for. A list of residents was developed utilizing the Census and Condition Report (672) for residents with toileting programs. These residents will have their care plans reviewed for effectiveness of toileting programs. Revisions will be made to the Care Plan as indicated. The *Skin Risk Assessments and Observations Policy*, *Nursing Assistant Protocols for Care and Reporting Resident Conditions*, and the *Care Plan Change Forms Policy* have been reviewed and remain appropriate. continued →	

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F 282	Continued From page 4 On 2/28/13, at 10:57 a.m. during an interview, RN-A reported R167's left heel ulcer measurements were 2.2 cm in length and 4.0 cm in width. RN-A further stated ulcers were to be assessed and measured weekly; however the previous assessment was dated 2/14/13. On 2/28/13, at 3:00 p.m. R167 was observed to lie down on his bed independently and place a flat pillow under the left lower leg with the left heel resting on the mattress. R167 stated this was how the foot was usually positioned. He had a heel boot at another facility before coming to this facility. On 3/1/13, 11:05 a.m. the director of nursing (DON) stated she would expect pressure ulcers to be assessed weekly. The DON stated R167's pressure ulcer should have been assessed, and R167 offered a boot or other device to float the heel off of the bed. The Skin Risk Assessment and Observation Policy revised 1/1/11, indicated a comprehensive Skin Risk Assessment/Braden-*R was to be completed upon admission, and then weekly thereafter, the Braden Scale For Prediction of Pressure Sore Risk was to be completed to monitor for changes in resident condition and implement necessary interventions. The policy further directed the licensed nurse to document the weekly observation in the chart, and to include observations for other conditions of the underlying tissue. R61 was not offered or provided toileting or incontinence care on 2/28/13, from 7:21 a.m. until 10:19 am, (2 hours, 58 minutes).	F 282	F282 continued The *Incontinence Assessment and Management Policy* has been reviewed and revised. THE NURSING ADMISSION CHECKLIST TOOL and *the Nursing Admission Checklist Policy* have been reviewed and revised. Nursing Staff will be trained on March 26 and 27, 2013 on facility policy in relation to following care plans, communication of the care plan, and changes to policies and tools. Nursing staff will also be retrained on Nursing Assistant protocols for pressure relief and promotion of skin integrity. Random audits will be completed daily by LN's to assure compliance with repositioning and toileting programs. Monitoring will be completed at a consistent level (daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the ~~IDT.~~ QA. The Director of Nursing is responsible. Completion Date is April 10, 2013	

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F 282	Continued From page 5 The nursing assistant (NA) care plan (Kardex) dated 5/28/12, indicated R61 was incontinent of bladder and required assistance of one staff for every two hour toileting/incontinence care. NA-L, interviewed on 2/28/13, at approximately 10:19 a.m., state R61 went 2 hours and 57 minutes with out toileting/incontinence care.	F 282		
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 did not ensure interventions were provided to promote healing of a pressure ulcer for 1 of 3 residents (R167) who was reviewed for pressure ulcers. This resulted in harm for R167. Findings included: R167's diagnoses included malignant neoplasm of the lung, chronic obstructive pulmonary disease, hypertension, benign prostatic hypertrophy, glaucoma, fracture of left femoral	F 314	F314 SMHRC provides necessary treatment and services to promote healing, infection, and prevention of pressure ulcers. R167 has had an updated Skin Risk Observation/Assessment completed and the Care Plan has been updated on March 13, 2013 All residents who currently have a pressure ulcer have been reviewed to assure compliance with weekly wound assessments. Continued →	

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F 314	Continued From page 6 neck, and status post arthroplasty. R167's Skin Risk Assessment dated 2/14/13, noted R167 was independent in bed mobility, had one stage 3 pressure ulcer measuring 3.0 cm in length and 2.0 cm in width, with slough noted in ulcer/wound bed, had +1 edema of lower extremities, and was rated at no risk for skin breakdown using the Braden Scale. Review of R167's electronic admission ulcer documentation dated 2/14/13, noted R167 had a stage 3 pressure ulcer on the left heel, measuring 3.0 cm in length by 2.0 in width and no measurements of depth. The assessment also noted R167's left heel ulcer wound bed contained 25% slough, with a scant amount of purulent drainage with no odor. The ulcer assessment further noted the wound edges were calloused and dry with intact surrounding skin and no lower extremity edema. The assessment also reported R167 experienced sharp pain in the ulcer area, rating the pain as a level 5 on a scale of 1 to 10. The assessment further described R167's treatment plan as daily dressing changes to be done by nursing, repositioning done independently, a pressure relieving device on the bed and in the wheelchair, and heels to be floated off pillows while in bed. R167's Skin Risk Assessment dated 2/21/13, noted R167 had an unhealed pressure ulcer at stage 1 or higher, required supervision with bed mobility, and contained no further information on the stage 3 pressure ulcer on R167's left heel. On 2/25/13, at 6:21 p.m. registered nurse (RN)-C was interviewed and reported R167 had two	F 314	A list of three (3) residents on each wing who are at risk for impaired skin integrity was developed by Clinical Mangers. These residents were reviewed for compliance with facility *Skin Risk Assessments and Observations Policy*, and appropriate interventions are care planned for. The *Skin Risk Assessments and Observations Policy*, *Nursing Assistant Protocols for Care and Reporting Resident Conditions*, and the *Care Plan Change Forms Policy* have been reviewed and remain appropriate. The NURSING ADMISSION CHECKLIST TOOL and *the Nursing Admission Checklist Policy* have been reviewed and revised. Nursing Staff will be trained on March 26 and 27, 2013 on facility policy in relation to following care plans, communication of the care plan, and changes to policies and tools. Nursing staff will also be retrained Nursing Assistant protocols for pressure relief and promotion of skin integrity. Continued →	

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F 314	Continued From page 7 stage 1 pressure ulcers, one on R167's left ear and the other on the right buttock, and R167 was admitted to the facility with these ulcers. RN-C did not report the stage 3 pressure ulcer on the left heel. On 2/27/13, at 11:00 a.m. R167 was observed to be laying flat on [his/her] back in bed, with one pillow under R167's left lower leg and with the left heel resting on the mattress. R167's left foot and heel were noted to be wrapped with white gauze and a small amount of medium-colored brown drainage was observed to be on both the white gauze on the bottom side of R167's left heel and also on the white sheet on the mattress under the left heel. Physician's orders dated 2/14/13, directed Calcium Alginate to heels daily and prn [as needed], then cover with Kerlix. If dry, leave alone. Sterile water used only to cleanse. Review of R167's electronic Treatment Administration Record (e-TAR) dated 2/14/13, noted R167's heel treatment was completed on 2/15/13, 2/16/13, 2/18/13, 2/19/13, 2/20/13, 2/21/13, 2/23/13, 2/24/13, and 2/25/13. R167's temporary care plan and Kardex dated 2/12/13, directed R167's heels were to be floated off pillows due to ulcer on left heel. On 2/28/13, at 10:33 a.m. RN-A assisted R167 to transfer from wheelchair to recliner chair and brought in dressings and supplies in a pink plastic wash basin, placing the basin on the floor in front of R167. RN-A proceeded to wash her hands in R167's bathroom and put on a pair of gloves. RN-A was then observed to remove the old	F 314	F314 Continued Random audits will be completed daily by LN's to assure compliance with repositioning. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. Audits on all new admissions will be completed to weekly assure compliance with facility policy on *Skin Risk Assessments and Observation Policy*. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the ~~IDT.~~ QA. The Director of Nursing is responsible. Completion Date is April 10, 2013	

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	245283	A. BUILDING _____ B. WING _____	03/01/2013

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F 314	Continued From page 8 dressing from R167's left lower leg and heel and RN-A noted the old dressing contained a large amount of yellowish-brown "purulent" drainage, no strikethough (drainage that seeps through the gauze dressing) noted on the outside of the Kerlix, and commented the wound had a foul odor. RN-A further commented the ulcer would be termed as unstageable due to slough present in the wound bed. RN-A disposed of the soiled dressings in a nearby garbage can and removed the gloves and opened several packages of sterile q-tip applicators, a gauze dressing package, and the sterile normal saline packets. RN-A then put on a pair of sterile gloves and used the q-tips to measure the length and width of the ulcer. RN-A then removed the gloves to mark down the ulcer measurements. RN-A then put on another pair of sterile gloves. and cleansed the ulcer with the sterile normal saline squirting it up into the wound bed. RN-A blotted the ulcer with the dry sterile 4 inch by 4 inch gauze pads, while R167's left leg jumped several times. RN-A removed the gloves and washed her hands in the bathroom sink, returning with another pair of gloves. RN-A put on the fourth pair of gloves and opened the package of Calcium Alginate with a pair of bandage scissors. RN-A trimmed the Calcium Alginate dressing with the same scissors, fitting the dressing into the wound bed. RN-A wrapped R167's left foot, heel, and ankle with the Kerlix gauze and then removed the gloves. RN-A used bandage tape to secure the Kerlix gauze in place. RN-A replaced R167's foot slippers. RN-A removed the gloves and washed her hands before returning the supplies to R167's closet and placing the garbage can in R167's bathroom. RN-A asked R167 how the dressing and heel felt and then assisted R167	F 314		

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F 314	Continued From page 9 back into the wheelchair from the recliner chair. On 2/28/13, at 10:57 a.m. during an interview, RN-A reported R167's left heel ulcer measurements were 2.2 cm in length and 4.0 cm in width. RN-A further stated ulcers were to be measured weekly and could not locate any measurements from the previous week, only measurements from 2/14/13, were found in R167's medical record. On 2/28/13, at 3:00 p.m. R167 was observed to be sitting on the edge of the bed in R167's room. R167 laid down on the bed independently and placed a flat pillow under the left lower leg with the left heel resting on the mattress. R167 stated this was how [he/she] was usually positioned and reported [he/she] had a heel boot at another facility before coming to this facility. On 2/28/13, at 3:10 p.m. RN-A entered R167's room with this surveyor. RN-A observed and then reported R167's left heel was resting on the bed with the pillow under R167's left lower leg. RN-A stated, "That does not do any good," and placed R167's legs on the same pillow folded in half along with a blanket, floating R167's left heel into the air and off the mattress. RN-A stated R167's left heel ulcer's condition had worsened with the larger measurements and foul, larger amounts of purulent drainage. RN-A further stated the medical record lacked evidence R167 had been provided the risks and benefits of floating the heels off the bed. On 3/1/13, 11:05 a.m. the director of nursing (DON) stated she would expect pressure ulcers to be measured weekly and R167's left heel	F 314		

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F 314	Continued From page 10 pressure ulcer should have been measured last week. The DON further stated R167's pressure ulcer should have been assessed, and R167 offered a boot or other device to float the heels off of the bed. The DON commented on the left heel pressure ulcer measurements from 2/14/13, to 2/28/13, stating the ulcer was significantly bigger. The Skin Risk Assessment and Observation Policy revised 1/1/11, indicated a comprehensive Skin Risk Assessment/Braden-*R was to be completed upon admission, and then weekly thereafter, the Braden Scale For Prediction of Pressure Sore Risk was to be completed to monitor for changes in resident condition and implement necessary interventions. The policy further directed the licensed nurse to document the weekly observation in the chart, and to include observations for other conditions of the underlying tissue.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F315 SMHRC provides necessary treatment and services in regards to incontinence care. R61 has had an Elimination Assessment completed and care plan revised. A list of residents was developed utilizing the Census and Condition Report (672) for residents with toileting programs. These residents will have their care plans reviewed for effectiveness of toileting programs. Revisions will be made to the Care Plan as indicated. Continued →	

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F 315	Continued From page 11 Based on observation, interview, and documentation review the facility did not provide incontinence care for 1 of 3 residents (R61) reviewed for incontinence care, Findings include: R61 was observed on 2/28/13, from 7:21 a.m. until 10:19 a.m., without being offered or provided toileting/incontinence care. On 2/28/13, at 7:21 a.m., R61 was observed self propelling a wheelchair in the hallway. After receiving medications R61 arrived at the dining room at 7:44 a.m. R61 remained in the dining room until 9:08 a.m. when they wheeled in the hallway. At 9:19 a.m. R61 was assisted to an activity in the dining room. At 9:23 a.m. R61 came into the hallway and was assisted to her bedroom at 9:23 a.m. At 9:47 a.m. the nursing assistant (NA)-L assists R 61 to lie down without offering toileting or checking for incontinence. At 10:19 a.m. NA-L was cued by the surveyor regarding R61's lack of toileting. NA-L assisted R61 to the toilet where the incontinence product was found to be wet with urine and soiled with feces. NA-L stated R61 went 2 hours and 57 minutes with out being assisted to the toilet or checked for incontinence. NA-L said she thought R61 needed to be toileted every two hours. The quarterly minimum data set (MDS) dated 1/10/13, indicated R61 had moderate cognitive impairment, was always incontinent of bowel, frequently incontinent of urine and required extensive assistance with weight bearing support of one staff to toilet. The incontinence care area assessment (CAA) dated 4/23/12, indicated R61	F 315	F315 continued The *Nursing Assistant Protocols for Care and Reporting Resident Conditions* and the *Care Plan Change Forms Policy* have been reviewed and remain appropriate. The *Incontinence Assessment and Management Policy* has been reviewed and revised. Nursing Staff will be trained on March 26 and 27, 2013 on facility policy in relation to following care plans, communication of the care plan, and changes to policies and tools. Random audits will be completed daily by LN's to assure compliance with toileting programs. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the ~~IDT~~ QA The Director of Nursing is responsible. Completion Date is April 10, 2013	

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F 315	Continued From page 12 had occasional incontinence. The care plan dated 5/29/09, and edited 4/30/12, indicated R61 toileted themself and would request assist if needed. It directed staff to refer to Kardex for specifics and approaches to toileting. The full care plan had not been updated to reflect R61's current needs. The nursing assistant care plan (Kardex) dated 5/28/12, indicated R61 was incontinent of bladder, continent of bowel and staff needed to ask R61 if she needed to use the toilet and would be checked and changed every two hours at night. The Kardex indicated R61 needed assist of one to the toilet and wore a peri pad during the day. On 2/28/13, at approximately 2:10 p.m. the registered nurse, (RN)-B stated R61 needed to be toileted as the Kardex indicated.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility did not ensure 1	F 323	F323 SMHRC ensures that residents remain free of accident hazards as is possible. R117 has been assessed for side rail use and care plan has been updated. All residents utilizing a side rail will have the Side Rail Assessment completed and Care Plan updated accordingly. Continued	

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F 323	Continued From page 13 of 3 resident's (R117) was free of accident hazards. Findings include: R117 was not assessed for safety with the use of bilateral half side rails. R117 was observed in bed on 2/25/13, at 6:16 p.m. with a fading ecchymotic areas around both eyes, an approximately 2 inch scrape over the left eye, and a bruised area on the neck in the shape of a triangle approximately three inches long. Two half side rails were observed to be up on the bed. On 2/25/13, at 5:16 p.m. the registered nurse (RN)-B was interviewed and stated R117 uses the two half side rails because of a history of seizure. R117 can get out of bed on her own but needs assist of one staff to be safe getting out of bed. The quarterly minimum data set (MDS) dated 2/8/13 indicated R117 was moderately cognitive impaired and did not use the side rails as a restraint. The MDS indicated R117 needed extensive assistance of two staff for transfers and had recent falls. R117's history of falls included: 2/13/13 at 5:00 a.m. fall from bed found by bed. 2/13/13 at 4:30 a.m. fall from bed found by bed. 2/1/13 at 9:05 p.m. fall in her room from wheel chair, resident stated she wanted to go back to bed for a while. The physician order dated 2/14/13, stated R117 should have cold packs four times a day for contusions, swelling of face and then warm packs for 2 days per physician order.	F 323	F323 continued A *Side Rail Assessment Policy* has been developed and includes utilization of the Matrix Side Rail Observation. The *Nursing Admission Checklist Policy* and NURSING ADMISSION CHECKLIST TOOL has been reviewed and revised. All LN's will be trained on 3/26/13. Audits on all residents newly utilizing a side rail will be completed weekly assure compliance with facility policy on *Side Rail Assessments.* Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the ~~IDT~~. QA. The Director of Nursing is responsible. Completion Date is April 10, 2013	

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F 323	Continued From page 14 1/31/13, at 11:15 p.m. fell from wheel chair in the hall. 12/6/12, at 1:48 a.m. found on the floor in sitting position by her bed. The falls risk assessment dated 2/13/13, indicated was admitted to the facility following a fall with a fractured coccyx. The assessment indicated R117 had an abnormal gait, mental retardation and convulsions. The assessment indicated R117's developmental disability and medications increased the risk of falls. The assessment noted the two recent falls out of bed and indicated the care plan had been changed to include blue mats by the low bed. The use of half side rails was not addressed. The care plan dated 12/7/12, indicated R117 should be encouraged to addend rehabilitation to enhance strength and transfer skills. The 2/21/13, goal was to remain free from injury. Interventions included the call light with in reach at all times and keep frequently used items within reach. Bed and chair alarms were utilized to remind R117 to call for assistance and to alert staff of attempts to self transfer. The care plan was updated on 3/1/13, but did not address the use of half side rails. The nursing assistant's care plan, (Kardex) dated 11/5/12, indicated R117 was to have half side rails up at all times and the bed low to the floor. On 2/13/13, the Kardex indicated a blue mat was added by the side of bed. RN-B, interviewed on 2/27/13, at 3:41 p.m., stated she could not find R117's side rails safety assessment in the paper record or computer	F 323		

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F 323	Continued From page 15 record. RN-B stated she did not assess R117 for safety with the half side rails and had not considered the risk of injury for R117 if there was a seizure. Interview on 3/1/13, at 2:30 p.m. with RN-E confirmed R117 was care planned to have half side rails up at all times when in bed and did not have a side rail risk assessment.	F 323		
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 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.	F 334	F334 SMHRC has policies and procedures in place for Influenza Immunizations. R117 received the influenza vaccination and consent after the fact is not realistic. R93 has been offered and informed of the influenza vaccine and appropriate documentation completed. A list of five (5) residents per wing will be developed by Clinical Managers. These resident's charts will be reviewed to assure that the vaccine was offered. If the vaccine was administered, the chart will be reviewed to assure that a consent is on file. Continued →	

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F 334	Continued From page 16 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 refuses the second immunization. This REQUIREMENT is not met as evidenced	F 334	F334 continued The Facility *Influenza Immunization Policy* been reviewed and revised. The Facility has updated the CONSENT TO ADMINISTER INFLUENZA VACCINATION FORM. LN's will receive training on changes to policy on March 26, 2013. During the Influenza Inoculation Season, Health Information will audit charts weekly to assure that a signed consent is on file for any influenza vaccination administered. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. Health Information will complete monthly audits on all recently admitted residents for influenza vaccine status. Monitoring will be completed at a consistent level (Monthly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the ~~IDT~~. QA. continued →	

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F 334	Continued From page 17 by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R93, R117) were provided with education explaining the benefits and potential side effects of the influenza vaccine. Findings include: On 2/27/13, five resident records were reviewed for education on the influenza vaccine. The medical records lacked documentation the resident or their authorized representative received education. R93's medical record lacked documentation of education on the influenza vaccine. R117's medical record lacked documentation of education on the influenza vaccine. The infection control registered nurse (RN)-C was interviewed on 2/27/13, at 11:45 a.m. RN-C verified the lack of documentation of education on the influenza vaccine. The facility policy and procedure on Influenza Immunization, dated 11/29/06, directs the resident or their authorized representative receive education regarding the benefits and potential side effects of the influenza vaccine prior to vaccination.	F 334	F334 continued The Infection Preventionist is responsible. Completion Date is April 10, 2013	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	F371 SMRHC strives to serve food that has been procured stored, prepared and served in a sanitary manner. The large floor mixer was cleaned on 2/25/13. Corrective actions have been taken to ensure that the food contact surfaces of the large mixer will be maintained in a sanitary manner to prevent food borne illnesses. continued →	

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F 371	Continued From page 18 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain food contact surface areas of kitchen equipment in a sanitary manner to prevent food borne illness, which had the potential to effect all 74 residents of the facility. On 2/25/13, at 1:56 p.m. during the initial tour of the facility's kitchen, a large floor mixer was covered with a large opaque plastic cover and noted to have multiple white raised areas of particulate matter on the front wire guard and back-splash solid metal guard surrounding the mechanism to propel the mixer blades. The dietary manager (DM) stated the mixer had been cleaned already today and was "ready to go." Review of the Daily Cleaning Schedule noted the Large Hobart mixer was cleaned on 2/24/13. Review of the Dietary Cleaning Schedules Policy dated 9/1/03, directed the dietary department to maintain equipment in a clean and sanitary condition. On 2/28/13, at 3:30 p.m. the DM stated the Hobart mixer was used late in the day on 2/24/13, and not cleaned after making cakes. The DM	F 371	F371 continued The Culinary Services Manager completed a comprehensive sanitation audit on all kitchen equipment to assure equipment has been properly cleaned. A *Cleaning Policy: Large Mixer* and VERIFYING LARGE MIXER IS CLEAN TOOL have been developed. The *Cleaning Schedules Policy* has been reviewed and the DAILY CLEANING SCHEDULE for PM Cooks has been modified including verification of large floor mixer cleaning. The *Dietary Sanitation Monitoring Policy* has been reviewed and revised and the CULINARY SERVICES SANITATION AUDIT TOOL has been updated to include Large Floor mixer. Culinary Services Staff will be educated on these changes by the Culinary Services Manager (CSM). The CSM will complete weekly Culinary Service Sanitation Audits to assure compliance with sanitation requirements. Continued →	

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	245283	A. BUILDING _____ B. WING _____	03/01/2013

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

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F 371	Continued From page 19 confirmed the cook should have cleaned the mixer before putting it away for the day.	F 371	F371 Continued	04/10/2013
F 431 SS=E	483.60(b); (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The Executive Director of Culinary Services (RD) will complete random sanitation audits monthly to assure Culinary Services Equipment meets standards. Monitoring will be completed at a consistent level (Monthly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the ~~IDT~~. QA. The Executive Director of Dietary Services (RD) is responsible. Completion Date: April 10, 2013 See next page for F431	

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F 431	Continued From page 20 This REQUIREMENT is not met as evidenced by:	F 431	F431 SMRHC maintains a system to assure accurate accountability of controlled medications.	

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F 431	Continued From page 21 medications were recorded and reconciled in loose leaf binders. The DON stated controlled medications were to be counted by off-going and on-coming licensed nurses at every change of shift to ensure accuracy. The DON did not know where the medication counts were documented or signed by staff. At 12:45 p.m., the DON stated if the controlled medications were not documented in the loose leaf binder, the controlled medication count would be in the EMAR. The documentation in the loose leaf binders was reconciled with resident EMARs with the following discrepancies identified: R60 had an order for lorazepam (anti-anxiety medication) 0.25 milligrams (mg) by mouth every four hours PRN (as needed). There were 18 doses of lorazepam unaccounted for in October 2012, and 28 doses unaccounted for in November 2012. The loose leaf binder lacked dates of administration, amounts given, and the prescription number. R94 had an order for lortab (narcotic analgesic) 5/325, 1-2 tablets mg by mouth every 6 hours as needed. Comparison between the loose leaf binder and the EMARs indicated a discrepancy of 8 doses unaccounted for between 2/11/13 and 2/18/13. The controlled substance medication sheet lacked the prescription number. R106 had an order for oxycontin (narcotic analgesic) 30 mg by mouth at bedtime. Comparison between the loose leaf binder and the EMARs indicated a discrepancy of 30 doses unaccounted for on 2/22/13. In addition, the loose	F 431	F431 continued All insulin found without an open date has been destroyed. All current insulin orders have been reviewed to assure open dates have been applied or have had dispensing date used as open date and dealt with accordingly. All Controlled Medications have been placed in a bound record keeping book on each wing. Included in the Record Book is; resident name, medication name, directions for use, prescription number, and count. The *Controlled Medication Policy* has been updated. It includes instructions for Fentanyl Disposal, accountability upon signing for delivery of controlled substances and documentation of the medication and count in the INDIVIDUAL NARCOTIC RECORD Book. The *Destruction of Medications Policy* was also reviewed and updated to include instructions for Fentanyl patch disposal. The *Medication Administration Policy* has been reviewed and remains appropriate. The MEDICATION WITH SHORTENED EXPIRATION DATE TOOL has been updated. All LN's will be trained on March 26, 2013 on these policies. continued →	

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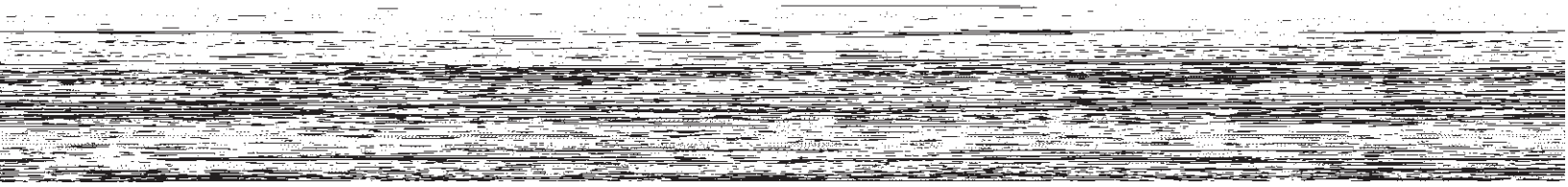
F 431	Continued From page 22 leaf binder lacked dates and dosages administered and the prescription number. R106 had an order for lorazepam 0.25 mg by mouth twice a day. There was a discrepancy with 56 doses unaccounted for on 2/24/13. The loose leaf binder lacked a prescription number. R20 had an order for lortab 5/325 mg by mouth every four hours. There was a discrepancy of 57 doses on 2/25/13, and 2/26/13. The loose leaf binder lacked dates the medication was given. R17 had an order for methadone (narcotic analgesic) 5 mg by mouth three times daily. The record had discrepancy of 30 doses from 2/21/13 to 2/25/13. In addition, the dates of administration were not documented. R114 had an order for lortab 5/325 mg by mouth three times daily PRN with 14 doses not documented or counted in the EMAR for July 1-31/12. The loose leaf binder lacked directions for use and the prescription number. R40 had an order for lorazepam 0.25 mg by mouth at bedtime. The loose leaf binder record from 2/20/13-2/27/13 indicated 8 doses were given, however, the EMAR lacked a count of the medication. The loose leaf binder lacked a prescription number. Six additional resident controlled medication pages in the loose leaf binder lacked a prescription number, and eight additional resident's controlled substance medications sheets were lacking both directions for use and a prescription number.	F 431	F431 continued The Consultant Pharmacist will review all Medication Destruction Sheets and the INDIVIDUAL NARCOTIC RECORD monthly with the Director of Nursing. Clinical Managers or designee will be responsible to audit their wing's Individual Narcotic Records daily to assure that shiftly counts per policy are being completed. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The DON will complete weekly audits on each wing to assure that all INDIVIDUAL NARCOTIC RECORDS are being counted shiftly per policy. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. continued →	



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F 431	Continued From page 24 be reviewing them monthly. CP-F stated he was unaware of discrepancies with controlled medications or that staff were not completing controlled substance medication counts every shift. The facility policy and procedure on Controlled/Scheduled Medications revised 2/1/12, directed controlled substances require a count which is added as a task on the EMAR, and LPNs are to count all controlled medications at the beginning of their shift, to ensure count accuracy, on the controlled substance medications sheets. The policy further directs when a controlled medication is received, the controlled substance medications sheets are completed with the resident's name, medication number, prescription number and current count. On 2/28/13, at 10:09 a.m., the medication cart on the Meadows unit was observed with LPN-D, and noted to have an open Novolog insulin FlexPen with a dispense date of 1/19/13, and no open or use by date; and an open Novolog Mix 70/30 insulin FlexPen with a dispense date of 12/14/12, and no open or use by date. The medication refrigerator on the Gardens unit contained an open vial of Lantus insulin with a dispense date of 1/22/13, and no open or use by date. LPN-D verified the FlexPen did not have an open or use by date, and all insulins should be dated when opened. LPN-D was unable to state when insulin expired after it was opened. On 3/1/13, at 11:10 a.m., the director of nursing (DON) was interviewed and stated she would expect insulin to be dated when opened. The manufacture's directions direct the following	F 431		

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F 431	Continued From page 25 expiration dates: Novolog FlexPen expires 28 days after opening, Novolog Mix 70/30 FlexPen expires 14 days after opening, and Lantus vials expire 28 days after opening. The facility was unable to provide a policy and procedure on dating insulin.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F441 SMHRC provides for a safe and healthy environment and trains all staff on safety, including infection control measures. The *Hand Washing Policy* was reviewed and revised. Nursing Staff will be trained on Infection Control March 29, 2013 to include hand washing, peri-care, standard precautions; use and disposal of disposable wipes, bagging of garbage, linen handling, and the chain of infection. Non-Nursing staff will also be trained on the hand washing policy. The Clinical Manager or designee will complete daily audits of Nursing staff for compliance with infection control policies and procedures. Continued →	

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F 441	Continued From page 26 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure infection control standards were maintained for 2 of 6 residents (R67, R47) observed during provision of care. Findings include: On 2/28/13, at 9:07 a.m. the nursing assistant (NA)-E placed soiled disposable washcloths into the sink after performing peri care for R47. The quarterly Minimum Data Set (MDS) dated 2/14/13, indicated R47 needed the extensive assistance of one staff with transferring, toileting and personal hygiene. On 2/28/13, at 9:07 a.m. R47 was observed during assisted transfer from the wheelchair to the toilet. NA-E wet three disposable washcloth with water and perineal wash and placed them in the bathroom sink. R47 had a bowel movement and NA-E was observed to cleanse the anal area and place the fecal soiled cloths back into the sink. NA-E then gathered all three cloths with her gloved hand and rolled them inside the gloves while removing them. NA-E threw the gloves containing the washcloths into the garbage can	F 441	F441 Continued Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the IDT. The Infection Preventionist or designee will complete weekly audits of non-nursing staff for compliance with infection control policies and procedures. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the ~~IDT.~~ QA. The Infection Preventionist is responsible for monitoring Completion Date: April 10, 2013	

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F 441	Continued From page 27 under the sink in the resident's bathroom. NA-E washed her hands with soap and water and wiped the sink with the paper towel used to dry her hands. NA-E stated this was the way she usually did it but then stated, "No, I usually throw them in the garbage but I was worried about R47's knees buckling." R47 shared the bedroom and the bathroom with another resident that also used the bathroom and sink. On 3/1/13, at 3:25 p.m., the the Director of Nursing (DON), was interviewed and stated soiled washcloths should not be placed in the sink before or after using them, even if the bathroom was not shared. On 2/28/13, at 10:33 a.m. RN-A was observed during a dressing change for R167. R167 was assisted to transfer from the wheelchair to recliner chair. The dressings and supplies in a pink plastic wash basin were placed on the floor in front of R167. RN-A proceeded to wash her hands in R167's bathroom and put on a pair of gloves. RN-A removed the old dressing from R167's left lower leg and heel and noted the a large amount of yellowish-brown "purulent" drainage, no strikethough (drainage that seeps through the gauze dressing) noted on the outside of the Kerlix, and commented the wound had a foul odor. RN-A further commented the ulcer would be termed as unstageable due to slough present in the wound bed. RN-A disposed of the soiled dressings in a nearby garbage can and removed the contaminated gloves. Without	F 441		

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F 441	Continued From page 28 washing her hands, RN-A opened several packages of sterile q-tip applicators, a gauze dressing package, and the sterile normal saline packets. RN-A then put on a pair of sterile gloves and used the q-tips to measure the length and width of the ulcer. RN-A removed the gloves to document the ulcer measurements. Without washing hands, RN-A donned another pair of sterile gloves and cleansed the ulcer with the sterile normal saline squirting it up into the wound bed. RN-A blotted the ulcer with the dry sterile 4 inch by 4 inch gauze pads and R167's left leg jumped several times. RN-A removed the gloves and washed her hands in the bathroom sink, returning with another pair of gloves. RN-A put on the fourth pair of gloves and opened the package of Calcium Alginate with a pair of bandage scissors. RN-A trimmed the Calcium Alginate dressing with the same scissors, fitting the dressing into the wound bed. RN-A wrapped R167's left foot, heel, and ankle with the Kerlix gauze and then removed the gloves. RN-A used bandage tape to secure the Kerlix gauze in place and replaced R167's foot slippers. RN-A removed the gloves and washed her hands before returning the supplies to R167's closet and placing the garbage can in R167's bathroom. RN-A asked R167 how the dressing and heel felt and then assisted R167 back into the wheelchair from the recliner chair. On 2/28/13, at 10:57 a.m., RN-A stated hands were to be washed between glove changes when completing a dressing change procedure. RN-A confirmed she did not wash her hands after removing the soiled dressing, disposing of it, and removing the used gloves, and should have washed her hands at that time.	F 441		

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F 441	Continued From page 29 On 3/1/13, 11:05 a.m. the director of nursing (DON) stated she would expect handwashing to be done after removing gloves from a dressing change procedure and before putting on clean gloves to perform ulcer care. The Handwashing/Hand Hygiene Policy (undated), directed employees to wash hands for at least 15 seconds using antimicrobial or non-antimicrobial soap and water before and after changing a dressing. The Personal Protective Equipment - Gloves Policy (undated), directed gloves were to be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin, and hands were to be washed after removing gloves.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**02/27/2013**

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K 000	INITIAL COMMENTS Surveyor: 03005 FIRE SAFETY At the time of this survey, St. Michael's Health and Rehabilitation Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and National Fire Protection Association (NFPA) Standard 101 - 2000 editioion. The original one-story building constructed in 1967, was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this inspection the building was inspected as a Type V(000), as one building, which meets the standard. It has a full basement and is fully sprinklered. The facility has a capacity of 96 beds. At the time of the survey the census was 76. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 4313

March 10, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5283023

Dear Ms. High:

The above facility was surveyed on February 25, 2013 through March 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 11 East Superior Street, Suite 290, Duluth, Minnesota 55802. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00582	A. BUILDING: _____ B. WING _____	03/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/25/13, through 3/1/13, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: errors 3/04/10/2013

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2 000	Continued From page 1 Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802 Census 76/96	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not provide care as directed by the plan of care for 1 of 3 residents (R167)	2 565		

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2 565	Continued From page 2 reviewed for pressure ulcers and for 1 of 3 residents (R61) reviewed for urinary incontinence. Findings included: R167 was not provided pressure relief and weekly assessment of a left heel pressure ulcer. R167's diagnoses included malignant neoplasm of the lung, chronic obstructive pulmonary disease, fracture of left femoral neck, and status post arthroplasty. R167's temporary care plan and Kardex dated 2/12/13, directed R167's heels were to be floated off pillows due to ulcer on left heel. Review of R167's electronic admission ulcer documentation dated 2/14/13, noted R167 had a stage 3 pressure ulcer on the left heel, measuring 3.0 cm in length by 2.0 in width and no measurements of depth. The assessment further described R167's treatment plan as daily dressing changes, a pressure relieving device on the bed and in the wheelchair, and heels to be floated off pillows while in bed. R167's Skin Risk Assessment dated 2/21/13, noted R167 had an unhealed pressure ulcer at stage 1 or higher, required supervision with bed mobility, and contained no further information on the stage 3 pressure ulcer on R167's left heel. On 2/27/13, at 11:00 a.m. R167 was observed to be laying flat on [his/her] back in bed, with one pillow under R167's left lower leg and with the left heel resting on the mattress. On 2/28/13, at 10:57 a.m. during an interview, RN-A reported R167's left heel ulcer measurements were 2.2 cm in length and 4.0 cm in width. RN-A further stated ulcers were to be	2 565		

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2 565	Continued From page 3 assessed and measured weekly; however the previous assessment was dated 2/14/13. On 2/28/13, at 3:00 p.m. R167 was observed to lie down on his bed independently and place a flat pillow under the left lower leg with the left heel resting on the mattress. R167 stated this was how the foot was usually positioned. He had a heel boot at another facility before coming to this facility. On 3/1/13, 11:05 a.m. the director of nursing (DON) stated she would expect pressure ulcers to be assessed weekly. The DON stated R167's pressure ulcer should have been assessed, and R167 offered a boot or other device to float the heel off of the bed. The Skin Risk Assessment and Observation Policy revised 1/1/11, indicated a comprehensive Skin Risk Assessment/Braden-*R was to be completed upon admission, and then weekly thereafter, the Braden Scale For Prediction of Pressure Sore Risk was to be completed to monitor for changes in resident condition and implement necessary interventions. The policy further directed the licensed nurse to document the weekly observation in the chart, and to include observations for other conditions of the underlying tissue. R61 was not offered or provided toileting or incontinence care on 2/28/13, from 7:21 a.m. until 10:19 am, (2 hours, 58 minutes). The nursing assistant (NA) care plan (Kardex) dated 5/28/12, indicated R61 was incontinent of bladder and required assistance of one staff for every two hour toileting/incontinence care.	2 565		

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2 565	Continued From page 4 NA-L, interviewed on 2/28/13, at approximately 10:19 a.m., state R61 went 2 hours and 57 minutes with out toileting/incontinence care. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that staff follow the written comprehensive care plan The director of nursing or her designee could then monitor the appropriate licensed and direct care staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods;	2 625		

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2 625	Continued From page 5 G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility and the consultant pharmacist failed to ensure a system for accurate accoutability of controlled medications to prevent misuse or diversion of controlled medications for 7 of 26 residents (R60, R94, R106, R20, R17, R114, R40) with controlled medication orders. In addition, expired insulin pens were observed in one of three medication carts, and one of three medication refrigerators. Findings include:	2 625		

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2 625	Continued From page 6 During observations of the Meadows unit medication cart on 2/28/13, at 10:09 a.m. with licensed practical nurse (LPN)-D, a loose leaf notebook was utilized for reconciliation of controlled medications. A review of the controlled medication reconciliation records indicated doses not signed out, gaps in the counts, no evidence of two staff reconciliation to ensure accuracy and accountability, and discrepancies with the electronic medication administration record (EMAR). LPN-D stated the facility tracked controlled medications in a loose leaf notebook for about a year. LPN-D further stated she did not routinely count controlled medications at the beginning or end of her shifts. If controlled medications were counted, there was not a second licensed nurse present. LPN-D stated the controlled substance medications count should correspond with the EMAR, but that is not routinely checked either. The director of nursing (DON) was interviewed on 2/28/13, at 10:54 a.m. The DON stated controlled medications were recorded and reconciled in loose leaf binders. The DON stated controlled medications were to be counted by off-going and on-coming licensed nurses at every change of shift to ensure accuracy. The DON did not know where the medication counts were documented or signed by staff. At 12:45 p.m., the DON stated if the controlled medications were not documented in the loose leaf binder, the controlled medication count would be in the EMAR. The documentation in the loose leaf binders was reconciled with resident EMARs with the following discrepancies identified: R60 had an order for lorazepam (anti-anxiety	2 625		

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2 625	Continued From page 7 medication) 0.25 milligrams (mg) by mouth every four hours PRN (as needed). There were 18 doses of lorazepam unaccounted for in October 2012, and 28 doses unaccounted for in November 2012. The loose leaf binder lacked dates of administration, amounts given, and the prescription number. R94 had an order for lortab (narcotic analgesic) 5/325, 1-2 tablets mg by mouth every 6 hours as needed. Comparison between the loose leaf binder and the EMARs indicated a discrepancy of 8 doses unaccounted for between 2/11/13 and 2/18/13. The controlled substance medication sheet lacked the prescription number. R106 had an order for oxycontin (narcotic analgesic) 30 mg by mouth at bedtime. Comparison between the loose leaf binder and the EMARs indicated a discrepancy of 30 doses unaccounted for on 2/22/13. In addition, the loose leaf binder lacked dates and dosages administered and the prescription number. R106 had an order for lorazepam 0.25 mg by mouth twice a day. There was a discrepancy with 56 doses unaccounted for on 2/24/13. The loose leaf binder lacked a prescription number. R20 had an order for lortab 5/325 mg by mouth every four hours. There was a discrepancy of 57 doses on 2/25/13, and 2/26/13. The loose leaf binder lacked dates the medication was given. R17 had an order for methadone (narcotic analgesic) 5 mg by mouth three times daily. The record had discrepancy of 30 doses from 2/21/13 to 2/25/13. In addition, the dates of administration were not documented. R114 had an order for lortab 5/325 mg by mouth	2 625		

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2 625	Continued From page 8 three times daily PRN with 14 doses not documented or counted in the EMAR for July 1-31/12. The loose leaf binder lacked directions for use and the prescription number. R40 had an order for lorazepam 0.25 mg by mouth at bedtime. The loose leaf binder record from 2/20/13-2/27/13 indicated 8 doses were given, however, the EMAR lacked a count of the medication. The loose leaf binder lacked a prescription number. Six additional resident controlled medication pages in the loose leaf binder lacked a prescription number, and eight additional resident's controlled substance medications sheets were lacking both directions for use and a prescription number. On 3/1/13, at 8:30 a.m. the DON verified the discrepancies in counts of controlled medications for R60, R94, R106, R20, R17, R114 and R40. The DON also verified the lack of directions for use and prescription numbers on the loose leaf binder control medication records for the above residents and the 14 additional residents. The DON stated she did not know what happened to the controlled medications that were unaccounted for, "I'd have to look further into it." Both the administrator and DON stated they were unaware licensed nurses were not completing controlled substance medication counts at every shift change. On 2/28/13, at 1:33 p.m., LPN-D was interviewed and stated she has not done a count of controlled medications for awhile because she has not had time. LPN- E was interviewed at 2:43 p.m., and stated she does not have time to count controlled medications. At 2:51 p.m., LPN-G	2 625		

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2 625	Continued From page 9 stated does a count of controlled medications alone when she has time, but she usually does not. On 2/28/13, at 1:41 p.m., the consultant pharmacist (CP)-F was interviewed and stated a bound controlled substance book is standard of practice, but a loose leaf binder is acceptable as long as the sheet is completed with the medication, directions for use and the prescription number. The EMAR is utilized to maintain accurate count of medications. CP-F stated controlled medications should be counted every shift by the off-going and on-coming nurse, and the DON should be monitoring. CP-F further stated he does not review the control medication records during his monthly visits; the DON should be reviewing them monthly. CP-F stated he was unaware of discrepancies with controlled medications or that staff were not completing controlled substance medication counts every shift. The facility policy and procedure on Controlled/Scheduled Medications revised 2/1/12, directed controlled substances require a count which is added as a task on the EMAR, and LPNs are to count all controlled medications at the beginning of their shift, to ensure count accuracy, on the controlled substance medications sheets. The policy further directs when a controlled medication is received, the controlled substance medications sheets are completed with the resident's name, medication number, prescription number and current count. . On 2/28/13, at 10:09 a.m., the medication cart on the Meadows unit was observed with LPN-D, and noted to have an open Novolog insulin FlexPen with a dispense date of 1/19/13, and no open or	2 625		

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2 625	Continued From page 10 use by date; and an open Novolog Mix 70/30 insulin FlexPen with a dispense date of 12/14/12, and no open or use by date. The medication refrigerator on the Gardens unit contained an open vial of Lantus insulin with a dispense date of 1/22/13, and no open or use by date. LPN-D verified the FlexPen did not have an open or use by date, and all insulins should be dated when opened. LPN-D was unable to state when insulin expired after it was opened. On 3/1/13, at 11:10 a.m., the director of nursing (DON) was interviewed and stated she would expect insulin to be dated when opened. The manufacture's directions direct the following expiration dates: Novolog FlexPen expires 28 days after opening, Novolog Mix 70/30 FlexPen expires 14 days after opening, and Lantus vials expire 28 days after opening. The facility was unable to provide a policy and procedure on dating insulin. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications are documented accurately in the medical record. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty - one (21) days	2 625		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director	2 900		

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2 900	Continued From page 11 of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not provide pressure ulcer care according to the assessed need for 1 of 3 residents (R167) reviewed for pressure ulcers. Findings included: R167's diagnoses included malignant neoplasm of the lung, chronic obstructive pulmonary disease, fracture of left femoral neck, and status post arthroplasty. R167's Skin Risk Assessment dated 2/14/13, noted R167 was independent in bed mobility, had one stage 3 pressure ulcer measuring 3.0 cm in length and 2.0 cm in width, with slough noted in ulcer/wound bed, had +1 edema of lower extremities, and was rated at no risk for skin breakdown using the Braden Scale. Review of R167's electronic admission ulcer documentation dated 2/14/13, noted R167 had a	2 900		

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2 900	Continued From page 12 stage 3 pressure ulcer on the left heel, measuring 3.0 cm in length by 2.0 in width and no measurements of depth. The assessment also noted R167's left heel ulcer wound bed contained 25% slough, with a scant amount of purulent drainage with no odor. The ulcer assessment further noted the wound edges were calloused and dry with intact surrounding skin and no lower extremity edema. The assessment described R167's treatment plan as daily dressing changes, a pressure relieving device on the bed and in the wheelchair, and heels to be floated off pillows while in bed. R167's Skin Risk Assessment dated 2/21/13, noted R167 had an unhealed pressure ulcer at stage 1 or higher and required supervision with bed mobility. The assessment lacked a description and measurements of the left heel ulcer. Physician's orders dated 2/14/13, directed Calcium Alginate to heels daily and PRN [as needed], then cover with Kerlix. If dry, leave alone. Sterile water used only to cleanse. R167's temporary care plan and Kardex dated 2/12/13, directed R167's heels were to be floated off pillows due to ulcer on left heel On 2/27/13, at 11:00 a.m. R167 was observed to be laying flat on [his/her] back in bed, with one pillow under the left lower leg and with the left heel resting on the mattress. R167's left foot and heel were noted to be wrapped with white gauze and a small amount of medium-colored brown drainage was observed to be on the dressing and on the bedding under the heel.. On 2/28/13, at 10:33 a.m., the registered nurse	2 900		

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2 900	Continued From page 13 (RN)-A RN-A was observed to remove the old dressing from R167's left lower leg and heel and RN-A noted the old dressing contained a large amount of yellowish-brown "purulent" drainage, no strikethough (drainage that seeps through the gauze dressing) noted on the outside of the Kerlix, and commented the wound had a foul odor. RN-A measured the ulcer and stated it was unstageable due to slough present in the wound bed. RN-A cleansed the ulcer with sterile normal saline, blotted the ulcer with the dry sterile 4 inch by 4 inch gauze pads. After hand hygiene and clean gloves RN-A fitted the Calcium Alginate dressing into the wound bed and wrapped the left foot, heel, and ankle with the Kerlix gauze. At 10:57 a.m., RN-A stated the left heel ulcer measurements were 2.2 cm in length and 4.0 cm in width. RN-A further stated ulcers were to be measured weekly and could not locate any measurements from the previous week. On 2/28/13, at 3:00 p.m. R167 was observed to lie down on the bed independently and place a flat pillow under the left lower leg with the left heel resting on the mattress. R167 stated this was how the heel was usually positioned and reported they had a heel boot at the previous facility. At 3:10 p.m. RN-A observed and verified the left heel was resting on the bed. RN-A stated, "That does not do any good." and folded the pillow to float the heels off the mattress. On 3/1/13, at 11:05 a.m. the director of nursing (DON) stated she would expect pressure ulcers to be measured weekly and R167's left heel pressure ulcer should have been measured last week. The DON further stated R167 should be offered a boot or other device to float the heels off of the bed.	2 900		

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2 900	Continued From page 14 The Skin Risk Assessment and Observation Policy revised 1/1/11, indicated a comprehensive Skin Risk Assessment/Braden-*R was to be completed upon admission, and then weekly thereafter, the Braden Scale For Prediction of Pressure Sore Risk was to be completed to monitor for changes in resident condition and implement necessary interventions. The policy further directed the licensed nurse to document the weekly observation in the chart, and to include observations for other conditions of the underlying tissue. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents receive appropriate treatment and services to prevent or minimize pressure sores as determined necessary by their individualized assessment. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home	2 910		

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2 910	Continued From page 15 without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review the facility did not provide incontinence care for 1 of 3 residents (R61) reviewed for incontinence care, Findings include: R61 was observed on 2/28/13, from 7:21 a.m. until 10:19 a.m., without being offered or provided toileting/incontinence care. On 2/28/13, at 7:21 a.m., R61 was observed self propelling a wheelchair in the hallway. After receiving medications R61 arrived at the dining room at 7:44 a.m. R61 remained in the dining room until 9:08 a.m. when they wheeled in the hallway. At 9:19 a.m. R61 was assisted to an activity in the dining room. At 9:23 a.m. R61 came into the hallway and was assisted to her bedroom at 9:23 a.m. At 9:47 a.m. the nursing assistant (NA)-L assists R 61 to lie down without offering toileting or checking for incontinence. At 10:19 a.m. NA-L was cued by the surveyor regarding R61's lack of toileting. NA-L assisted R61 to the toilet where the incontinence product was found to be wet with urine and soiled with feces. NA-L stated R61 went 2 hours and 57 minutes with out	2 910		

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2 910	Continued From page 16 being assisted to the toilet or checked for incontinence. NA-L said she thought R61 needed to be toileted every two hours. The quarterly minimum data set (MDS) dated 1/10/13, indicated R61 had moderate cognitive impairment, was always incontinent of bowel, frequently incontinent of urine and required extensive assistance with weight bearing support of one staff to toilet. The incontinence care area assessment (CAA) dated 4/23/12, indicated R61 had occasional incontinence. The care plan dated 5/29/09, and edited 4/30/12, indicated R61 toileted themself and would request assist if needed. It directed staff to refer to Kardex for specifics and approaches to toileting. The full care plan had not been updated to reflect R61's current needs. The nursing assistant care plan (Kardex) dated 5/28/12, indicated R61 was incontinent of bladder, continent of bowel and staff needed to ask R61 if she needed to use the toilet and would be checked and changed every two hours at night. The Kardex indicated R61 needed assist of one to the toilet and wore a peri pad during the day. On 2/28/13, at approximately 2:10 p.m. the registered nurse, (RN)-B stated R61 needed to be toileted as the Kardex indicated. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could develop policies and procedures to ensure that residents receive timely toileting according to their assessed needs. The Director of Nursing could educate all	2 910		

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2 910	Continued From page 17 appropriate staff on this plan and develop a monitoring plan to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain food contact surface areas of kitchen equipment in a sanitary manner to prevent food borne illness, which had the potential to effect all 74 residents of the facility. On 2/25/13, at 1:56 p.m. during the initial tour of the facility's kitchen, a large floor mixer was covered with a large opaque plastic cover and noted to have multiple white raised areas of particulate matter on the front wire guard and back-splash solid metal guard surrounding the mechanism to propel the mixer blades. The dietary manager (DM) stated the mixer had been cleaned already today and was "ready to go." Review of the Daily Cleaning Schedule noted the Large Hobart mixer was cleaned on 2/24/13. Review of the Dietary Cleaning Schedules Policy dated 9/1/03, directed the dietary department to maintain equipment in a clean and sanitary	21015		

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21015	Continued From page 18 condition. On 2/28/13, at 3:30 p.m. the DM stated the Hobart mixer was used late in the day on 2/24/13, and not cleaned after making cakes. The DM confirmed the cook should have cleaned the mixer before putting it away for the day. SUGGESTED METHOD OF CORRECTION: The Dietary Manager (DM) or designee could develop, review, and/or revise policies and procedures to ensure sanitary conditions in the kitchen. . The Dietary Manager (DM) or designee could educate all appropriate staff on the policies and procedures. The Dietary Manager (DM) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure infection control standards were maintained for 2 of 6 residents (R67, R47) observed during provision of care.	21375		

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21375	Continued From page 19 Findings include: On 2/28/13, at 9:07 a.m. the nursing assistant (NA)-E placed soiled disposable washcloths into the sink after performing peri care for R47. The quarterly Minimum Data Set (MDS) dated 2/14/13, indicated R47 needed the extensive assistance of one staff with transferring, toileting and personal hygiene. On 2/28/13, at 9:07 a.m. R47 was observed during assisted transfer from the wheelchair to the toilet. NA-E wet three disposable washcloth with water and perineal wash and placed them in the bathroom sink. R47 had a bowel movement and NA-E was observed to cleanse the anal area and place the fecal soiled cloths back into the sink. NA-E then gathered all three cloths with her gloved hand and rolled them inside the gloves while removing them. NA-E threw the gloves containing the washcloths into the garbage can under the sink in the resident's bathroom. NA-E washed her hands with soap and water and wiped the sink with the paper towel used to dry her hands. NA-E stated this was the way she usually did it but then stated, "No, I usually throw them in the garbage but I was worried about R47's knees buckling." R47 shared the bedroom and the bathroom with another resident that also used the bathroom and sink. On 3/1/13, at 3:25 p.m., the the Director of Nursing (DON), was interviewed and stated soiled washcloths should not be placed in the sink before or after using them, even if the bathroom was not shared. R167: On 2/28/13, at 10:33 a.m. RN-A was observed	21375		

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21375	Continued From page 20 during a dressing change for R167. R167 was assisted to transfer from the wheelchair to recliner chair. The dressings and supplies in a pink plastic wash basin were placed on the floor in front of R167. RN-A proceeded to wash her hands in R167's bathroom and put on a pair of gloves. RN-A removed the old dressing from R167's left lower leg and heel and noted the a large amount of yellowish-brown "purulent" drainage, no strikethough (drainage that seeps through the gauze dressing) noted on the outside of the Kerlix, and commented the wound had a foul odor. RN-A further commented the ulcer would be termed as unstageable due to slough present in the wound bed. RN-A disposed of the soiled dressings in a nearby garbage can and removed the contaminated gloves. Without washing her hands, RN-A opened several packages of sterile q-tip applicators, a gauze dressing package, and the sterile normal saline packets. RN-A then put on a pair of sterile gloves and used the q-tips to measure the length and width of the ulcer. RN-A removed the gloves to document the ulcer measurements. Without washing hands, RN-A donned another pair of sterile gloves and cleansed the ulcer with the sterile normal saline squirting it up into the wound bed. RN-A blotted the ulcer with the dry sterile 4 inch by 4 inch gauze pads and R167's left leg jumped several times. RN-A removed the gloves and washed her hands in the bathroom sink, returning with another pair of gloves. RN-A put on the fourth pair of gloves and opened the package of Calcium Alginate with a pair of bandage scissors. RN-A trimmed the Calcium Alginate dressing with the same scissors, fitting the dressing into the wound bed. RN-A wrapped R167's left foot, heel, and ankle with the Kerlix gauze and then removed the gloves. RN-A used bandage tape to secure the Kerlix gauze in place	21375		

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21375	Continued From page 21 and replaced R167's foot slippers. RN-A removed the gloves and washed her hands before returning the supplies to R167's closet and placing the garbage can in R167's bathroom. RN-A asked R167 how the dressing and heel felt and then assisted R167 back into the wheelchair from the recliner chair. On 2/28/13, at 10:57 a.m., RN-A stated hands were to be washed between glove changes when completing a dressing change procedure. RN-A confirmed she did not wash her hands after removing the soiled dressing, disposing of it, and removing the used gloves, and should have washed her hands at that time. On 3/1/13, 11:05 a.m. the director of nursing (DON) stated she would expect handwashing to be done after removing gloves from a dressing change procedure and before putting on clean gloves to perform ulcer care. The Handwashing/Hand Hygiene Policy (undated), directed employees to wash hands for at least 15 seconds using antimicrobial or non-antimicrobial soap and water before and after changing a dressing. The Personal Protective Equipment - Gloves Policy (undated), directed gloves were to be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin, and hands were to be washed after removing gloves. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure infection control standards are being met in the facility. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director	21375		

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21375	Continued From page 22 of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21375		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waver: - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease.	21400		

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21400	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R159, R117, R75, R24) were screened for active tuberculin (TB) symptoms according to the Centers for Disease Control (CDC) Guidelines. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. A two-step TST (mantoux), or a single interferon gamma release assay (IGRA), or chest x-ray results must be maintained in the resident's record. On 2/27/13, five resident records were reviewed for baseline TB screening. The medical records lacked proper documentation on the results of the two-step mantoux. In addition, a physical screening for active symptoms on TB were not completed for R24. R159 had a second-step mantoux (a screening test for TB) administered 2/6/13, and was recorded as negative 2/8/13.	21400		

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21400	Continued From page 24 R117 had a second-step mantoux administered 1/7/13, and was recorded as negative 1/10/13. R75 had a first-step mantoux administered on 1/6/13, and was recorded as negative on 1/8/13. R75 had a second-step mantoux administered on 1/20/13, and was recorded as negative on 1/22/13. R24 did not have a current TB screening tool completed. R24 had a first-step mantoux administered 10/11/12, and was recorded as negative on 9/29/12, with no date recorded for a result of negative. R24 had a second-step mantoux administered 10/13/12, and was recorded as negative on 10/13/12. Registered nurse (RN)-C was interviewed on 2/27/13, at 12:33 p.m., and verified R24 did not have a current TB screening tool. RN-C also verified all readings of mantoux's were to be recorded in mm of indurating. The facility policy and procedure on Tuberculosis Screening and Mantoux Administration dated 11/1/11, directs newly admitted residents to receive a TB screening within the first 72 hours. The policy further directs the mantoux test to be read by millimeters (mm) of induration. The hard copy policy is in the employee TB packet. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are receiving tuberculosis screening according to the CDC guidelines. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee could develop monitoring	21400		

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21400	Continued From page 25 systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21400		
21405	MN Rule 4658.0810 Subp. 2 Resident Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines: Nursing Homes, Minnesota Rule 4658.0810 Subp 2 Resident Tuberculosis Program is waved. Condition of Waiver: - Follow the U.S. Centers for Disease Control and Prevention's "(Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," (MMWR) 2005; 54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to the "CDC Guidelines" for complete definitions of terms. - Assign administrative responsibility for the tuberculosis (TB) infection control & prevention program to appropriate personnel. Administrative responsibilities include establishment of an infection control team (one or more individuals), completion (and periodic review) of a written TB risk assessment, and development (and periodic review) of a written TB infection control plan.	21405		

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	00582	A. BUILDING: _____ B. WING _____	03/01/2013

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

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21405	Continued From page 26 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a facility risk assessment as indicated by the Centers for Disease Control (CDC) Guidlines for prevention of tuberculosis (TB). Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005; (MMWR) directed health-care facilities should complete a TB risk assessment to include, but not limited to, a review of the community profile of TB disease in collaboration with the local or state health department, and to consult the local or state TB-control program to obtain epidemiologic surveillance data necessary to conduct a TB risk assessment for the health-care setting. On 2/27/13, at 3:41 p.m., the infection control registered nurse (RN)-C confirmed she was unable to locate the TB Risk Assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are receiving tuberculosis screening according to the CDC guidelines. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one	21405		

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21405	Continued From page 27 (21) days.	21405		
21410	MN Rule 4658.0815 Subp. 1 Employee Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Information bulletin 09-02 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4658.0815 Subpart 1 Employee Tuberculosis Program is waived. Conditions of Wavier: - Follow the U. S. Centers for Disease Control and Prevention ' s "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," Morbidity and Mortality Weekly Report (MMWR) 2005;54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to this document for complete definitions of terms. - Assign administrative responsibility for the TB infection control program to appropriate personnel. Administrative responsibilities include the establishment of an infection control team (one or more individuals), completion (and periodic update) of a written TB risk assessment, development (and periodic review) of a written TB infection control plan, and screening of health care workers (HCWs) for TB as discussed below. - Conduct a problem evaluation if a case of suspected or confirmed TB disease is not promptly recognized and appropriate measures are not taken. - Perform an investigation in collaboration with	21410		

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21410	Continued From page 28 the local health department if health-care-associated transmission of M. tuberculosis is suspected. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 recently hired employees (nursing assistant [NA]-N, dietary aide[DA]-A, NA-M, NA-G, certified occupational therapy assistant [COTA]-H) were screened for active tuberculin (TB) symptoms according to the Centers for Disease Control (CDC) guidelines. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all health care workers must receive a baseline TB screening upon hire. The screening must include an assessment of the employee's risk factors for TB, and any current TB symptoms. A two-step TST (tuberculin skin test) or a single interferon gamma release assay (IGRA), or a chest x-ray result must be maintained in the employee's record. NA-N had a hire date of 2/11/13. The first step	21410		

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21410	Continued From page 29 mantoux (a screening test for exposure to tuberculosis) was administered 2/13/13, the result was recorded, however the date it was read was lacking. On 2/27/13, at 11:45 a.m., registered nurse (RN)-C verified the lack of date. DA-A had a hire date of 2/12/13. The first step mantoux was administered 2/12/13, recorded as negative, and lacked a date of the reading. The second step mantoux was administered 2/21/13, and lacked a date that it was read and the result of the mantoux. On 2/27/13, at 11:45 a.m., RN-C verified the lack of date, and the result. NA-M had a hire date of 12/20/12. The first step mantoux was administered on 12/20/12, but lacked a date that it was read and the result of the mantoux. On 2/27/13, at 11:45 a.m., RN-C verified the lack of date, and the result. NA-G had a hire date date of 10/31/12. The employee file lacked the TB screening tool. On 2/27/13, at 11:45 a.m., RN-C verified the facility had no TB screening records for NA-G. COTA-H had a hire date of 1/15/13. The employee file lacked the TB screening tool. RN-C verified the lack of screening on 2/27/13, at 11:45 a.m. The facility policy and procedure on Tuberculosis Screening and Mantoux Administration dated 11/1/11, directs new employees complete the baseline screening tool for health care workers prior to orientation on the floor or working with residents. The policy further directs the mantoux test is to be read in millimeters (mm) of induration, and employee records are to be kept in the employee's medical files.	21410		

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21410	Continued From page 30 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure employees are receiving tuberculosis screening according to the CDC guidelines. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21410		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide for dignity with an exposed lift sling for 1 of 3 residents (R13) reviewed. Findings included: On 2/25/13, at 5:10 p.m. during the evening meal R13 was observed in the dining room with a bright yellow lift sling over the back of the wheelchair. At approximately 5:12 p.m., R13 stated she did not like the bright yellow lift sling to be left under her in the wheelchair, "Would you like it?!"	21805		

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21805	Continued From page 31 The quarterly Minimum Data Set (MDS) dated 2/18/13, indicated R13 had moderate cognitive impairment and required extensive assistance of one person for transfers with a mechanical lift. The care plan dated 12/12/12, and the nursing assistant care plan indicated the ceiling lift would be used for transfers and did not identify R13's preference regarding the visible sling when she was in public. On 2/26/13, at 1:00 p.m., the nursing assistant (NA)-L, was interviewed and said that all lift slings were to be removed from residents in the chair unless the care plan directed it. NA-L said R13 should not have the sling left under her after transfer. NA-L further said that the lift sling was cut away so that it could be removed easily. On 2/27/13, at 10:00 a.m. R13 was observed in her wheelchair with the yellow sling visible under her back with the ends crossed between her legs. R13 stated she would like the sling removed when she was up. At 10:18 a.m. R13 was assisted to a group activity with approximately 10 other residents and staff. At 11:02 a.m. R13 remained in the group with the bright yellow sling crossed between her legs. From 12:03 p.m. through 12:32 p.m., R13 was observed sitting in the wheel chair with the sling visible under her, the ends crossed between her legs and the straps hanging out behind each shoulder. On 2/28/13, at 7:25 a.m. through 7:45 a.m. R13 was in the wheelchair, in her room, with the bright yellow sling crossed between her legs. At approximately 2 p.m., NA-K was interviewed and stated she left the sling visible under R13 because it was on nursing assistant care plan. NA-K reviewed the care plan and admitted the	21805		

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21805	Continued From page 32 care plan did not direct the sling be left under R13. The registered nurse (RN)-B, interviewed on 2/28/13, at approximately 3:05 p.m., stated slings are left under residents because they are difficult to remove and replace. RN-B stated residents were not assessed or consulted for their preference regarding the visible lift slings in public. Review of Mechanical Lift policy dated May, 2012, did not address dignity concerns for residents who required use of lift slings. The policy said with the sling mechanical lifts may be left under the resident in their wheel chairs but never to be left under the resident when in bed. The manufacturer's information did not address the slings being left under the residents when not in use, however, indicated the use of slings must be assessed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		