MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 24, 2017

Mr. Richard Meyer, Administrator
St. Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

Subject: St. Gertrudes Health & Rehabilitation Center - Independent Dispute Resolution (IDR)
CMS Certification Number (CCN): 24 5610
Project Number: H5610030

Dear Mr. Meyer:

This is in response to your letter of December 13, 2016, in regards to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F323 issued pursuant to an abbreviated standard survey event 5S5Q11, completed on December 2, 2016.

The information presented with your letter, the CMS 2567 dated December 2, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of OHFC staff have been carefully considered and the following determination has been made:

F323 S/S - G 42 CFR §483.25(d) Accidents: The resident environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Summary of the facility's reason for IDR of this tag:

R1: The facility alleges R1's care plan was implemented as written at the time of the accident. The facility provided documentation for R1 including occupational/physical therapy assessments, care plan, nurse progress notes, incident reports, staff documentation and interviews which revealed, at the time of the fall, R1 was receiving care according to her assessed and care planned needs.

R2: Although the facility agrees R2's care plan was not implemented which resulted in R2's fall, they had reported the incident to the Office of Health Facility Complaints (OHFC) for possible maltreatment with conclusionary findings that no further action was necessary by OHFC. The facility contends that due to self-reporting the incident and subsequent OHFC review, the facility considered R2's incident to have been thoroughly investigated therefore should not have been included in F323.

Summary of facts.

R1 fell in the bathroom while standing and washing her hands, with staff present, as directed by the care plan.

R2 required staff assistance with toileting and was left alone in the bathroom which resulted in a fall. R2's care plan directed staff to remain with R2 while in the bathroom. The facility submitted a Vulnerable Adult report due to possible maltreatment as a result of the failure to implement R2's care plan. The Office of Health Facility Complaints reviewed R2's reported incident and determined no further action was needed by OHFC at that time.

Conclusion:
The facility provided documentation for R2 including the Office of Health Facility Complaints disposition letter. Although OHFC had determined no further action was needed by their office, it did not preclude the facility from having this incident investigated further.

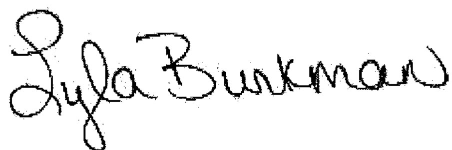
R1 is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies. The removal of this example does not negate the findings in the remainder of the deficiency related to R2. The deficiency remains valid at a lower scope and severity of D.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-308-2104 Fax: 218-308-2122

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Annette Winters, OHFC Supervisor

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245610	A. Building B. Wing	2/3/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/31/2017	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVISED

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) LB/mm	DATE 03/24/2017	SIGNATURE OF SURVEYOR 37564	DATE 02/03/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING ______ B. WING ______	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	**1850 SARAZIN STREET** **SHAKOPEE, MN 55379**

(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 Revised 2567 as a result of an Informal dispute Resolution An abbreviated standard survey was conducted to investigate case #H5610030. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
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 interview and document review the facility failed to ensure adequate supervision was provided to reduce the risk of falls for 1 of 4 residents (R2) reviewed who was left unsupervised while in the bathroom which resulted in a fall. The findings include: R2's medical record was reviewed. R2's face sheet dated 7/19/16, included diagnoses of neoplasm of craniopharyngeal duct (brain tumor), syncope (fainting), and other abnormalities of gait and mobility (difficulty walking.) R2's admission	F 323	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan of care does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are	1/31/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/16/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING ____ B. WING ____	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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F 323	Continued From page 1 falls care plan dated 7/19/16, specified 16 interventions for fall prevention. R2's Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 8/29/16, indicated severe cognitive impairment with a score of 6 out of 15. R2's Falls Care Area Assessment (CAA) dated 8/29/16 indicated R1 had cognitive deficits and would try to stand independently. R1 was to walk with therapy only, and needed extensive assistance of two to three staff for transfers/toileting and activities of daily living (ADL's.) R2's physician's order dated 8/1/16, directed staff not to leave R2 alone in bathroom, related to fainting episodes while straining on the toilet. R2's physical therapy care plan dated 8/23/16, indicated R2 was able to stand for one minute 15 seconds before losing balance and was able to walk 30 feet with a front wheeled walker, which placed R2 at a high risk for falls and diminished mobility. R2's event report dated 9/4/16, indicated R2 was assisted by one staff to the bathroom, was left alone, and had fall at 10:00 a.m. with injuries including a large bruise on right side of the back, scrapes to both knees, and two small cuts on the right lower back. R2 had a fall while in the bathroom on 9/9/16 without injury. Post falls assessment dated 9/9/16, directed nursing assistants to not leave R2 alone in bathroom due to cognitive inabilities (unable to use the call light for assistance.)	F 323	correctly applied. Please accept this Plan of Correction as our credible allegation of compliance. F323 Free of Accident Hazards/Supervision/Devices SPECIFIC RESIDENTS: Resident R1 affected by alleged deficient practice was discharged on 08/17/16. Resident R2 affected by alleged deficient practice will not be left alone when in the bathroom. OTHER RESIDENTS: Residents who are at risk for falls are assessed for safety and appropriate interventions upon admission, quarterly and as needed for safety. Fall preventions are put into place according to their fall risk assessment. Certified Nursing Assistants were provided education on: 1. Proper supervision of those residents specifically ordered to have supervision at all times when in the bathroom. MONITOR: The Director of Nursing and/or designee will observe and assess via audits for those residents who need attendance at all times when in bathroom with care: Weekly x 4 weeks, then twice monthly for 1 month, then monthly for 1 month with review by Quality Assurance Committee for further needs. DATE OF COMPLIANCE: January 31st, 2017	

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 24, 2017

Mr. Richard Meyer, Administrator
St. Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

Subject: St. Gertrudes Health & Rehabilitation Center - Independent Dispute Resolution (IDR)
CMS Certification Number (CCN): 24 5610
Project Number: H5610030

Dear Mr. Meyer:

This is in response to your letter received on December 13, 2016, in regards to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F323 where corresponding correction orders were issued pursuant to an abbreviated standard survey completed on December 2, 2016.

The information presented with your letter, the CMS and State 2567s dated December 2, 2016, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

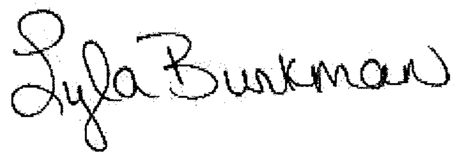
State Tag ID Prefix – 0830: Adequate and Proper Nursing Care; 1850: Patients & Residents of Hc Fac. Bill of Rights

- Refer to summary outlined in the MDH letter dated March 9, 2017, addressing the IDR for federal deficiencies.
- The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

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

Sincerely,



Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-308-2104
Fax: 218-308-2122

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Annette Winters, Unit supervisor, Office of Health Facility Complaints

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00459 Y1	A. Building B. Wing Y2	2/3/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 01/31/2017	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 01/31/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVISED

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) LB/MM	DATE 03/24/2017	SIGNATURE OF SURVEYOR 37564	DATE 02/03/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00459	A. BUILDING: ______ B. WING ______	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTE	1850 SARAZIN STREET SHAKOPEE, MN 55379

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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: Revised STATE FORM as a result of an Informal Dispute Resolution A complaint investigation was conducted to investigate complaint H5610030. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt	2 000		

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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure adequate supervision was provided to reduce the risk of falls for 1 of 4	2 830	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long	12/16/16

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 2 residents (R2) reviewed who was left unsupervised while in the bathroom which resulted in a fall. The findings include: R2's medical record was reviewed. R2's face sheet dated 7/19/16, included diagnoses of neoplasm of craniopharyngeal duct (brain tumor), syncope (fainting), and other abnormalities of gait and mobility (difficulty walking.) R2's admission falls care plan dated 7/19/16, specified 16 interventions for fall prevention. R2's Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 8/29/16, indicated severe cognitive impairment with a score of 6 out of 15. R2's Falls Care Area Assessment (CAA) dated 8/29/16 indicated R1 had cognitive deficits and would try to stand independently. R1 was to walk with therapy only, and needed extensive assistance of two to three staff for transfers/toileting and activities of daily living (ADL's.) R2's physician's order dated 8/1/16, directed staff not to leave R2 alone in bathroom, related to fainting episodes while straining on the toilet. R2's physical therapy care plan dated 8/23/16, indicated R2 was able to stand for one minute 15 seconds before losing balance and was able to walk 30 feet with a front wheeled walker, which placed R2 at a high risk for falls and diminished mobility. R2's event report dated 9/4/16, indicated R2 was assisted by one staff to the bathroom, was left	2 830	term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan of care does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Please accept this Plan of Correction as our credible allegation of compliance. F323 Free of Accident Hazards/Supervision/Devices SPECIFIC RESIDENTS: Resident R1 affected by alleged deficient practice was discharged on 08/17/16. Resident R2 affected by alleged deficient practice will not be left alone when in the bathroom. OTHER RESIDENTS: Residents who are at risk for falls are assessed for safety and appropriate interventions upon admission, quarterly and as needed for safety. Fall preventions are put into place according to their fall risk assessment. Certified Nursing Assistants were provided education on: 1. Proper supervision of those residents specifically ordered to have supervision at all times when in the bathroom. MONITOR: The Director of Nursing and/or designee will observe and assess via audits for those residents who need	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 3 alone, and had fall at 10:00 a.m. with injuries including a large bruise on right side of the back, scrapes to both knees, and two small cuts on the right lower back. R2 had a fall while in the bathroom on 9/9/16 without injury. Post falls assessment dated 9/9/16, directed nursing assistants to not leave R2 alone in bathroom due to cognitive inabilities (unable to use the call light for assistance.) An interview with nursing assistant (NA)-G was conducted on 9/20/16, at 2:28 p.m. NA-G stated at the beginning the shift nursing assistants were to look at the nursing assistant communication book. NA-G recalled the doctor's order to stay in the bathroom with R2 had been placed in the back of the book. An interview with director of nursing (DON)-D was conducted on 9/21/16, at 12:40 p.m. DON-D stated nursing assistants were provided with information about the residents and it was expected the nursing assistants followed the care plan. DON-D stated that NA-G did not follow the plan of care for R2 when s/he left R2 alone in the bathroom. An interview conducted on 9/21/16, at 3:34 p.m. registered nurse (RN)-C stated nursing assistants used the 24 hour report sheet (nursing assistant communication book) as a guide for care. Fall assessment and plan of care policy revised 02/05/07, directed staff, resident, and family be educated as to the care plan. Resident safety policy (undated,) indicated that before performing any procedure with a resident, the staff shall checked the resident's identity, the	2 830	attendance at all times when in bathroom with care: Weekly x 4 weeks, then twice monthly for 1 month, then monthly for 1 month with review by Quality Assurance Committee for further needs. DATE OF COMPLIANCE: January 31st, 2017	

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 4 physician's order and/or the resident's care plan. The policy also indicated staff were to provide support to the residents body during transfers/ambulation and to use a gait belt. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by:	21850		12/16/16

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21850		21850		

Continued From page 5

Based on interview and document review the facility failed to ensure adequate supervision was provided to reduce the risk of falls for 1 of 4 residents (R2) reviewed who was left unsupervised while in the bathroom which resulted in a fall.

The findings include:

R2's medical record was reviewed. R2's face sheet dated 7/19/16, included diagnoses of neoplasm of craniopharyngeal duct (brain tumor), syncope (fainting), and other abnormalities of gait and mobility (difficulty walking.) R2's admission falls care plan dated 7/19/16, specified 16 interventions for fall prevention.

R2's Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 8/29/16, indicated severe cognitive impairment with a score of 6 out of 15.

R2's Falls Care Area Assessment (CAA) dated 8/29/16 indicated R1 had cognitive deficits and would try to stand independently. R1 was to walk with therapy only, and needed extensive assistance of two to three staff for transfers/toileting and activities of daily living (ADL's.)

R2's physician's order dated 8/1/16, directed staff not to leave R2 alone in bathroom, related to fainting episodes while straining on the toilet.

R2's physical therapy care plan dated 8/23/16, indicated R2 was able to stand for one minute 15 seconds before losing balance and was able to walk 30 feet with a front wheeled walker, which placed R2 at a high risk for falls and diminished mobility.

This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan of care does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Please accept this Plan of Correction as our credible allegation of compliance.

F323 Free of Accident Hazards/Supervision/Devices

SPECIFIC RESIDENTS: Resident R1 affected by alleged deficient practice was discharged on 08/17/16. Resident R2 affected by alleged deficient practice will not be left alone when in the bathroom.

OTHER RESIDENTS: Residents who are at risk for falls are assessed for safety and appropriate interventions upon admission, quarterly and as needed for safety. Fall preventions are put into place according to their fall risk assessment.

Certified Nursing Assistants were provided education on:
1. Proper supervision of those residents specifically ordered to have supervision at all times when in the bathroom.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00459	A. BUILDING: ______ B. WING ______	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTE	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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
21850	Continued From page 6 R2's event report dated 9/4/16, indicated R2 was assisted by one staff to the bathroom, was left alone, and had fall at 10:00 a.m. with injuries including a large bruise on right side of the back, scrapes to both knees, and two small cuts on the right lower back. R2 had a fall while in the bathroom on 9/9/16 without injury. Post falls assessment dated 9/9/16, directed nursing assistants to not leave R2 alone in bathroom due to cognitive inabilities (unable to use the call light for assistance.) An interview with nursing assistant (NA)-G was conducted on 9/20/16, at 2:28 p.m. NA-G stated at the beginning the shift nursing assistants were to look at the nursing assistant communication book. NA-G recalled the doctor's order to stay in the bathroom with R2 had been placed in the back of the book. An interview with director of nursing (DON)-D was conducted on 9/21/16, at 12:40 p.m. DON-D stated nursing assistants were provided with information about the residents and it was expected the nursing assistants followed the care plan. DON-D stated that NA-G did not follow the plan of care for R2 when s/he left R2 alone in the bathroom. An interview conducted on 9/21/16, at 3:34 p.m. registered nurse (RN)-C stated nursing assistants used the 24 hour report sheet (nursing assistant communication book) as a guide for care. Fall assessment and plan of care policy revised 02/05/07, directed staff, resident, and family be educated as to the care plan.	21850	MONITOR: The Director of Nursing and/or designee will observe and assess via audits for those residents who need attendance at all times when in bathroom with care: Weekly x 4 weeks, then twice monthly for 1 month, then monthly for 1 month with review by Quality Assurance Committee for further needs. DATE OF COMPLIANCE: January 31st, 2017	

REVISED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00459	A. BUILDING: ______ B. WING ______	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTE	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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
21850	Continued From page 7 Resident safety policy (undated,) indicated that before performing any procedure with a resident, the staff shall checked the resident's identity, the physician's order and/or the resident's care plan. The policy also indicated staff were to provide support to the residents body during transfers/ambulation and to use a gait belt. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	21850		

REVISED

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5288
Facility ID: 00459

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245610**
2. STATE VENDOR OR MEDICAID NO. (L2) **440886100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST GERTRUDES HEALTH & REHABILITATION CENTER**
(L4) **1850 SARAZIN STREET**
(L5) **SHAKOPEE, MN** (L6) **55379**

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 **02/22/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **105** (L18)
13. Total Certified Beds **105** (L17)

10. THE FACILITY IS CERTIFIED AS:
✓ A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(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 :
Gayle Lantto, Unit Supervisor 02/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 04/27//2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/08/1996** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **03/02/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245610

April 2, 2016

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

Dear Mr. Meyer:

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 February 15, 2016 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds.

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

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

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

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 24, 2016

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

RE: Project Number S5610024

Dear Mr. Meyer:

On January 27, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 14, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On February 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 8, 2016 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 a standard survey, completed on January 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 5, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 14, 2016, effective February 5, 2016 and therefore remedies outlined in our letter to you dated January 27, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

Protecting, Maintaining and Improving the Health of all Minnesotans

Electronically Delivered
April 27, 2016

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

Re: Removal of Reinspection Results - Project Number S5610024

Dear Mr. Meyer:

On February 26, 2016 notice of reinspection results were delivered electronically to the facility via the electronic Plan of Correction (ePoC) website. The February 22, 2016 Post Certification Revisit (PCR) was completed by review of the facility's plan of correction. Since an onsite visit was not conducted, the State correction orders could not be verified as corrected.

As a result of the PCR by review of the plan of correction and not onsite visit conducted. The results of the State correction orders have been removed. This does not change in an way the status of the facility's certification and you are considered in compliance with Medicare's participation requirements and the certification letter (948ltr) will remain unchanged.

Feel free to contact me if you have questions related to the changes within ePoC and/or this eNotice.

Sincerely,

Mark Meath

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

cc: Licensing & Certification file

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245610 Y1	A. Building B. Wing Y2	2/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 02/05/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 02/05/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 02/05/2016
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 02/05/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 02/05/2016	ID Prefix F0463 Reg. # 483.70(f) LSC	Correction Completed 02/05/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) GL/mm	DATE 02/24/2016	SIGNATURE OF SURVEYOR 15507	DATE 02/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245610	A. Building 01 - MAIN BUILDING 01 B. Wing	2/8/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 02/04/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/mm	DATE 02/24/2016	SIGNATURE OF SURVEYOR 34764	DATE 02/08/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245610	A. Building 02 - 2008 & 2011 ADDITION B. Wing	2/8/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 02/04/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/mm	DATE 02/24/2016	SIGNATURE OF SURVEYOR 34764	DATE 02/08/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245610 Y1	A. Building 03 - BLDG THREE NEW ADDITION B. Wing Y2	2/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 01/27/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 02/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 02/24/2016	**SIGNATURE OF SURVEYOR** 34764	**DATE** 02/08/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5288
Facility ID: 00459

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245610**
2. STATE VENDOR OR MEDICAID NO. (L2) **440886100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST GERTRUDES HEALTH & REHABILITATION CENTER**
(L4) **1850 SARAZIN STREET**
(L5) **SHAKOPEE, MN** (L6) **55379**

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 **01/14/2016** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA** **02 SNF/NF/Dual** **06 PRTF** **10 NF** **14 CORF** **03 SNF/NF/Distinct** **07 X-Ray** **11 ICF/IID** **15 ASC** **04 SNF** **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(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 :
Lisa Hakanson, HFE NEII 02/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/08/1996** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

St-Gertrude's attached to each POC (tag)

Initial Comments

Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction.

In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Corrections prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the receipt of the CMS 2567 form as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		2/5/16

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

Electronically Signed | | 02/04/2016

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide personal privacy for 3 of 3 residents (R8, R42, R105) whose privacy was observed breached. Findings include: R105's medication administration was conducted on 1/11/16, at 6:05 p.m. R105 was observed wheeling himself from his room to the dining room. A registered nurse (RN)-B approached R105 and asked him if he was ready for his insulin and R105 replied, "yes." RN-B handed R105 a pre-set insulin pen, R105 pulled his shirt up and self-administered the insulin to his right side of the abdomen. R105 was exposed to other residents and staff who were already seated in the dining table. RN-B was interviewed following the administration and explained R105 self-administered his insulin after set-up. RN-B explained that R105 usually administered it at the dining table and said, "he does not mind doing it in the dining area." RN-B said staff was supposed to offer to take him to a private area, and confirmed she had not done so for R105. RN-B stated, "I guess I should have asked him first." There were three residents who shared a dining	F 164	In order to comply with the regulation that St. Gertrude's must ensure that all residents receive personal privacy that maintains each resident's dignity, St. Gertrude's will do the following: a. Resident R105 has been informed of the benefit of personal privacy and encouraged to do self-administration of his insulin in his room. We will continue to encourage him to do this. R105 care plan was revised for self-administration and encouragement to go to his room for injections. There are no other residents/patients that are doing self-administration of insulin. b. Staff associates will be reminded of the importance of personal privacy (knocking on the patient/resident door and providing for personal privacy during procedures) through staff education. Attendance will be documented. c. An audit will be conducted weekly for four weeks and then monthly for two more months for a total of three months to monitor for personal privacy. d. All audits and information will be reported through the Quality Council.	

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F 164	Continued From page 2 room table with R105. R8's medication was prepared on 1/13/16, at 9:34 a.m. by RN-A. RN-A opened the door to R8's room without first knocking. R8 and his wife were in the room at the time. RN-A was interviewed immediately after leaving R8's room. RN-A explained that staff was supposed to knock on each resident's room and wait for a response before entering. RN-A confirmed that she did not knock on R8's door before entering and said, "I forgot to knock, but I usually knock the door before entering." R42 was being interviewed later that morning at 9:47 a.m. by the surveyor. During the interview RN-A again entered R42's room without knocking, and then apologized for interrupting the interview and left the resident's room. Following the interview with R42 at approximately 10:00 a.m. RN-A was interviewed. She confirmed she had again entered a resident's room without knocking. She stated, I thought I knocked, but I guess I did not." At 10:05 a.m. the assistant director of nursing (ADON)-A was interviewed, and explained it was an expectation staff knock on a resident's door and wait for a response before entering. ADON-A explained that staff had been provided education regarding the expectation. In addition, ADON-A also explained nursing staff was supposed to ensure insulin was administered in a private area. Regarding R105, ADON-A explained that staff was supposed to offer to take him to his room, "but he usually refuses and we respect his rights." When questioned if it was reflected in R105's	F 164		

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F 164	Continued From page 3 care plan ADON-A replied, "I guess not." A facility's Dignity policy dated 2012, directed that, "Residents' private space and property shall be respected at all times. Staff will knock and request permission before entering a residents' rooms...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures."	F 164		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 279	In order to comply with the regulation for	2/5/16

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F 279	Continued From page 4 facility failed to develop a care plan that included relevant interventions related to potential medication side effects for 1 of 5 (R110) residents reviewed for unnecessary medication use. Findings include: R110's physician orders upon admission dated 11/22/15, included the use of the antidepressant medication Zoloft 25 milligrams (mg) every morning, as well as three pain medications, Ultram 25 mg three times daily (potential side effects included loss of appetite), Extra Strength Tylenol 1000 mg three times daily, and a Lidoderm patch every 12 hours following a hip fracture. A Psychotropic Side Effects Checklist dated 11/22/15, revealed some occurrences of side effects possibly related to R110's Zoloft use including moderate constipation, minimal diarrhea and mild anxiety. The Minimum Data Set (MDS) dated 11/29/15, indicated R110 had severely impaired cognition, but no mood indicators were displayed. The resident's diagnoses included Alzheimer's dementia and major depressive disorder, recurrent. The MDS noted her weight was 128 pounds with no weight losses. The resident had pain management interventions for indicators of pain. R110's corresponding Care Area Assessment (CAA) also dated 11/29/15, indicated R110 was prescribed Zoloft for depression, however, showed no signs or symptoms of depression. The CAA also noted, "Zoloft can increase her fall risk, it is known to have a low sedation rate...will	F 279	F279 (comprehensive plan of care to include antidepressant medication use) St. Gertrude s has made the following changes: a. A care plan for the antidepressant was developed for Resident R110 immediately. b. The MDS nurses reviewed all patients/residents on antidepressants for the presence of a care plan addressing the antidepressant medication. c. Admissions nurses and MDS nurses reviewed the requirement for the presence of a care plan addressing the use of an antidepressant and the need to monitor the antidepressant for effectiveness. d. Nursing associates were educated on the need to monitor for the effectiveness of antidepressants. Attendance at this education was documented. e. An audit will be conducted weekly for four weeks and then monthly for two more months for a total of three months on the presence of a care plan for antidepressants and monitoring for effectiveness. f. Audit results and actions taken will be reported through the Quality Council.	

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F 279	Continued From page 5 not proceed to care plan for psychotropic medication use. She has been on the medication p/t [prior to] admission to the hospital and does not exhibit any depression like behaviors." R110's care plan dated 12/10/15, did not include interventions related to psychotropic medication use, pain, a risk for falls, or potential correlation between medication use and loss of appetite/weight loss. R110 experienced loss of appetite and an unplanned significant weight loss. On 12/10/15, the resident's weight was 124 pounds. A progress note revealed R110's daughter reported she was not eating well at all. "Daughter concerned and would like to talk to NP [nurse practioner]." On 1/4/16 Ultram was discontinued and on 1/8/16, the Lidoderm patch was discontinued. On 1/11/16, a nutritional progress note indicated, "Poor to fair intakes recorded. Current weight: 112.6 (1/11). Weight is down significantly in comparison to her admission weight. UBW [usual body weight] 129 lbs. NP [nurse practioner] aware of weight status. Met with daughter today and she indicates she will likely be...admitting her to hospice r/t [related to] decline in status. Daughter is here often with evening meal and feels her intakes, appetite, and desire to eat have declined significantly." The assistant director of nursing (ADON)-A was interviewed regarding the lack of care planning related to psychotropic drug use on 1/14/16, at 1:52 p.m. After reviewing the care plans in both the electronic and paper medical record she stated, "Maybe it didn't trigger [to proceed to care planning]...No mention of medications that I can see." ADON-A said the resident had resided at the facility long enough that a care plan related to psychotropic medication use should have been	F 279		

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F 279	Continued From page 6 developed. The facility's 8/13 Psychotropic Medication policy indicated nursing staff, "Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence of functional decline."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's care plan for 1 of 3 residents (R42) in the sample who required skin monitoring. Findings include: R42's care plan dated 3/10/15, identified potential for bruising/bleeding related to need for "anticoagulant therapy, receives aspirin daily" (thins the blood and can contribute to bruising). The care plan identified the goal as "will not have any bleeding related to aspirin use." Interventions identified included monitoring for sign and symptoms of bleeding and bruising, monitor laboratory work as ordered, notifying the nurse and physician if any bruising or bleeding was noted. R42 was interviewed on 1/12/16, at 9:54 a.m. and	F 282	In order to comply with the regulation that St. Gertrude's must provide services in accordance with each resident's written plan of care as it relates to skin monitoring, St Gertrude's has done the following: a. After the bruising was reported to the Nurse for R42, documentation was completed. b. Staff were reminded of the requirement to follow the plan of care to monitor for skin integrity/bruising and report it to the unit nurse through education sessions and printed educational information. c. An audit will be conducted weekly for four weeks and then monthly for two more months for a total of three months to check on staff compliance. d. All audits and information will be reported through the Quality Council.	2/5/16

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F 282	Continued From page 7	F 282		

dark purple bruises were observed on the base of the right thumb, right forearm and left inner arm. R42 explained the bruising was the result of "blood draws." at the hospital "couple of days ago."

R42's medical record was reviewed on 11/19/15, at approximately 11:00 a.m. No skin issues were identified on R42's medical records. None of the documentation in the medical records revealed R42's bruising on her hand and arms. A nursing progress note dated 1/10/16, at 3:21 p.m. revealed that, "Resident returned from ER [hospital emergency room] with paperwork." The note did not mention any bruising.

A nursing assistant (NA)-A was interviewed on 1/13/16, at 11:31 a.m. and explained that if a bruise was identified, it was supposed to be reported to the nurse "immediately and the nurse would will let us know if it has already been reported. I should have done that." NA-A confirmed that she had observed the bruising when R42 was given a shower that morning. NA-A explained she did not report to the nurse as "the bruise looked old and I thought someone had reported by now."

A registered nurse (RN)-A was interviewed on 1/13/16, at 11:47 a.m. and explained that once a bruise was identified, the nurse opened an "event" and then it was documented in the treatment administration record (TAR) until healed. RN-A explained that she was unaware of R42's bruising. RN-A confirmed no bruise documentation was available in R42's medical record. RN-A explained that nurses did not perform routine skin body audits, rather "We rely on the NA's to let us know." RN-A stated that

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F 282	Continued From page 8 R42's bruises should have been reported. The assistant director of nursing (ADON)-A was interviewed on 1/13/16, at 1:13 p.m. and explained that her expectations were for bruises or other skin conditions be reported to the nurse. The nurse then opened an "event" and monitored the bruising. ADON-A stated that, "I review all bruise incidents and determine if it's reportable or not...If you identified the bruise, my staff should have identified that too." A facility's Tub bath/shower policy dated 2014, directed that, "Observe the resident's skin for any redness, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point, blisters, or skin breakdown. Report any changes to the unit Nurse."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to monitoring of bruises for 1 of 3 residents (R42) in the sample identified as having non-pressure related skin conditions.	F 309	In order to comply with the regulation that St. Gertrude s must ensure that residents are monitored for bruising, St. Gertrude s has done the following: a. See actions for F 282.	2/5/16

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F 309	Continued From page 9	F 309		

Findings include:

R42 was interviewed on 1/12/16, at 9:54 a.m. and dark purple bruises were observed on the base of the right thumb, right forearm and left inner arm. R42 explained the bruising was the result of "blood draws." at the hospital "couple of days ago."

In a follow-up observation and interview on 1/13/16, at 10:34 a.m. R42 explained that she was aware of the bruises to her hands. R42 stated that, "I think staff are aware of them." R42 stated that she had received a shower that morning, but was was unaware if staff were monitoring the bruises.

R42's quarterly Minimum Data Set (MDS) dated 11/19/15, indicated R42 required extensive physical assistance from two persons with bed mobility and toilet use and extensive physical assistance from one persons with transferring, locomotion, dressing, and personal hygiene. The MDS also identified that R42 was totally dependent of one person physical assist with bathing.

R42's medical record was reviewed on 11/19/15, at approximately 11:00 a.m. No skin issues were identified on R42's medical records. None of the documentation in the medical records revealed R42's bruising on her hand and arms. A nursing progress note dated 1/10/16, at 3:21 p.m. revealed that, "Resident returned from ER [hospital emergency room] with paperwork." The note did not mention any bruising.

R42's care plan dated 3/10/15, identified potential for bruising/bleeding related to need for

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"anticoagulant therapy, receives aspirin daily" (thins the blood and can contribute to bruising). The care plan identified the goal as "will not have any bleeding related to aspirin use." Interventions identified included monitoring for sign and symptoms of bleeding and bruising, monitor laboratory work as ordered, notifying the nurse and physician if any bruising or bleeding was noted.

A nursing assistant (NA)-A was interviewed on 1/13/16, at 11:31 a.m. and explained that if a bruise was identified, it was supposed to be reported to the nurse "immediately and the nurse would will let us know if it has already been reported. I should have done that." NA-A confirmed that she had observed the bruising when R42 was given a shower that morning. NA-A explained she did not report to the nurse as "the bruise looked old and I thought someone had reported by now."

A registered nurse (RN)-A was interviewed on 1/13/16, at 11:47 a.m. and explained that once a bruise was identified, the nurse opened an "event" and then it was documented in the treatment administration record (TAR) until healed. RN-A explained that she was unaware of R42's bruising. RN-A confirmed no bruise documentation was available in R42's medical record. RN-A explained that nurses did not perform routine skin body audits, rather "We rely on the NA's to let us know." RN-A stated that R42's bruises should have been reported.

The assistant director of nursing (ADON)-A was interviewed on 1/13/16, at 1:13 p.m. and explained that her expectations were for bruises or other skin conditions be reported to the nurse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 The nurse then opened an "event" and monitored the bruising. ADON-A stated that, "I review all bruise incidents and determine if it's reportable or not...If you identified the bruise, my staff should have identified that too." A facility's Tub bath/shower policy dated 2014, directed that, "Observe the resident's skin for any redness, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point, blisters, or skin breakdown. Report any changes to the unit Nurse."	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		2/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	**1850 SARAZIN STREET SHAKOPEE, MN 55379**

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F 329	Continued From page 12	F 329		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to monitor for potential medication side effects for 1 of 5 residents (R110) reviewed for unnecessary medication use.

Findings include:

R110 was seated in the dining area with a visitor on 1/12/16, 1:18 p.m. The resident was alert and although was not speaking, made eye contact with the visitor.

R110's physician orders upon admission dated 11/22/15, included the use of the antidepressant medication Zoloft 25 milligrams (mg) every morning, as well as three pain medications, Ultram 25 mg three times daily (potential side effects included loss of appetite), Extra Strength Tylenol 1000 mg three times daily, and a Lidoderm patch every 12 hours following a hip fracture.

A Psychotropic Side Effects Checklist dated 11/22/15, revealed some occurrences of side effects possibly related to R110's Zoloft use including moderate constipation, minimal diarrhea and mild anxiety.

The Minimum Data Set (MDS) dated 11/29/15, indicated R110 had severely impaired cognition, but no mood indicators were displayed. The resident's diagnoses included Alzheimer's dementia and major depressive disorder, recurrent. The MDS noted her weight was 128

Provider's plan of correction:

In order to comply with the regulation that St. Gertrude s must monitor the effectiveness of antidepressant medication, we have done the following:
a. See the actions for F 279.

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 329	Continued From page 13 pounds with no weight losses. The resident had pain management interventions for indicators of pain. R110's corresponding Care Area Assessment (CAA) also dated 11/29/15, indicated R110 was prescribed Zoloft for depression, however, showed no signs or symptoms of depression. The CAA also noted, "Zoloft can increase her fall risk, it is known to have a low sedation rate...will not proceed to care plan for psychotropic medication use. She has been on the medication p/t [prior to] admission to the hospital and does not exhibit any depression like behaviors." The CAA did not indicate whether decreasing or discontinuing the medication would be considered. Progress notes 12/31/15, revealed the resident experienced an unwitnessed fall. R110's care plan dated 12/10/15, did not include interventions related to psychotropic medication use, pain, a risk for falls, or potential correlation between medication use and loss of appetite/weight loss. R110 experienced loss of appetite and an unplanned significant weight loss. On 12/10/15, the resident's weight was 124 pounds. A progress note revealed R110's daughter reported she was not eating well at all. "Daughter concerned and would like to talk to NP [nurse practioner]." On 1/4/16 Ultram was discontinued and on 1/8/16, the Lidoderm patch was discontinued. On 1/11/16, a nutritional progress note indicated, "Poor to fair intakes recorded. Current weight: 112.6 (1/11). Weight is down significantly in comparison to her admission weight. UBW [usual body weight] 129 lbs. NP [nurse practioner] aware of weight status. Met with daughter today and she indicates she will likely be...admitting her to hospice r/t [related to]	F 329		

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 329	Continued From page 14 decline in status. Daughter is here often with evening meal and feels her intakes, appetite, and desire to eat have declined significantly." The assistant director of nursing (ADON)-A was interviewed regarding the lack of care planning related to psychotropic drug use on 1/14/16, at 1:52 p.m. After reviewing the care plans in both the electronic and paper medical record she stated, "Maybe it didn't trigger [to proceed to care planning]...No mention of medications that I can see." ADON-A said the resident had resided at the facility long enough that a care plan related to psychotropic medication use should have been developed. The facility's 8/13 Psychotropic Medication policy indicated nursing staff, "Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence of functional decline."	F 329		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call system was properly functioning for 1 of 3 (R360) residents on the 300 unit reviewed for environmental quality. Findings include:	F 463	In order to comply with the regulation that St. Gertrude's must ensure functional call lights, we have done the following: a. The call light for R110 was immediately repaired. b. An audit of all call lights was conducted to ensure functionality in the	2/5/16

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F 463	Continued From page 15 R360's beside call light was tested on 1/12/16 at 12:58 p.m. The light was a gray bulb-type call light, in which the cord was connected to an Arial modular call light wall unit near the head of the bed. Pressing the bulb did not activate the light of the wall unit, nor the light of a call light display at the end of the hallway. NA-B was immediately called to the room and informed of the problem. She stated the testing had not activated an automatic voice message on her walkie-talkie as it should have. She also indicated the testing should have turned on the wall unit and the hall display's lights, which she verified were not on. NA-B then pushed the cord connector more tightly into the wall unit and wiggled it. She then retested the call light on the bed, which then activated the wall unit light and hall display, and a request for assistance message was heard over the walkie-talkie she carried. On 1/14/16 at 12:45 p.m. the assistant director of nursing (ADON)-A indicated R360 utilized the call light at night. Later at 1:49 p.m. ADON-A stated, "I'm thinking he pulled it out. It wasn't functioning--he's a 'puller.'" She said nursing staff did not routinely test call lights for function, but maintenance staff kept a record of the Arial system light activations. The Device Activity Report registered when a light was activated, as well at the time taken for staff to answer the call light. The report from 1/16 revealed there were no calls for R360 between 1/6/16 at 12:07 p.m. and 1/12/16 at 12:56 p.m. The ADON clarified there had been a gap of several days of call light non-use or potentially non-function, but explained the resident was admitted from the hospital on	F 463	rest of the resident rooms. c. Staff were informed of this requirement through education sessions and printed educational information. d. An audit for compliance with this requirement will be conducted every week times 3 months to check on staff compliance. e. All audit results will be reported through the Quality Council.	

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F 463	Continued From page 16 1/8/16, and the room had been empty prior to his arrival. When it was pointed out the log indicated no use from 1/8 to 1/12/16, and then a number of usages after 1/12/16 she said, "It may have been out all that time, or the staff may have been meeting his needs to where he didn't need to use it." ADON-A stated regarding R360's call light, "It should have worked." The facility's 10/10, Call Lights policy indicated "Each resident is provided with a functioning, accessible call light or other appropriate signaling device...Report malfunctioning call lights to plant operations."	F 463		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 27, 2016

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

RE: Project Number S5610024

Dear Mr. Meyer:

On January 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs the most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

An equal opportunity employer

<u>Informal Dispute Resolution</u> - 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 February 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

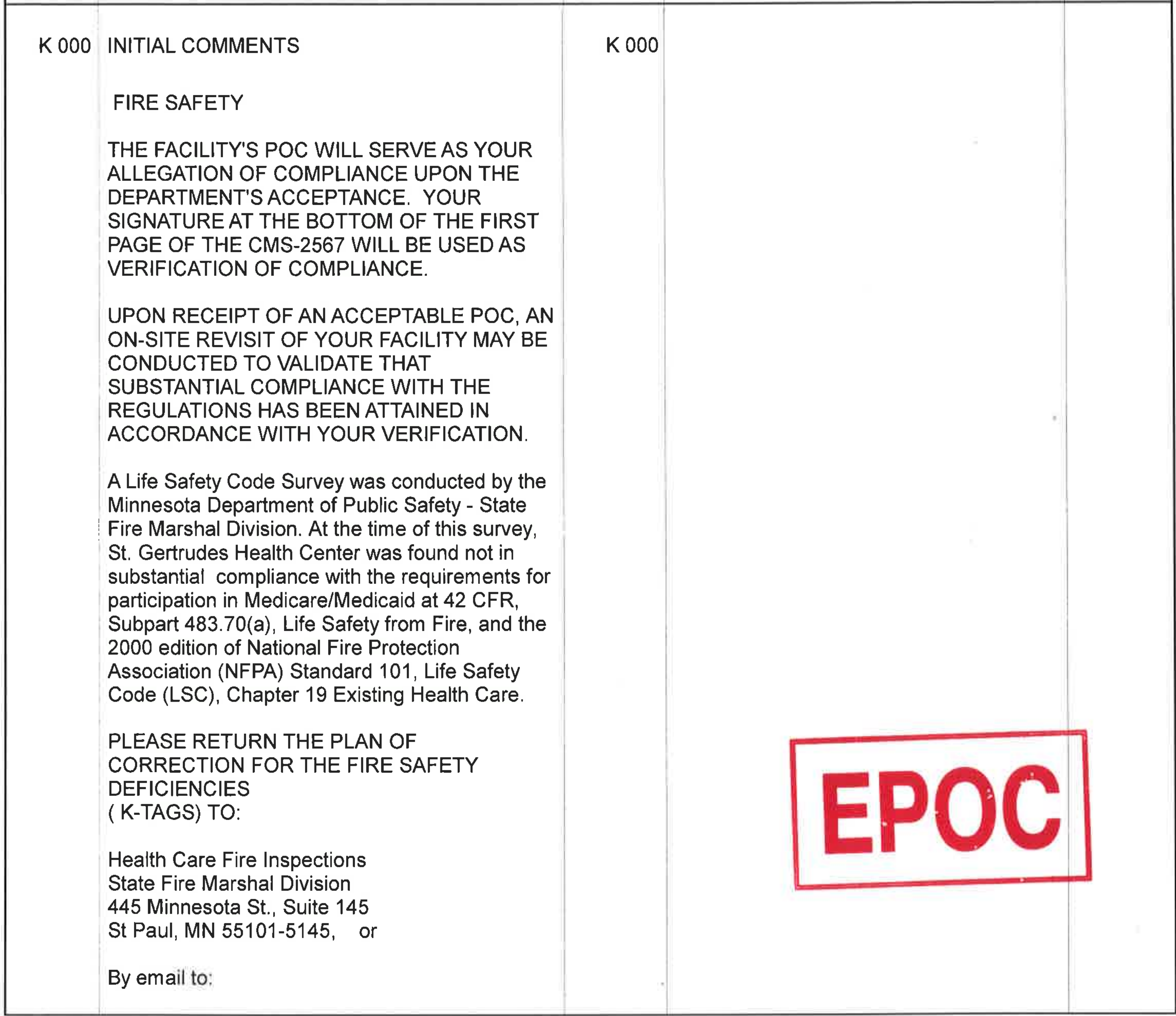
Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

F5610022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING 01 B. WING	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Gertrudes Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/04/2016

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

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as three separate buildings. St. Gertrudes Health Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1996 and was determined to be of Type V (111) construction. In 1999, an addition was constructed to the East Wing that was determined to be of Type V(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in resident room, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a census of 97 at the time of the survey.	K 000		

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

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on documentation review, the facility failed to have proper policy for fire alarm out of service following requirements of 2000 NFPA 101, Section 9.6.1.8. The deficient practice could affect all patients, visitors, and staff. Findings include: On January 13, 2016 at 8:30 am, during documentation review revealed that the facility failed to have a written policy for procedures to implement when the fire alarm system is out of service for a period of more than 4 hours in a 24 hour period. This deficient practice was verified by the Maintenance	K 155	The facility had a policy that was combined on the same sheet with another policy. The written policy for out of service conditions will be revised and placed on its own sheet by the Plant Manager.	2/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING 02 - 2008 & 2011 ADDITION B. WING ______	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Gertrudes Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/04/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING **02 - 2008 & 2011 ADDITION** B. WING	**01/13/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as three separate buildings. St. Gertrudes Health Center, 2007 addition is a 1-story building with no basement. In 2007, an addition was constructed and was determined to be of Type V(111) construction. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in resident room, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a census of 97 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the	K 155		2/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 155	Continued From page 2 building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on documentation review, the facility failed to have proper policy for fire alarm out of service following requirements of 2000 NFPA 101, Section 9.6.1.8. The deficient practice could affect all patients, visitors, and staff. Findings include: On January 13, 2016 at 8:30 am during documentation review revealed that the facility failed to have a written policy for procedures to implement when the fire alarm system is out of service for a period of more than 4 hours in a 24 hour period. This deficient practice was verified by the Maintenance	K 155	The facility had a policy that was combined on the same sheet with another policy. The written policy for out of service conditions will be revised and placed on its own sheet by the Plant Manager.	

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

F5610022

PRINTED: 02/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING **03 - BLDG THREE NEW ADDITION** B. WING ______	**01/13/2016**

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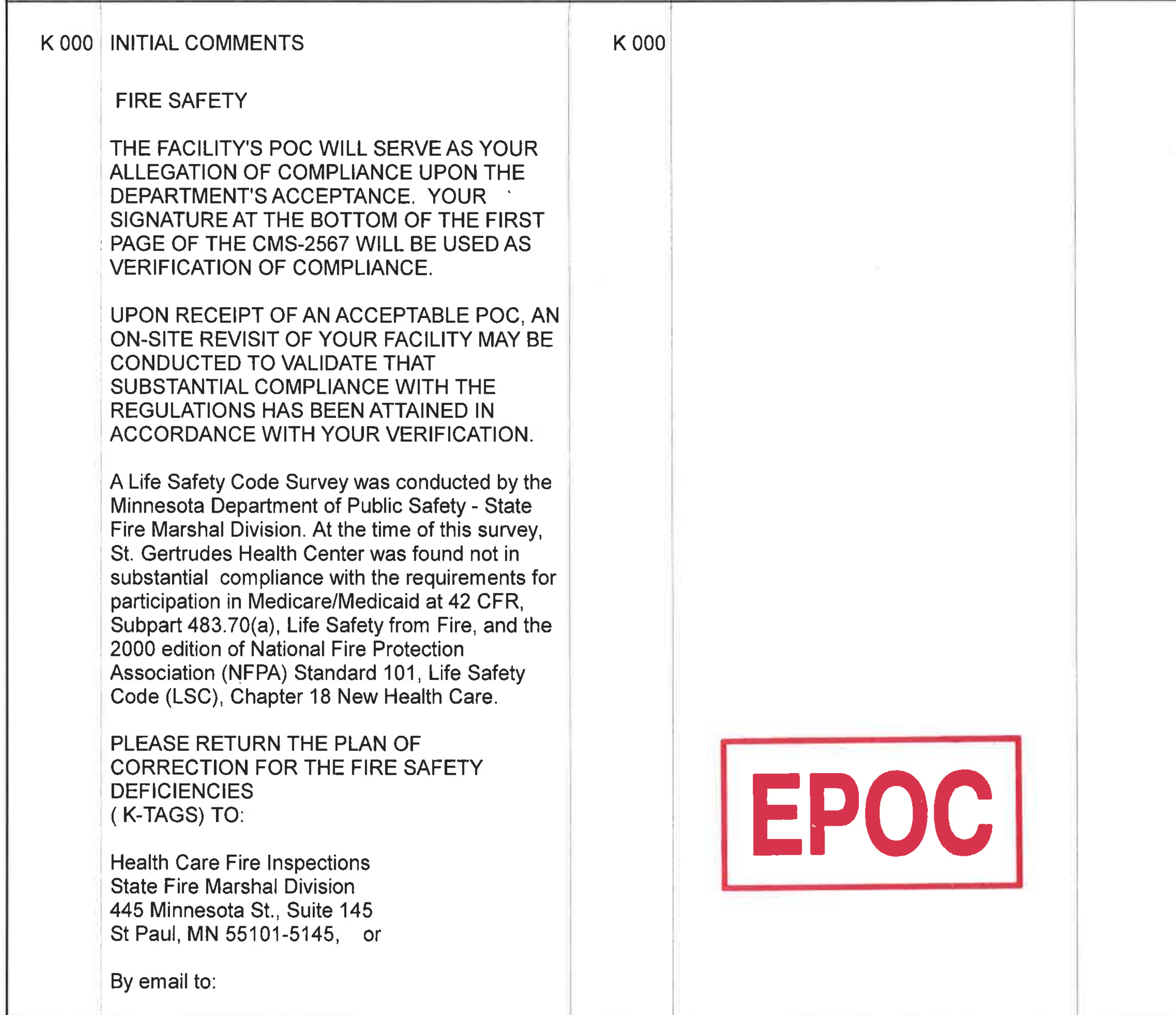

K 000 INITIAL COMMENTS — K 000

FIRE SAFETY

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

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Gertrudes Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:

EPOC

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

Electronically Signed — 02/04/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING **03 - BLDG THREE NEW ADDITION** B. WING ______	**01/13/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	**1850 SARAZIN STREET** **SHAKOPEE, MN 55379**

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K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved	K 056		1/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING 03 - BLDG THREE NEW ADDITION B. WING	01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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K 056	Continued From page 2 components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.	K 056		
	This STANDARD is not met as evidenced by: Based on observations and an interview with staff it was determined that the automatic fire sprinkler system has not been installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems and NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.3.5. This deficient practice could allow a fire to progress throughout the building and negatively effect all patients, the staff and any guests of the facility. Findings include: On the facility tour between 8:30 AM and 1:30 PM on 01/13/2016, observations revealed that in LL RM 115 there is wood shelving that comes away from the wall 7 feet and is the full length of the wall which is approximately 15 feet, which has mattresses piled on these shelves not allowing the sprinkler the reach the area below the wood shelving. This deficient practice was verified by the		The wood shelving was removed allowing the existing sprinkler to reach all areas. The Plant Manager assisted with the removal and verifies that this has been completed.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 056	Continued From page 3 Maintenance.	K 056		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on documentation review, the facility failed to have proper policy for fire alarm out of service following requirements of 2000 NFPA 101, Section 9.6.1.8. The deficient practice could affect all patients, visitors, and staff. Findings include: On January 13, 2016 at 8:30 am during documentation review revealed that the facility failed to have a written policy for procedures to implement when the fire alarm system is out of service for a period of more than 4 hours in a 24 hour period. This deficient practice was verified by the Maintenance	K 155	The facility had a policy that was combined on the same sheet with another policy. The written policy for out of service conditions will be revised and placed on its own sheet by the Plant Manager.	2/4/16

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 27, 2016

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5610024

Dear Mr. Meyer:

The above facility was surveyed on January 11, 2016 through January 14, 2016 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, Health Regulation 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Gail Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.**

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.

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

Sincerely,

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00459	A. BUILDING: ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION (	**1850 SARAZIN STREET SHAKOPEE, MN 55379**

(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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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

Electronically Signed — 02/04/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 1/14/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan that included relevant interventions related to potential medication side effects for 1 of 5 (R110) residents reviewed for unnecessary medication use. Findings include: R110's physician orders upon admission dated 11/22/15, included the use of the antidepressant medication Zoloft 25 milligrams (mg) every morning, as well as three pain medications, Ultram 25 mg three times daily (potential side effects included loss of appetite), Extra Strength Tylenol 1000 mg three times daily, and a Lidoderm patch every 12 hours following a hip fracture.	2 560	In order to comply with the regulation for F279 (comprehensive plan of care to include antidepressant medication use) St. Gertrude s has made the following changes: a. A care plan for the antidepressant was developed for Resident R110 immediately. b. The MDS nurses reviewed all patients/residents on antidepressants for the presence of a care plan addressing the antidepressant medication. c. Admissions nurses and MDS nurses reviewed the requirement for the presence of a care plan addressing the use of an antidepressant and the need to monitor the antidepressant for effectiveness. d. Nursing associates were educated on the need to monitor for the effectiveness	2/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 560	Continued From page 3	2 560		

A Psychotropic Side Effects Checklist dated 11/22/15, revealed some occurrences of side effects possibly related to R110's Zoloft use including moderate constipation, minimal diarrhea and mild anxiety.

The Minimum Data Set (MDS) dated 11/29/15, indicated R110 had severely impaired cognition, but no mood indicators were displayed. The resident's diagnoses included Alzheimer's dementia and major depressive disorder, recurrent. The MDS noted her weight was 128 pounds with no weight losses. The resident had pain management interventions for indicators of pain.

R110's corresponding Care Area Assessment (CAA) also dated 11/29/15, indicated R110 was prescribed Zoloft for depression, however, showed no signs or symptoms of depression. The CAA also noted, "Zoloft can increase her fall risk, it is known to have a low sedation rate...will not proceed to care plan for psychotropic medication use. She has been on the medication p/t [prior to] admission to the hospital and does not exhibit any depression like behaviors."

R110's care plan dated 12/10/15, did not include interventions related to psychotropic medication use, pain, a risk for falls, or potential correlation between medication use and loss of appetite/weight loss. R110 experienced loss of appetite and an unplanned significant weight loss. On 12/10/15, the resident's weight was 124 pounds. A progress note revealed R110's daughter reported she was not eating well at all. "Daughter concerned and would like to talk to NP [nurse practioner]." On 1/4/16 Ultram was discontinued and on 1/8/16, the Lidoderm patch was discontinued. On 1/11/16, a nutritional

of antidepressants. Attendance at this education was documented.
e. An audit will be conducted weekly for four weeks and then monthly for two more months for a total of three months on the presence of a care plan for antidepressants and monitoring for effectiveness.. Audit results and actions taken will be reported through the Quality Council.

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2 560	Continued From page 4	2 560		

progress note indicated, "Poor to fair intakes recorded. Current weight: 112.6 (1/11). Weight is down significantly in comparison to her admission weight. UBW [usual body weight] 129 lbs. NP [nurse practioner] aware of weight status. Met with daughter today and she indicates she will likely be...admitting her to hospice r/t [related to] decline in status. Daughter is here often with evening meal and feels her intakes, appetite, and desire to eat have declined significantly."

The assistant director of nursing (ADON)-A was interviewed regarding the lack of care planning related to psychotropic drug use on 1/14/16, at 1:52 p.m. After reviewing the care plans in both the electronic and paper medical record she stated, "Maybe it didn't trigger [to proceed to care planning]...No mention of medications that I can see." ADON-A said the resident had resided at the facility long enough that a care plan related to psychotropic medication use should have been developed.

The facility's 8/13 Psychotropic Medication policy indicated nursing staff, "Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence of functional decline."

SUGGESTED METHOD OF CORRECTION:
The facility could ensure policies for care plan development are current. Staff could be educated related to developing care plans. Care plan audits could be conducted and the results brought to the quality committee for review

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 565	Continued From page 5	2 565		
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 failed to provide services in accordance with the resident's care plan for 1 of 3 residents (R42) in the sample who required skin monitoring. Findings include: R42's care plan dated 3/10/15, identified potential for bruising/bleeding related to need for "anticoagulant therapy, receives aspirin daily" (thins the blood and can contribute to bruising). The care plan identified the goal as "will not have any bleeding related to aspirin use." Interventions identified included monitoring for sign and symptoms of bleeding and bruising, monitor laboratory work as ordered, notifying the nurse and physician if any bruising or bleeding was noted. R42 was interviewed on 1/12/16, at 9:54 a.m. and dark purple bruises were observed on the base of the right thumb, right forearm and left inner arm. R42 explained the bruising was the result of "blood draws." at the hospital "couple of days ago." R42's medical record was reviewed on 11/19/15,	2 565	In order to comply with the regulation that St. Gertrude s must provide services in accordance with each resident s written plan of care as it relates to skin monitoring, St Gertrude s has done the following: a. After the bruising was reported to the unit nurse for R42, documentation was completed. b. Staff were reminded of the requirement to follow the plan of care to monitor for skin integrity/bruising and report it to the unit nurse through education sessions and printed educational information. c. An audit will be conducted weekly for four weeks and then monthly for two more months for a total of three months to check on staff compliance. d. All audits and information will be reported through the Quality Council.	2/5/16

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2 565	Continued From page 6	2 565		

at approximately 11:00 a.m. No skin issues were identified on R42's medical records. None of the documentation in the medical records revealed R42's bruising on her hand and arms. A nursing progress note dated 1/10/16, at 3:21 p.m. revealed that, "Resident returned from ER [hospital emergency room] with paperwork." The note did not mention any bruising.

A nursing assistant (NA)-A was interviewed on 1/13/16, at 11:31 a.m. and explained that if a bruise was identified, it was supposed to be reported to the nurse "immediately and the nurse would will let us know if it has already been reported. I should have done that." NA-A confirmed that she had observed the bruising when R42 was given a shower that morning. NA-A explained she did not report to the nurse as "the bruise looked old and I thought someone had reported by now."

A registered nurse (RN)-A was interviewed on 1/13/16, at 11:47 a.m. and explained that once a bruise was identified, the nurse opened an "event" and then it was documented in the treatment administration record (TAR) until healed. RN-A explained that she was unaware of R42's bruising. RN-A confirmed no bruise documentation was available in R42's medical record. RN-A explained that nurses did not perform routine skin body audits, rather "We rely on the NA's to let us know." RN-A stated that R42's bruises should have been reported.

The assistant director of nursing (ADON)-A was interviewed on 1/13/16, at 1:13 p.m. and explained that her expectations were for bruises or other skin conditions be reported to the nurse. The nurse then opened an "event" and monitored the bruising. ADON-A stated that, "I review all

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2 565	Continued From page 7 bruise incidents and determine if it's reportable or not...If you identified the bruise, my staff should have identified that too." A facility's Tub bath/shower policy dated 2014, directed that, "Observe the resident's skin for any redness, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point, blisters, or skin breakdown. Report any changes to the unit Nurse." SUGGESTED METHOD OF CORRECTION: The facility could ensure policies for following care plans are current. Staff could be educated related to following resident care plans. Care audits could be conducted to ensure care plans are being followed, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		2/5/16

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2 830	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services related to monitoring of bruises for 1 of 3 residents (R42) in the sample identified as having non-pressure related skin conditions. Findings include: R42 was interviewed on 1/12/16, at 9:54 a.m. and dark purple bruises were observed on the base of the right thumb, right forearm and left inner arm. R42 explained the bruising was the result of "blood draws." at the hospital "couple of days ago." In a follow-up observation and interview on 1/13/16, at 10:34 a.m. R42 explained that she was aware of the bruises to her hands. R42 stated that, "I think staff are aware of them." R42 stated that she had received a shower that morning, but was was unaware if staff were monitoring the bruises. R42's quarterly Minimum Data Set (MDS) dated 11/19/15, indicated R42 required extensive physical assistance from two persons with bed mobility and toilet use and extensive physical assistance from one persons with transferring, locomotion, dressing, and personal hygiene. The MDS also identified that R42 was totally dependent of one person physical assist with bathing. R42's medical record was reviewed on 11/19/15, at approximately 11:00 a.m. No skin issues were identified on R42's medical records. None of the documentation in the medical records revealed	2 830	In order to comply with the regulation that St. Gertrude s must provide services in accordance with each resident s written plan of care as it relates to skin monitoring, St Gertrude s has done the following: a. After the bruising was reported to the unit nurse for R42, documentation was completed. b. Staff were reminded of the requirement to follow the plan of care to monitor for skin integrity/bruising and report it to the unit nurse through education sessions and printed educational information. c. An audit will be conducted weekly for four weeks and then monthly for two more months for a total of three months to check on staff compliance. d. All audits and information will be reported through the Quality Council.	

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2 830	Continued From page 9	2 830		

R42's bruising on her hand and arms. A nursing progress note dated 1/10/16, at 3:21 p.m. revealed that, "Resident returned from ER [hospital emergency room] with paperwork." The note did not mention any bruising.

R42's care plan dated 3/10/15, identified potential for bruising/bleeding related to need for "anticoagulant therapy, receives aspirin daily" (thins the blood and can contribute to bruising). The care plan identified the goal as "will not have any bleeding related to aspirin use." Interventions identified included monitoring for sign and symptoms of bleeding and bruising, monitor laboratory work as ordered, notifying the nurse and physician if any bruising or bleeding was noted.

A nursing assistant (NA)-A was interviewed on 1/13/16, at 11:31 a.m. and explained that if a bruise was identified, it was supposed to be reported to the nurse "immediately and the nurse would will let us know if it has already been reported. I should have done that." NA-A confirmed that she had observed the bruising when R42 was given a shower that morning. NA-A explained she did not report to the nurse as "the bruise looked old and I thought someone had reported by now."

A registered nurse (RN)-A was interviewed on 1/13/16, at 11:47 a.m. and explained that once a bruise was identified, the nurse opened an "event" and then it was documented in the treatment administration record (TAR) until healed. RN-A explained that she was unaware of R42's bruising. RN-A confirmed no bruise documentation was available in R42's medical record. RN-A explained that nurses did not perform routine skin body audits, rather "We rely

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2 830	Continued From page 10 on the NA's to let us know." RN-A stated that R42's bruises should have been reported. The assistant director of nursing (ADON)-A was interviewed on 1/13/16, at 1:13 p.m. and explained that her expectations were for bruises or other skin conditions be reported to the nurse. The nurse then opened an "event" and monitored the bruising. ADON-A stated that, "I review all bruise incidents and determine if it's reportable or not...If you identified the bruise, my staff should have identified that too." A facility's Tub bath/shower policy dated 2014, directed that, "Observe the resident's skin for any redness, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point, blisters, or skin breakdown. Report any changes to the unit Nurse." SUGGESTED METHOD OF CORRECTION: The facility could ensure policies related to non-pressure related skin conditions is appropriate. Staff could be educated regarding the policy. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the	21540		2/5/16

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21540	Continued From page 11 resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for potential medication side effects for 1 of 5 residents (R110) reviewed for unnecessary medication use. Findings include: R110 was seated in the dining area with a visitor on 1/12/16, 1:18 p.m. The resident was alert and although was not speaking, made eye contact with the visitor. R110's physician orders upon admission dated 11/22/15, included the use of the antidepressant medication Zoloft 25 milligrams (mg) every morning, as well as three pain medications, Ultram 25 mg three times daily (potential side effects included loss of appetite), Extra Strength Tylenol 1000 mg three times daily, and a	21540	In order to comply with the regulation that St. Gertrude s must monitor the effectiveness of antidepressant medication, we have done the following: a. See the actions for 2560.	

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Lidoderm patch every 12 hours following a hip fracture.

A Psychotropic Side Effects Checklist dated 11/22/15, revealed some occurrences of side effects possibly related to R110's Zoloft use including moderate constipation, minimal diarrhea and mild anxiety.

The Minimum Data Set (MDS) dated 11/29/15, indicated R110 had severely impaired cognition, but no mood indicators were displayed. The resident's diagnoses included Alzheimer's dementia and major depressive disorder, recurrent. The MDS noted her weight was 128 pounds with no weight losses. The resident had pain management interventions for indicators of pain.

R110's corresponding Care Area Assessment (CAA) also dated 11/29/15, indicated R110 was prescribed Zoloft for depression, however, showed no signs or symptoms of depression. The CAA also noted, "Zoloft can increase her fall risk, it is known to have a low sedation rate...will not proceed to care plan for psychotropic medication use. She has been on the medication p/t [prior to] admission to the hospital and does not exhibit any depression like behaviors." The CAA did not indicate whether decreasing or discontinuing the medication would be considered. Progress notes 12/31/15, revealed the resident experienced an unwitnessed fall.

R110's care plan dated 12/10/15, did not include interventions related to psychotropic medication use, pain, a risk for falls, or potential correlation between medication use and loss of appetite/weight loss. R110 experienced loss of appetite and an unplanned significant weight loss.

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21540	Continued From page 13	21540		

On 12/10/15, the resident's weight was 124 pounds. A progress note revealed R110's daughter reported she was not eating well at all. "Daughter concerned and would like to talk to NP [nurse practioner]." On 1/4/16 Ultram was discontinued and on 1/8/16, the Lidoderm patch was discontinued. On 1/11/16, a nutritional progress note indicated, "Poor to fair intakes recorded. Current weight: 112.6 (1/11). Weight is down significantly in comparison to her admission weight. UBW [usual body weight] 129 lbs. NP [nurse practioner] aware of weight status. Met with daughter today and she indicates she will likely be...admitting her to hospice r/t [related to] decline in status. Daughter is here often with evening meal and feels her intakes, appetite, and desire to eat have declined significantly."

The assistant director of nursing (ADON)-A was interviewed regarding the lack of care planning related to psychotropic drug use on 1/14/16, at 1:52 p.m. After reviewing the care plans in both the electronic and paper medical record she stated, "Maybe it didn't trigger [to proceed to care planning]...No mention of medications that I can see." ADON-A said the resident had resided at the facility long enough that a care plan related to psychotropic medication use should have been developed.

The facility's 8/13 Psychotropic Medication policy indicated nursing staff, "Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence of functional decline."

SUGGESTED METHOD OF CORRECTION:
The director of nursing, resident primary physicians and pharmacist could systematically review all resident medication regimens to ensure the unnecessary medications are not used and

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21540	Continued From page 14 side effects of those medications are monitored. A quality tool could be developed and information shared with the quality committee for review as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide personal privacy for 3 of 3 residents (R8, R42, R105) whose privacy was observed breached. Findings include: R105's medication administration was conducted on 1/11/16, at 6:05 p.m. R105 was observed wheeling himself from his room to the dining room. A registered nurse (RN)-B approached R105 and asked him if he was ready for his insulin and R105 replied, "yes." RN-B handed R105 a pre-set insulin pen, R105 pulled his shirt	21855	In order to comply with the regulation that St. Gertrude s must ensure that all residents receive personal privacy that maintains each resident s dignity, St. Gertrude s will do the following: a. Resident R105 has been informed of the benefit of personal privacy and encouraged to do self-administration of his insulin in his room. We will continue to encourage him to do this. R105 care plan was revised for self-administration and encouragement to go to his room for injections. There are no other residents/patients that are doing	2/5/16

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21855	Continued From page 15 up and self-administered the insulin to his right side of the abdomen. R105 was exposed to other residents and staff who were already seated in the dining table. RN-B was interviewed following the administration and explained R105 self-administered his insulin after set-up. RN-B explained that R105 usually administered it at the dining table and said, "he does not mind doing it in the dining area." RN-B said staff was supposed to offer to take him to a private area, and confirmed she had not done so for R105. RN-B stated, "I guess I should have asked him first." There were three residents who shared a dining room table with R105. R8's medication was prepared on 1/13/16, at 9:34 a.m. by RN-A. RN-A opened the door to R8's room without first knocking. R8 and his wife were in the room at the time. RN-A was interviewed immediately after leaving R8's room. RN-A explained that staff was supposed to knock on each resident's room and wait for a response before entering. RN-A confirmed that she did not knock on R8's door before entering and said, "I forgot to knock, but I usually knock the door before entering." R42 was being interviewed later that morning at 9:47 a.m. by the surveyor. During the interview RN-A again entered R42's room without knocking, and then apologized for interrupting the interview and left the resident's room. Following the interview with R42 at approximately 10:00 a.m. RN-A was interviewed. She confirmed she had again entered a resident's room without knocking. She stated, I thought I knocked, but I	21855	self-administration of insulin. b. Staff associates will be reminded of the importance of personal privacy (knocking on the patient/resident door and providing for personal privacy during procedures) through staff education. Attendance will be documented. c. An audit will be conducted weekly for four weeks and then monthly for two more months for a total of three months to monitor for personal privacy. d. All audits and information will be reported through the Quality Council.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00459	A. BUILDING: ______ B. WING ______	01/14/2016

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21855	Continued From page 16 guess I did not." At 10:05 a.m. the assistant director of nursing (ADON)-A was interviewed, and explained it was an expectation staff knock on a resident's door and wait for a response before entering. ADON-A explained that staff had been provided education regarding the expectation. In addition, ADON-A also explained nursing staff was supposed to ensure insulin was administered in a private area. Regarding R105, ADON-A explained that staff was supposed to offer to take him to his room, "but he usually refuses and we respect his rights." When questioned if it was reflected in R105's care plan ADON-A replied, "I guess not." A facility's Dignity policy dated 2012, directed that, "Residents' private space and property shall be respected at all times. Staff will knock and request permission before entering a residents' rooms...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." SUGGESTED METHOD OF CORRECTION: The facility could re-educate staff regarding resident rights to privacy and appropriate policies. Audits could be conducted to ensure privacy is respected for all residents. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a	23010		2/5/16

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23010	Continued From page 17 communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: ased on observation, interview, and document review, the facility failed to ensure the call system was properly functioning for 1 of 3 (R360) residents on the 300 unit reviewed for environmental quality. Findings include: R360's beside call light was tested on 1/12/16 at 12:58 p.m. The light was a gray bulb-type call light, in which the cord was connected to an Arial modular call light wall unit near the head of the bed. Pressing the bulb did not activate the light of the wall unit, nor the light of a call light display at the end of the hallway.	23010	In order to comply with the regulation that St. Gertrude s must ensure functional call lights, we have done the following: a. The call light for R110 was immediately repaired. b. An audit of all call lights was conducted to ensure functionality in the rest of the resident rooms. c. Staff were informed of this requirement through education sessions and printed educational information. d. An audit for compliance with this requirement will be conducted every week times 3 months to check on staff compliance.	

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23010	Continued From page 18	23010		

NA-B was immediately called to the room and informed of the problem. She stated the testing had not activated an automatic voice message on her walkie-talkie as it should have. She also indicated the testing should have turned on the wall unit and the hall display's lights, which she verified were not on. NA-B then pushed the cord connector more tightly into the wall unit and wiggled it. She then retested the call light on the bed, which then activated the wall unit light and hall display, and a request for assistance message was heard over the walkie-talkie she carried.

On 1/14/16 at 12:45 p.m. the assistant director of nursing (ADON)-A indicated R360 utilized the call light at night. Later at 1:49 p.m. ADON-A stated, "I'm thinking he pulled it out. It wasn't functioning--he's a 'puller.'" She said nursing staff did not routinely test call lights for function, but maintenance staff kept a record of the Arial system light activations. The Device Activity Report registered when a light was activated, as well at the time taken for staff to answer the call light. The report from 1/16 revealed there were no calls for R360 between 1/6/16 at 12:07 p.m. and 1/12/16 at 12:56 p.m. The ADON clarified there had been a gap of several days of call light non-use or potentially non-function, but explained the resident was admitted from the hospital on 1/8/16, and the room had been empty prior to his arrival. When it was pointed out the log indicated no use from 1/8 to 1/12/16, and then a number of usages after 1/12/16 she said, "It may have been out all that time, or the staff may have been meeting his needs to where he didn't need to use it." ADON-A stated regarding R360's call light, "It should have worked."

e. All audit results will be reported through the Quality Council.

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23010	Continued From page 19 The facility's 10/10, Call Lights policy indicated "Each resident is provided with a functioning, accessible call light or other appropriate signaling device...Report malfunctioning call lights to plant operations." SUGGESTED METHOD OF CORRECTION: The facility could review the call system for proper operation. A system of monitoring the function of call lights could be developed, and appropriate staff trained. This could include audits, and the results of those audits could be brought to the quality committee for reivew. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	23010		