

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.

St. Gertrudes Health & Rehabilitation Center March 24, 2017 Page 2

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

Ja Burkman

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

POS	T-CERTIFICATI	ON REVISIT R	EPORT	
PROVIDER / SUPPLIER / CLIA / MULTIPL IDENTIFICATION NUMBER A. Buildin	E CONSTRUCTION ig			DATE OF REVISIT
245610 _{Y1} B. Wing			Y2	2/3/2017 _{Y3}
NAME OF FACILITY		STREET ADDRESS, C		
ST GERTRUDES HEALTH & REHABILI	IATION CENTER	1850 SARAZIN STREE SHAKOPEE, MN 55379		
This report is completed by a qualified S program, to show those deficiencies pre corrected and the date such corrective a provision number and the identification p the survey report form).	viously reported on the CMS- action was accomplished. Eac	2567, Statement of Deficiency should be fu	encies and Plan of Correct lly identified using either the	tion, that have been ne regulation or LSC
ITEM DAT	E ITEM	DATE	ITEM	DATE
Y4 Y5	Y4	Y5	Y4	Y5
ID Prefix F0323 Correct	tion Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(h) Compl	ated Reg	Completed	Reg. #	Completed
LSC 01/31/2	017 LSC		LSC	
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Reg. # Compl	eted Reg. #	Completed	Reg. #	Completed
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ID Prefix Correct	tion ID Prefix	Correction	ID Prefix	Correction
Reg. # Compl	eted Reg. #	Completed	Reg. #	Completed
LSC	LSC		LSC	
REVIEWED BY STATE AGENCY (INITIALS) LB/r		NATURE OF SURVEYOR 375	564	DATE 02/03/2017
REVIEWED BY CMS RO REVIEWED BY (INITIALS)	DATE TITL	.E		DATE
FOLLOWUP TO SURVEY COMPLETED O		UNCORRECTED DEFICIEN DEFICIENCIES (CMS-2567)		YES NO

PRINTED: 03/24/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (2		SURVEY PLETED
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		245610	B. WING			12/0	02/2016
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		18	TREET ADDRESS, CITY, STATE, ZIP CODE 350 SARAZIN STREET HAKOPEE, MN 55379		
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F 000	INITIAL COMMENT	rs .	F	000			
F 323 SS=D	Resolution An abbreviated start to investigate case following deficiencing enrolled in ePOC a required at the botto CMS-2567 form. EPOC will be used a 483.25(h) FREE OI HAZARDS/SUPER The facility must enenvironment remains is possible; and		F3	323			1/31/17
	by: Based on interview facility failed to ens provided to reduce residents (R2) revidents unsupervised while resulted in a fall. The findings included R2's medical record sheet dated 7/19/10 neoplasm of cranio syncope (fainting),	in the bathroom which		4	This plan of correction is submitted required under Federal and State regulations and statutes applicable t 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 plan of care does not constitute agreement by the facility that the surveyor's findings and/or conclusion accurate, that the findings constitute deficiency or that the scope and severegarding any of the deficiencies cited.	o long of the ns are a a verity	
LABORATOR'	 Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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

Electronically Signed

12/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER ST GERTRUDES HEALTH & R	EHABILITATION CENTER	٠	18	REET ADDRESS, CITY, STATE, ZIP CODE 50 SARAZIN STREET HAKOPEE, MN 55379		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
interventions for fall R2's Minimum Data Mental Status (BIM severe cognitive im of 15. R2's Falls Care Are 8/29/16 indicated R would try to stand ir with therapy only, a assistance of two to transfers/toileting a (ADL's.) R2's physician's ore not to leave R2 alor fainting episodes w R2's physical theral indicated R2 was a seconds before los walk 30 feet with a placed R2 at a high mobility. R2's event report da assisted by one sta alone, and had fall including a large br scrapes to both kne right lower back. R2 had a fall while without injury. Post 9/9/16, directed nur R2 alone in bathroo	d 7/19/16, specified 16 I prevention. a Set (MDS) Brief Interview for S) dated 8/29/16, indicated pairment with a score of 6 out a Assessment (CAA) dated that cognitive deficits and ndependently. R1 was to walk and needed extensive	F3	323	correctly applied. Please accept the of Correction as our credible allegate compliance. F323 Free of Accident Hazards/Supervision/Devices SPECIFIC RESIDENTS: Resident affected by alleged deficient practic discharged on 08/17/16. Resident affected by alleged deficient practic not be left alone when in the bathround of the properties of the properties of the properties of the provided education on admission, quarterly and as needed safety. Fall preventions are put into according to their fall risk assessment of the provided education on: 1. Proper supervision of those residence of the provided education on: 1. Proper supervision of those residence of the provided education on: 1. Proper supervision of those residence of the provided education on: 1. Proper supervision of those residence of the provided education on: 1. Proper supervision of those residence of the provided education on: 1. Proper supervision of those residence of the provided education on: 1. Proper supervision of those residents when in the bathroom. MONITOR: The Director of Nursing and/or designee will observe and a via audits for those residents when in bat with care: Weekly x 4 weeks, then monthly for 1 month, then monthly month with review by Quality Assur Committee for further needs. DATE OF COMPLIANCE: January 2017	R1 ee was R2 ee will oom. cho are eety d for o place ent. dents ision at ssess need hroom twice for 1 ance	



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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.

St Gertrudes Health & Rehabilitation Center March 24, 2017 Page 2

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 / MULTIPLE CONSTRUCTION DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building B. Wing 00459 2/3/2017 Υ3 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 DATE ITEM DATE ITEM DATE Y4 Y5 Y4 Y5 Y4 Y5 ID Prefix 20830 Correction ID Prefix 21850 Correction **ID Prefix** Correction MN Rule 4658.0520 MN St. Statute 144.651 Reg. # Completed Reg. # Completed Reg. # Completed Subp. 1 Subd. 14 LSC 01/31/2017 LSC 01/31/2017 LSC **ID Prefix** ID Prefix Correction **ID Prefix** Correction Correction Reg. # Completed Rég.# Completed Reg. # Completed LSC LSC LSC **ID Prefix ID** Prefix Correction Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix** Correction Correction **ID** Prefix **ID Prefix** Correction Reg. # Reg. # Reg.# Completed Completed Completed LSC LSC ID Prefix ID Prefix Correction **ID** Prefix Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR STATE AGENCY (INITIALS) LB/MM 03/24/2017 37564 02/03/2017 **REVIEWED BY REVIEWED BY** DATE TITLE DATE CMS RO (INITIALS) **FOLLOWUP TO SURVEY COMPLETED ON** CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

Page 1 of 1

EVENT ID:

5S5Q12

☐ YES ☐ NO

12/2/2016

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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 Minnesota Department of Health

STATE FORM

Electronically Signed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Minnesota Department of Health

6899

If continuation sheet 1 of 8

(X6) DATE

12/16/16

TITLE

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 2 000 Continued From page 1 2 000 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/inf obul.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. 2 830 MN Rule 4658.0520 Subp. 1 Adequate and 12/16/16 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 This plan of correction is submitted as facility failed to ensure adequate supervision was required under Federal and State provided to reduce the risk of falls for 1 of 4 regulations and statutes applicable to long

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 830 Continued From page 2 2 830 residents (R2) reviewed who was left term care providers. This plan of unsupervised while in the bathroom which correction does not constitute an resulted in a fall. admission of liability on the part of the facility and, such liability is hereby The findings include: specifically denied. The submission of the plan of care does not constitute R2's medical record was reviewed. R2's face agreement by the facility that the sheet dated 7/19/16, included diagnoses of surveyor's findings and/or conclusions are neoplasm of craniopharyngeal duct (brain tumor), accurate, that the findings constitute a syncope (fainting), and other abnormalities of gait deficiency or that the scope and severity and mobility (difficulty walking.) R2's admission regarding any of the deficiencies cited are falls care plan dated 7/19/16, specified 16 correctly applied. Please accept this Plan interventions for fall prevention. of Correction as our credible allegation of compliance. R2's Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 8/29/16, indicated F323 Free of Accident severe cognitive impairment with a score of 6 out Hazards/Supervision/Devices of 15. SPECIFIC RESIDENTS: Resident R1 R2's Falls Care Area Assessment (CAA) dated affected by alleged deficient practice was 8/29/16 indicated R1 had cognitive deficits and discharged on 08/17/16. Resident R2 would try to stand independently. R1 was to walk affected by alleged deficient practice will with therapy only, and needed extensive not be left alone when in the bathroom. assistance of two to three staff for transfers/toileting and activities of daily living OTHER RESIDENTS. Residents who are (ADL's.) at risk for falls are assessed for safety and appropriate interventions upon admission, R2's physician's order dated 8/1/16, directed staff quarterly and as needed for safety. Fall not to leave R2 alone in bathroom, related to preventions are put into place according to fainting episodes while straining on the toilet. their fall risk assessment. R2's physical therapy care plan dated 8/23/16, Certified Nursing Assistants were provided indicated R2 was able to stand for one minute 15 education on: seconds before losing balance and was able to 1. Proper supervision of those residents walk 30 feet with a front wheeled walker, which specifically ordered to have supervision at placed R2 at a high risk for falls and diminished all times when in the bathroom. mobility. MONITOR: The Director of Nursing and/or R2's event report dated 9/4/16, indicated R2 was designee will observe and assess via assisted by one staff to the bathroom, was left audits for those residents who need

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: С B. WING 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 830 Continued From page 3 2 830 attendance at all times when in bathroom alone, and had fall at 10:00 a.m. with injuries including a large bruise on right side of the back, with care: Weekly x 4 weeks, then twice scrapes to both knees, and two small cuts on the monthly for 1 month, then monthly for 1 right lower back. month with review by Quality Assurance Committee for further needs. R2 had a fall while in the bathroom on 9/9/16 without injury. Post falls assessment dated DATE OF COMPLIANCE: January 31st, 9/9/16, directed nursing assistants to not leave 2017 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

Minnesota Department of Health

5S5Q11

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 830 Continued From page 4 2 830 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 MN St. Statute 144.651 Subd. 14 Patients & 12/16/16 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

Minnesota Department of Health

5S5Q11

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 21850 Continued From page 5 21850 Based on interview and document review the This plan of correction is submitted as facility failed to ensure adequate supervision was required under Federal and State provided to reduce the risk of falls for 1 of 4 regulations and statutes applicable to long residents (R2) reviewed who was left term care providers. This plan of unsupervised while in the bathroom which correction does not constitute an resulted in a fall. admission of liability on the part of the facility and, such liability is hereby The findings include: specifically denied. The submission of the plan of care does not constitute R2's medical record was reviewed. R2's face agreement by the facility that the sheet dated 7/19/16, included diagnoses of surveyor's findings and/or conclusions are neoplasm of craniopharyngeal duct (brain tumor), accurate, that the findings constitute a syncope (fainting), and other abnormalities of gait deficiency or that the scope and severity and mobility (difficulty walking.) R2's admission regarding any of the deficiencies cited are falls care plan dated 7/19/16, specified 16 correctly applied. Please accept this Plan interventions for fall prevention. of Correction as our credible allegation of compliance. R2's Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 8/29/16, indicated F323 Free of Accident severe cognitive impairment with a score of 6 out Hazards/Supervision/Devices of 15. SPECIFIC RESIDENTS: Resident R1 R2's Falls Care Area Assessment (CAA) dated affected by alleged deficient practice was 8/29/16 indicated R1 had cognitive deficits and discharged on 08/17/16. Resident R2 would try to stand independently. R1 was to walk affected by alleged deficient practice will with therapy only, and needed extensive not be left alone when in the bathroom. assistance of two to three staff for transfers/toileting and activities of daily living OTHER RESIDENTS: Residents who are (ADL's.) at risk for falls are assessed for safety and appropriate interventions upon admission, R2's physician's order dated 8/1/16, directed staff quarterly and as needed for safety. Fall not to leave R2 alone in bathroom, related to preventions are put into place according to fainting episodes while straining on the toilet. their fall risk assessment. R2's physical therapy care plan dated 8/23/16, Certified Nursing Assistants were provided indicated R2 was able to stand for one minute 15 education on: seconds before losing balance and was able to 1. Proper supervision of those residents walk 30 feet with a front wheeled walker, which specifically ordered to have supervision at placed R2 at a high risk for falls and diminished all times when in the bathroom. mobility

Minnesota Department of Health

5S5Q11

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: С B. WING 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 21850 Continued From page 6 21850 MONITOR: The Director of Nursing and/or R2's event report dated 9/4/16, indicated R2 was designee will observe and assess via assisted by one staff to the bathroom, was left audits for those residents who need alone, and had fall at 10:00 a.m. with injuries attendance at all times when in bathroom including a large bruise on right side of the back. with care: Weekly x 4 weeks, then twice scrapes to both knees, and two small cuts on the monthly for 1 month, then monthly for 1 right lower back. month with review by Quality Assurance Committee for further needs. R2 had a fall while in the bathroom on 9/9/16 without injury. Post falls assessment dated DATE OF COMPLIANCE: January 31st, 9/9/16, directed nursing assistants to not leave 2017 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.

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: С B. WING 00459 12/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTE SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 21850 Continued From page 7 21850 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5288 Facility ID: 00459

	IAKI I-	TO BE COMIT	DETEDDIT	IIIE SIAI	IE SURVET AGENCI		racinty ID. 00439
1. MEDICARE/MEDICAID PROVIDER (L1) 245610	R NO.		UDES HEALT		ABILITATION CENTER	4. TYPE OF ACTIO	ON: 7 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO).	(L4) 1850 SARAZ	ZIN STREET			3. Termination	4. CHOW
(L2) 440886100		(L5) SHAKOPEF	E, MN		(L6) 55379	5. Validation 7. On-Site Visit	 Complaint Other
5. EFFECTIVE DATE CHANGE OF OV (L9)	WNERSHIP	7. PROVIDER/SU	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Afte	
6. DATE OF SURVEY 02/22/2	2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR END	ING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	_ ` `	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		✓ A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirem	nents:
To (b):		▼	equirements		2. Technical Personnel	_ 6. Scope of S	Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical D	irector
12 T (15 T) D 1	105 (110)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Roo	om Size
12. Total Facility Beds	105 (L18)	D. M. C.	II M.D.		5. Life Safety Code	9. Beds/Room	n
13.Total Certified Beds	105 (L17)	B. Not in Comp Requirements	and/or Applied \		* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS	(===)	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
105	17 5141	ici	пр		1801 (c) (1) 01 1801 (j) (1).	(210)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Gayle Lantto, Unit Supervis	or	0	02/24/2016	(L19)	Enforceme	ent Specialist	04/27//2016 (L20)
PAR	Γ II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	,
19. DETERMINATION OF ELIGIBILITY	ГҮ		MPLIANCE WITH	H CIVIL	21. 1. Statement of Final	ncial Solvency (HCFA-25'	
_X 1. Facility is Eligible to Par	ticipate	Rigi	1157101.		3. Both of the Above		(110111 1010)
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	:	(L30)
OF PARTICIPATION	BEGINNING		ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	
11/08/1996	BEGINNING	DAIL	LINDING DI	II.	01-Merger, Closure		Meet Health/Safety
	(7.41)		(1.25)		02-Dissatisfaction W/ Reimburse		Meet Agreement
(L24)	(L41)	NE GANGEIONG	(L25)		03-Risk of Involuntary Termination	nn	
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	OTHER	ler Status Change
	A. Suspension	n of Admissions:	(L44)			00-Active	-
(L27)	B. Rescind S	uspension Date:	(L44)			oo neave	•
			(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	DATE			
	(132)	03/02/2016		(L33)	DETERMINIATION A PRI	DOMAI	
	(L32)			(L33)	DETERMINATION APPI	KUVAL	



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 Weath

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 Meeth

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 Weath

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

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245610 _{Y1}	B. Wing	Y2	2/22/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTRUDES HEALTH & REH.	ABILITATION 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).

ITEI		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0164	Correction	ID Prefix F	F0279		Correction	ID Prefix	F0282		Correction
Reg. #	483.10(e), 483.75(l	Completed	Reg. #	·83.20(d), 483.20(k)(1)	Completed	Reg. #	483.20(k)(3)(ii)		Completed
LSC		02/05/2016	LSC _			02/05/2016	LSC			02/05/2016
ID Prefix	F0309	Correction	ID Prefix F	F0329		Correction	ID Prefix	F0463		Correction
Reg. #	483.25	Completed	Reg. #	83.25(I)		- Completed	Reg.#	483.70(f)		Completed
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	R / SUPPLIER / C	LIA /	MULTIPLE CONS						DATE OF RE	VISIT
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NAME OF			ABILITATION CE	ENTER		STREET ADDRESS, CIT 1850 SARAZIN STREET SHAKOPEE, MN 55379				
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245610	CATION NUMBER	Y1	A. Building 02 - B. Wing	2008 & 2011 ADE	DITION			Y2	2/8/2016	3 _{Y3}
NAME OF	FACILITY					STREET ADDRESS, CIT	Y, STATE, ZIP	CODE		
ST GERT	RUDES HEALT	H & REH	ABILITATION CE	NTER		1850 SARAZIN STREET				
						SHAKOPEE, MN 55379				
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Reg.#	NFPA 101		Completed	Reg. #		Completed	Reg. #			Completed
LSC	K0155		02/04/2016	LSC			LSC			
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NAME OF	FACILITY						STREE	T ADDRESS, CIT	Y, STATE, ZIP	CODE	•	
ST GERT	RUDES HEALT	H & REH	ABILITATION CE	NTER			1850 SA	ARAZIN STREET				
							SHAKO	PEE, MN 55379				
program, corrected provision	to show those d	eficiencie ich correc	fied State surveyors previously repo ctive action was action prefix code p	rted on the complished	CMS-25 d. Each	567, Stater deficiency	ment of E / should	Deficiencies and be fully identifie	Plan of Correct Using either	ection, that have r the regulation or	LSC	
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LSC	K0056		01/27/2016	LSC	K0155			02/04/2016	LSC			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		ARE/MEDICAII TO BE COMPI						ID: 5288 Facility ID: 00459
1. MEDICARE/MEDICAID PROVIDI (L1) 245610 2.STATE VENDOR OR MEDICAID N (L2) 440886100		3. NAME AND AE (L3) ST GERTRU (L4) 1850 SARAZ (L5) SHAKOPEE	JDES HEALT ZIN STREET		ABILITATION (L6) 5		4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)6. DATE OF SURVEY 01/14	OWNERSHIP 1/2016 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	PPLIER CATEG 05 HHA 06 PRTF	ORY 09 ESRD 10 NF	02 (L7) 13 PTIP 14 CORF	22 CLIA	7. On-Site Visit 8. Full Survey Aft	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE		FISCAL YEAR END 06/30	ING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 105 (L37) (L38) 16. STATE SURVEY AGENCY REM 17. SURVEYOR SIGNATURE Lisa Hakanson, HFE 1	105 (L18) 105 (L17) WN 19 SNF (L39) ARKS (IF APPLICA	X B. Not in Com Requirements ICF (L42) BLE SHOW LTC CA Date:	nce With equirements be Based On: cceptable POC appliance with Progrand/or Applied V IID (L43) NCELLATION II 2/09/2016	gram Waivers: DATE):	2. Techr 2. Techr 3. 24 Hd 4. 7-Day 5. Life S * Code: E 15. FACILITY M 1861 (e) (1) or	ical Personnel our RN v RN (Rural SN dafety Code * HEETS 1861 (j) (1): VEY AGENCY	9. Beds/Roon (L12) (L15)	Services Limit Director om Size n Date:
DETERMINATION OF ELIGIBIL	JTY Participate	20. COM	PLIANCE WITH		21. 1. Sta 2. Ov	atement of Finan	ncial Solvency (HCFA-25 ol Interest Disclosure Stm	,
22. ORIGINAL DATE OF PARTICIPATION 11/08/1996	23. LTC AGREEN BEGINNING		LTC AGREEN		26. TERMINAT VOLUNTARY 01-Merger, Closu		05-Fail to	(L30) UNTARY Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)		02-Dissatisfaction 03-Risk of Involur 04-Other Reason f	ntary Termination	n <u>OTHER</u>	o Meet Agreement der Status Change e
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/	CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				

(L33)

DETERMINATION APPROVAL

(L32)

Initial Comments

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

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

PRINTED: 02/09/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION	` '	E SURVEY MPLETED
		245610	B. WING		· · · · · · · · · · · · · · · · · · ·	01/	14/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		18	REET ADDRESS, CITY, STATE, ZIP CODE 350 SARAZIN STREET HAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	INITIAL COMMENT The facility's plan of as your allegation of Department's acceen rolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. 483.10(e), 483.75(IPRIVACY/CONFIDEMENTAL Treatment, communications, personal privacy in medical treatment, communications, personal privacy in the resider release of personal individual outside the treatment of the resident's right.	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with (1)(4) PERSONAL ENTIALITY OF RECORDS ne right to personal privacy and so or her personal and clinical cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private dent. It in paragraph (e)(3) of this nt may approve or refuse the I and clinical records to any		000	CROSS-REFERENCED TO THE APPROPI		
I ADODATODY	institution; or record	red to another health care d release is required by law. DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
		245610	B. WING		01/14/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
F 164	contained in the re the form or storage release is required healthcare institution contract; or the res	eep confidential all information sident's records, regardless of e methods, except when by transfer to another on; law; third party payment	F 164		
	by: Based on observareview the facility for privacy for 3 of 3 rowhose privacy was Findings include: R105's medication on 1/11/16, at 6:05 wheeling himself for room. A registered R105 and asked himsulin and R105 rowheeling himself for room and self-adminiside of the abdomoresidents and staff the dining table. RN-B was interview administered his in explained that R10 dining table and sain the dining area."	ation, interview, and document ailed to provide personal residents (R8, R42, R105) to observed breached. administration was conducted p.m. R105 was observed om his room to the dining nurse (RN)-B approached im if he was ready for his replied, "yes." RN-B handed ulin pen, R105 pulled his shirt stered the insulin to his right en. R105 was exposed to other who were already seated in		In order to comply with the regulation St. Gertrude's must ensure that all residents receive personal privacy to maintains each resident's dignity, St. Gertrude's will do the following: a. Resident R105 has been inform the benefit of personal privacy and encouraged to do self-administration his insulin in his room. We will contend encourage him to do this. R105 can was revised for self-administration at 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 the importance of personal privacy (knocking on the patient/resident do providing for personal privacy during procedures) through staff education Attendance will be documented. c. An audit will be conducted week four weeks and then monthly for two months for a total of three months to monitor for personal privacy. d. All audits and information will be reported through the Quality Council	hat t. ned of in of inue to re plan and r d of or and common and

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245610	B. WING _		01	/14/2016
NAME OF PROVIDER OR SUPPLIER ST GERTRUDES HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 164	a.m. by RN-A. RN-room without first kin the room at the first kin the room. RN-A esupposed to knock wait for a response confirmed that she before entering and usually knock the confirmed that she before entering and usually knock the confirmed that she before entering and usually knock the confirmed that starn expectation and the first knocking, and there interview and left the following the interview and left the following the interview and left the following the interview and again enter knocking. She starn guess I did not." At 10:05 a.m. the and (ADON)-A was interested and wait for a respectation star and wait for a respectation that stafregarding the expectation.	05. as prepared on 1/13/16, at 9:34 A opened the door to R8's cnocking. R8 and his wife were	F 16			
	ensure insulin was Regarding R105, A was supposed to c "but he usually refu	administered in a private area. ADON-A explained that staff ffer to take him to his room, uses and we respect his rights." If it was reflected in R105's				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1850 SARAZIN STREET SHAKOPEE, MN 55379	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279 SS=D	A facility's Dignity por "Residents' private respected at all time request permission roomsStaff shall president privacy, including tunder §483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, an needs that are identassessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under §483.10, including to under §483.10, including to the resident's §483.10 (b) (4) This REQUIREMENT.	olicy dated 2012, directed that, space and property shall be es. Staff will knock and before entering a residents' promote, maintain and protect cluding bodily privacy during sonal care and during es." (a) (1) DEVELOP E CARE PLANS The results of the assessment and revise the resident's in of care. In of care. In other includes measurable tables to meet a resident's ind mental and psychosocial tified in the comprehensive In describe the services that are tain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise east and to refuse treatment in the resident in the resident in the resident's physical, mental, and eing as required under ervices that would otherwise east 25 but are not provided in the right to refuse treatment	F 1			2/5/16
	by: Based on interview	and document review, the		In order to comply with the re	gulation for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245610	B. WING			01/1	4/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		185	REET ADDRESS, CITY, STATE, ZIP CODE 50 SARAZIN STREET HAKOPEE, MN 55379		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			N BE RIATE	(X5) COMPLETION DATE
F 279	relevant intervention medication side effective wed for unnear the side of the	velop a care plan that included ons related to potential fects for 1 of 5 (R110) residents cessary medication use. orders upon admission dated the use of the antidepressant 25 milligrams (mg) every significantly the times daily (potential side significantly for a soft appetite), Extra Strength force times daily, and a very 12 hours following a hip of the times daily, and a very 12 hours following a hip of the times daily (potential side significantly following a hip of the times daily, and a very 12 hours following a hip of the times daily and a seconstipation, minimal diarrhea as Set (MDS) dated 11/29/15, diseverely impaired cognition, ators were displayed. The es included Alzheimer's or depressive disorder, as noted her weight was 128 sight losses. The resident had interventions for indicators of ding Care Area Assessment 11/29/15, indicated R110 was or depression, however, or symptoms of depression. For indicators of the times of the times and the times of the t	F 2		F279 (comprehensive plan of care include antidepressant medication St. Gertrude s has made the follow changes: a. A care plan for the antidepress was developed for Resident R110 immediately. b. The MDS nurses reviewed all patients/residents on antidepressant the presence of a care plan address the antidepressant medication. c. Admissions nurses and MDS in reviewed the requirement for the presence of a care plan addressing use of an antidepressant and the numonitor the antidepressant for effectiveness. d. Nursing associates were educated the need to monitor for the effective of antidepressants. Attendance at education was documented. e. An audit will be conducted wee four weeks and then monthly for two months for a total of three months of presence of a care plan for antidepressants and monitoring for effectiveness. f. Audit results and actions take be reported through the Quality Co	use) ving ant outs for sing urses githe eed to ented on eness this kly for o more on the	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER ST GERTRUDES HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379	, ,		
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F 279	medication use. Sh p/t [prior to] admiss not exhibit any depin R110's care plan da interventions relate use, pain, a risk for between medication appetite/weight loss appetite and an unp On 12/10/15, the repounds. A progress daughter reported s "Daughter concerne [nurse practioner]." discontinued and o was discontinued. progress note indic recorded. Current down significantly in weight. UBW [usua [nurse practioner] a with daughter today likely beadmitting decline in status. D evening meal and f desire to eat have of the electronic and pstated, "Maybe it di planning]No men see." ADON-A said the facility long eno	e plan for psychotropic e has been on the medication ion to the hospital and does ression like behaviors." ated 12/10/15, did not include d to psychotropic medication falls, or potential correlation	F 27	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 282 SS=D	indicated nursing significated nursing significated somnole 483.20(k)(3)(ii) SEPERSONS/PER Control of the services proving the services accordance with example the services of the services accordance with the services (R42) in monitoring. Findings include: R42's care plan day for bruising/bleeding included are the services and bleeding relations the blood are any bleeding relations included symptoms of bleeding the services and the services are plan identified included symptoms of bleeding relations and the services are plan identified included symptoms of bleeding relations are services and the services are plan identified included symptoms of bleeding relations are services and the services are services and the services are services and the services are services are services and the services are services as a services are services as a services are services and the services are services and the services are services and the services are services are services and the services are services are services as a services are services and the services are services are services and the services are services are services and the services are services are services are services are services are services and the services are s	Psychotropic Medication policy staff, "Monitors psychotropic ng any adverse effects such as ence of functional decline."	F 279		nn e the to	
	noted.	red on 1/12/16, at 9:54 a.m. and		months for a total of three months to check on staff compliance. d. All audits and information will be reported through the Quality Council.		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245610	B. WING _	····	01	/14/2016		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379	•	, , , , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 282	Continued From page	•	F 28	2				
	the right thumb, rig R42 explained the	s were observed on the base of the forearm and left inner arm. bruising was the result of the hospital "couple of days						
	at approximately 1 identified on R42's documentation in t R42's bruising on I progress note date revealed that, "Res	ord was reviewed on 11/19/15, 1:00 a.m. No skin issues were medical records. None of the he medical records revealed ner hand and arms. A nursing ed 1/10/16, at 3:21 p.m. sident returned from ER by room] with paperwork." The on any bruising.						
	1/13/16, at 11:31 a bruise was identific reported to the nur would will let us kn reported. I should confirmed that she when R42 was giv NA-A explained sh	t (NA)-A was interviewed onm. and explained that if a ed, it was supposed to be se "immediately and the nurse low if it has already been have done that." NA-A had observed the bruising en a shower that morning. e did not report to the nurse as old and I thought someone had						
	1/13/16, at 11:47 a bruise was identific "event" and then it treatment administ healed. RN-A expl. R42's bruising. RN documentation wa record. RN-A explaperform routine sk	(RN)-A was interviewed onm. and explained that once a ed, the nurse opened an was documented in the tration record (TAR) until ained that she was unaware of I-A confirmed no bruise s available in R42's medical ained that nurses did not in body audits, rather "We rely us know." RN-A stated that						

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ST GERTRUDES HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379			
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F 282	The assistant direct	Id have been reported.	F 2	32			
	explained that her e or other skin conditi The nurse then ope the bruising. ADON bruise incidents and	/16, at 1:13 p.m. and expectations were for bruises ions be reported to the nurse. In the nurse and an "event" and monitored A stated that, "I review all did determine if it's reportable or the bruise, my staff should too."					
F 309 SS=D	directed that, "Obs- redness, broken ski reddish or blue-gray point, blisters, or sk changes to the unit	CARE/SERVICES FOR	F 30	09		2/5/16	
	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain lest practicable physical, social well-being, in e comprehensive assessment					
	by: Based on observat review, the facility fa care and services re for 1 of 3 residents	NT is not met as evidenced ion, interview, and document ailed to provide the necessary elated to monitoring of bruises (R42) in the sample identified sure related skin conditions.		In order to comply with the regular St. Gertrude s must ensure that residents are monitored for bruisin Gertrude s has done the following a. See actions for F 282.	ıg, St.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245610	B. WING		_	01/	14/2016	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STA 1850 SARAZIN STREET SHAKOPEE, MN 55379	TE, ZIP CODE			
(X4) ID PREFIX TAG			ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE	
F 309	dark purple bruises the right thumb, right R42 explained the label blood draws." at the ago." In a follow-up obse 1/13/16, at 10:34 at was aware of the bis stated that, "I think stated that she had morning, but was with morning the bruise R42's quarterly Min 11/19/15, indicated physical assistance mobility and toilet un assistance from on locomotion, dressing MDS also identified dependent of one properties of the progress moterate of the progress note date revealed that, "Resign flospital emergency note did not mention R42's care plan date."	ed on 1/12/16, at 9:54 a.m. and were observed on the base of the forearm and left inner arm. bruising was the result of the hospital "couple of days" rvation and interview on the mean management of the mospital "couple of days" rvation and interview on the mean management of the mean management	F 3	09				

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	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1850 SARAZIN STREET SHAKOPEE, MN 55379		
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F 309	(thins the blood and The care plan identified included symptoms of bleed laboratory work as and physician if an noted. A nursing assistant 1/13/16, at 11:31 a bruise was identified reported to the nur would will let us known reported. I should have confirmed that she when R42 was given NA-A explained should be reported by now." A registered nurse 1/13/16, at 11:47 a bruise was identified revent and then it treatment administ healed. RN-A explained have record. RN-A explained should record. RN-A explained that her expla	age 10 apy, receives aspirin daily" d can contribute to bruising). tified the goal as "will not have ed to aspirin use." Interventions monitoring for sign and ling and bruising, monitor ordered, notifying the nurse y bruising or bleeding was t (NA)-A was interviewed on .m. and explained that if a ed, it was supposed to be se "immediately and the nurse ow if it has already been have done that." NA-A had observed the bruising en a shower that morning. e did not report to the nurse as old and I thought someone had (RN)-A was interviewed on .m. and explained that once a ed, the nurse opened an was documented in the ration record (TAR) until ained that she was unaware of -A confirmed no bruise s available in R42's medical ained that nurses did not in body audits, rather "We rely as know." RN-A stated that all have been reported. etter of nursing (ADON)-A was 3/16, at 1:13 p.m. and expectations were for bruises tions be reported to the nurse.	F 30			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 329 SS=D	the bruising. ADON bruise incidents and notIf you identified have identified that A facility's Tub bath directed that, "Obstredness, broken sk reddish or blue-grapoint, blisters, or sk changes to the unit 483.25(I) DRUG REUNNECESSARY DEACH TEACH TEA	ened an "event" and monitored I-A stated that, "I review all d determine if it's reportable or d the bruise, my staff should too." /shower policy dated 2014, erve the resident's skin for any in, tender places, irritation, y area of skin over a pressure kin breakdown. Report any Nurse." EGIMEN IS FREE FROM PRUGS g regimen must be free from any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any	F3			2/5/16	
	·	2					

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F 329	Continued From pa	ge 12	F 329			
	by: Based on observatoreview, the facility for medication side effort reviewed for unnect. Findings include: R110 was seated in on 1/12/16, 1:18 p. 10 although was not symith the visitor. R110's physician on 11/22/15, included for medication Zoloft 2 morning, as well as Ultram 25 mg three effects included los Tylenol 1000 mg the Lidoderm patch ever fracture. A Psychotropic Side 11/22/15, revealed effects possibly relaincluding moderate and mild anxiety. The Minimum Data indicated R110 had but no mood indicated resident's diagnose	Ition, interview and document ailed to monitor for potential ects for 1 of 5 residents (R110) essary medication use. In the dining area with a visitor m. The resident was alert and beaking, made eye contact of the use of the antidepressant 5 milligrams (mg) every at three pain medications, at times daily (potential side is of appetite), Extra Strength ree times daily, and a ery 12 hours following a hip effects Checklist dated some occurrences of side ated to R110's Zoloft use constipation, minimal diarrhea est (MDS) dated 11/29/15, aseverely impaired cognition, tors were displayed. The est included Alzheimer's ar depressive disorder,		In order to comply with the regula St. Gertrude s must monitor the effectiveness of antidepressant medication, we have done the fol a. See the actions for F 279.		

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	PROVIDER OR SUPPLIER	EHABILITATION CENTER		185	REET ADDRESS, CITY, STATE, ZIP CODE O SARAZIN STREET AKOPEE, MN 55379		
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F 329	pain management in pain. R110's correspondid (CAA) also dated 1 prescribed Zoloft for showed no signs on The CAA also noted risk, it is known to have not proceed to care medication use. She p/t [prior to] admission not exhibit any deptication use. She p/t [prior to] admission not exhibit any deptication use. She p/t [prior to] admission not exhibit any deptication and the resident experies. R110's care plan dainterventions related use, pain, a risk for between medication appetite/weight loss appetite and an union on 12/10/15, the repounds. A progress daughter reported is "Daughter concerne [nurse practioner]." discontinued and o was discontinued.	ght losses. The resident had interventions for indicators of ang Care Area Assessment 1/29/15, indicated R110 was or depression, however, resymptoms of depression. d, "Zoloft can increase her fall have a low sedation ratewill explan for psychotropic e has been on the medication ion to the hospital and does ression like behaviors." The exwhether decreasing or redication would be ess notes 12/31/15, revealed enced an unwitnessed fall.	F 3	29			
	down significantly in weight. UBW [usua [nurse practioner] a with daughter today	weight: 112.6 (1/11). Weight is n comparison to her admission. I body weight] 129 lbs. NP ware of weight status. Met and she indicates she will her to hospice r/t [related to]					

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		245610	B. WING _		01/	14/2016
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 463 SS=D	evening meal and for desire to eat have of the desire to eat have of the desire to eat have of the assistant direct interviewed regarding related to psychotrom 1:52 p.m. After revithe electronic and pstated, "Maybe it displanning]No ment see." ADON-A said the facility long eno psychotropic medic developed. The facility's 8/13 Prindicated nursing st drug use daily noting increased somnoled 483.70(f) RESIDEN ROOMS/TOILET/B. The nurses' station resident calls through from resident calls through from resident rooms facilities. This REQUIREMENT by: Based on observative review, the facility for the facility for the facility for the facility for the same and t	aughter is here often with eels her intakes, appetite, and leclined significantly." for of nursing (ADON)-A was not the lack of care planning opic drug use on 1/14/16, at iewing the care plans in both eaper medical record she don't trigger [to proceed to care ion of medications that I can the resident had resided at ugh that a care plan related to ation use should have been sychotropic Medication policy aff, "Monitors psychotropic g any adverse effects such as noce of functional decline." IT CALL SYSTEM - ATH must be equipped to receive gh a communication system is; and toilet and bathing NT is not met as evidenced ion, interview, and document ailed to ensure the call system oning for 1 of 3 (R360) on unit reviewed for	F 46		ion that nal call	2/5/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245610	B. WING			01/14/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 1850 SARAZIN STREET SHAKOPEE, MN 55379	ZIP CODE	
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F 463	12:58 p.m. The lig light, in which the comodular call light with bed. Pressing the light with the wall unit, nor the the wall unit, nor the the end of the hallow NA-B was immediated informed of the prohad not activated a her walkie-talkie as indicated the testin wall unit and the haverified were not of connector more tig wiggled it. She the bed, which then ach hall display, and a message was hear carried. On 1/14/16 at 12:4 nursing (ADON)-A light at night. Later "I'm thinking he purfunctioning-he's a did not routinely termintenance staff system light activated at the time take light. The report from the calls for R360 beand 1/12/16 at 12:5 there had been a genon-use or potential.	light was tested on 1/12/16 at ht was a gray bulb-type call cord was connected to an Arial wall unit near the head of the bulb did not activate the light of a light of a call light display at way. Ately called to the room and oblem. She stated the testing an automatic voice message on a it should have. She also g should have turned on the hall display's lights, which she hall display into the wall unit and hall retested the call light on the stivated the wall unit light and request for assistance and over the walkie-talkie she she in the stivated R360 utilized the call at 1:49 p.m. ADON-A stated,	F 4	rest of the resident room c. Staff were informed requirement through ed and printed educational d. An audit for complia requirement will be con- times 3 months to chec compliance. e. All audit results will through the Quality Cou	d of this ducation session I information. ance with this ducted every work on staff be reported	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
		245610	B. WING		01/	/14/2016
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE 1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 463	arrival. When it wa no use from 1/8 to usages after 1/12/1 out all that time, or meeting his needs it." ADON-A stated should have worked The facility's 10/10, "Each resident is praccessible call light	m had been empty prior to his s pointed out the log indicated 1/12/16, and then a number of 6 she said, "It may have been the staff may have been to where he didn't need to use regarding R360's call light, "It	F 4	.63		



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:

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

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

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

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

<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

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

PRINTED: 02/08/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG 01	(X3) DATE SURVEY COMPLETED
		245610	B, WING_	<u></u>	01/13/2016
	ROVIDER OR SUPPLIE	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 1850 SARAZIN STREET SHAKOPEE, MN 55379	
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K 000	INITIAL COMMEN	NTS	K 00	00	
	FIRE SAFETY				
	ALLEGATION OF DEPARTMENT'S SIGNATURE AT PAGE OF THE C	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR THE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS OF COMPLIANCE.			-
	ON-SITE REVISION CONDUCTED TO SUBSTANTIAL CREGULATIONS F	OF AN ACCEPTABLE POC, AND TOF YOUR FACILITY MAY BE DVALIDATE THAT OMPLIANCE WITH THE HAS BEEN ATTAINED IN WITH YOUR VERIFICATION.			
	Minnesota Departire Marshal Divisions. St. Gertrudes Heasubstantial comparticipation in Modular 483.70(a 2000 edition of Nassociation (NFP).	e Survey was conducted by the tment of Public Safety - State sion. At the time of this survey, alth Center was found not in diance with the requirements for edicare/Medicaid at 42 CFR,), Life Safety from Fire, and the ational Fire Protection A) Standard 101, Life Safety pter 19 Existing Health Care.	r		
	PLEASE RETUR CORRECTION F DEFICIENCIES (K-TAGS) TO:	N THE PLAN OF OR THE FIRE SAFETY		E	POC
	Health Care Fire State Fire Marsha 445 Minnesota St St Paul, MN 5510	al Division , Suite 145			
	By email to:				

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.

Electronically Signed

02/04/2016

PRINTED: 02/08/2016 FORM APPROVED OMB NO. 0938-0391

	N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING 01			COMPLETED			
		245610	B. WING			01/1	3/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		185	REET ADDRESS, CITY, STATE, ZIP CODE 50 SARAZIN STREET AKOPEE, MN 55379		
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K 000		state.mn.us and n@state.mn.us RRECTION FOR EACH	K	000			
•	FOLLOWING INFO	what has been, or will be, done					
	2. The actual, or pr	oposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					
	buildings. St. Gertr building with no ba constructed at 2 di building was constructed determined to be of 1999, an addition with Wing that was dete construction. Becathe 1 addition are of	surveyed as three separate udes Health Center is a 1-story sement. The building was fferent times. The original ructed in 1996 and was f Type V (111) construction. In was constructed to the East ermined to be of Type V(111) use the original building and of the same type of ed for existing buildings, the ed as one building.					
	fire alarm system v	v sprinklered. The facility has a vith smoke detection in ridors and spaces open to the pnitored for automatic fire ation.				€ n	
		apacity of 105 beds and had a time of the survey.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00459

PRINTED: 02/08/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245610	B. WING	_		01/	13/2016
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		18	REET ADDRESS, CITY, STATE, ZIP CODE 150 SARAZIN STREET HAKOPEE, MN 55379		
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	Based on docume failed to have proper service following results 101, Section 9.6.1. affect all patients, which was a section of the section o	s not met as evidenced by: ntation review, the facility er policy for fire alarm out of equirements of 2000 NFPA 8. The deficient practice could visitors, and staff. 16 at 8:30 am, during liew revealed that the facility tten policy for procedures to the fire alarm system is out of the of more than 4 hours in a 24			The facility had a policy that was combined on the same sheet with policy. The written policy for out of conditions will be revised and place its own sheet by the Plant Manage	service ed on	
	This deficient pract Maintenance	tice was verified by the			×		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00459

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

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - 2008 & 2011 ADDITION 245610 B; WING 01/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTER SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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:

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:	l ` ′	IPLE CONSTRUCTION NG 02 - 2008 & 2011 ADDITION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1850 SARAZIN STREET SHAKOPEE, MN 55379	DE	
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	to correct the defic					
	3. The name and/o	or title of the person rection and monitoring to ence of the deficiency.				
	buildings. St. Gertr addition is a 1-stor In 2007, an additio	surveyed as three separate udes Health Center, 2007 y building with no basement. n was constructed and was f Type V(111) construction.				
	fire alarm system v resident room, cor	y sprinklered. The facility has a with smoke detection in ridors and spaces open to the pointored for automatic fire ation.				
		apacity of 105 beds and had a time of the survey.				
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - 2008 & 2011 ADDITION		E SURVEY PLETED
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	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379		
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K 155	provided for all pa shutdown until the returned to service. This STANDARD Based on docume failed to have prop service following r 101, Section 9.6.1 affect all patients, Findings include: On January 13, 20 documentation re- failed to have a wi implement when t service for a perio- hour period.	ted or an approved fire watch is rities left unprotected by the fire alarm system has been e. 9.6.1.8 is not met as evidenced by: entation review, the facility per policy for fire alarm out of equirements of 2000 NFPA .8. The deficient practice could	K 15	The facility had a policy that we combined on the same sheet we policy. The written policy for our conditions will be revised and prits own sheet by the Plant Man	vith another It of service placed on	

F5610022

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

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 03 - BLDG THREE NEW ADDITION 245610 B. WING 01/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1850 SARAZIN STREET** ST GERTRUDES HEALTH & REHABILITATION CENTER SHAKOPEE, MN 55379 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Electronically Signed

Event ID: 528821

Facility ID: 00459

If continuation sheet Page 1 of 4

02/04/2016

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 03 - BLDG THREE NEW ADDIT		(X3) DATE SURVEY COMPLETED	
		245610	B. WING		01/	/13/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	Continued From pa Marian.Whitney@s Angela.Kappenmai	state.mn.us and	K 0	00		
	DEFICIENCY MUS FOLLOWING INFO					
	A description of to correct the deficition	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency.				
	buildings. St. Gertr addition is a 2-story In 2011, an addition	surveyed as three separate udes Health Center, 2011 y building with a full basement. n was constructed and was f Type II(222) construction.				
	fire alarm system v resident room, corr	v sprinklered. The facility has a with smoke detection in ridors and spaces open to the politored for automatic fire ation.		20 3		4.
		apacity of 105 beds and had a time of the survey.				
K 056	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD	K 0	56		1/27/16
SS=D	There is an automa in accordance with	atic sprinkler system, installed NFPA 13, Standard for the akler Systems, with approved				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION O3 - BLDG THREE NEW ADDITION		SURVEY PLETED
		245610	B. WING	1		01/	13/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		18	REET ADDRESS, CITY, STATE, ZIP CODE 850 SARAZIN STREET HAKOPEE, MN 55379		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 056	complete coverage The system is main NFPA 25, Standard and Maintenance of Systems. There is supply for the system with waterflow and connected to the first STANDARD Based on observation staff it was determined by the system of Sprinkler system in accordance with New Installation of Spring The Life Safety Consection 18.3.5. The afire to progress to	ces, and equipment, to provide e of all portions of the facility nationed in accordance with d for the Inspection, Testing, of Water-Based Fire Protection is a reliable, adequate water em. The system is equipped I tamper switches which are ire alarm system. 18.3.5. Is not met as evidenced by: ations and an interview with ined that the automatic fire as not been installed in IFPA 13, Standard for the inkler Systems and NFPA 101 ode" 2000 edition (LSC) is deficient practice could allow throughout the building and II patients, the staff and any	K	056	The wood shelving was remove the existing sprinkler to reach all The Plant Manager assisted with removal and verifies that this ha completed.	l areas.	
	on 01/13/2016, ob RM 115 there is w from the wall 7 fee wall which is appro- mattresses piled of	between 8:30 AM and 1:30 PM servations revealed that in LL ood shelving that comes away at and is the full length of the eximately 15 feet, which has an these shelves not allowing each the area below the wood					
	This deficient prac	tice was verified by the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 03 - BLDG THREE NEW ADDITION (X			X3) DATE SURVEY COMPLETED	
		245610	B. WING			01/	13/2016
	PROVIDER OR SUPPLIER RUDES HEALTH & F	REHABILITATION CENTER		18	TREET ADDRESS, CITY, STATE, ZIP CODE 850 SARAZIN STREET HAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDÉR'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 056 K 155 SS=C	Where a required to service for more that the authority having building is evacuated provided for all parashutdown until the returned to service. This STANDARD Based on docume failed to have proposervice following realing to have proposervice following realing to have all patients, which is service for a period to have a wrimplement when the service for a period hour period.	AFETY CODE STANDARD fire alarm system is out of lan 4 hours in a 24-hour period, give jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been 9.6.1.8 is not met as evidenced by: entation review, the facility er policy for fire alarm out of equirements of 2000 NFPA 8. The deficient practice could		056 155	The facility had a policy that was combined on the same sheet with policy. The written policy for out of conditions will be revised and placits own sheet by the Plant Manage	service ed on	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 <u>only a suggestion</u> 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

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

PRINTED: 05/24/2016 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B WING 04/4//2016 00450

		00459	B. WING		01/14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
ST GERT	RUDES HEALTH & R	REHABII ITATION (RAZIN STREI		
		SHAKOP	EE, MN 553		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Initial Comments		2 000		
	****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deputermination of which corrected requires requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been			
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic insure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 02/04/16

STATE FORM 6899 If continuation sheet 1 of 20 528811

TITLE

(X6) DATE

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00459	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST GER	TRUDES HEALTH & R	EHARII ITATION (AZIN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETE DATE
2 000	Continued From na	no 1	2 000	DEFICIENCY)		
2 000	Department of Hea you electronically. is necessary for State in text. You must then State licensure procompletion date, the corrected prior to e Minnesota Department on 1/14/16, survey visited the above procorrection orders a your electronic plar reviewed these ord they will be comple Minnesota Department the State Licensing federal software. To assigned to Minnesota Nursing Homes.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Ors of this Department's staff, rovider and the following re issued. Please indicate in of correction that you have ers, and identify the date when ted. The ent of Health is documenting correction Orders using ag numbers have been tota state statutes/rules for	2 000			
	column entitled "ID statute/rule out of co "Summary Statement and replaces the "To correction order. The findings which are in after the statement evidence by." Follow	umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column o Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE NUMBER OF STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00459	B. WING		01/1	4/2016
	PROVIDER OR SUPPLIER	FHARILITATION (1850 SAR	DRESS, CITY, S AZIN STREE EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	THERE IS NO REC	ge 2 QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.	2 000			
2 560	MN Rule 4658.0405 Plan of Care; Contents comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The com must include the income assessment and mental and psy identified in the com assessment. The com must include the income assessment and mental and psy identified in the com assessment. The com must include the income assessment and mental and psy identified in the com assessment and mental include the income assessment and mental and psy identified in the com assessment and psy identified in the com assess	of plan of care. The nof care must list measurable tables to meet the resident's no goals for medical, nursing, rchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560	In order to comply with the regulat F279 (comprehensive plan of care include antidepressant medication Gertrude s has made the followin changes: a. A care plan for the antidepress developed for Resident R110 imm b. The MDS nurses reviewed all patients/residents on antidepressat the presence of a care plan address the antidepressant medication. c. Admissions nurses and MDS reviewed the requirement for the pof a care plan addressing the use antidepressant and the need to me the antidepressant for effectiveness d. Nursing associates were educated to meaning the design of the effectiveness of the present to monitor for the effectiveness of the present to monitor for the effectiveness of the present to monitor for the effectiveness of the present the effectiveness of the present the presen	e to luse) St. lg sant was ediately. ants for ssing nurses presence of an onitor ss. eated on	2/5/16

Minnesota Department of Health STATE FORM

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 560 Continued From page 3 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"		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
ST GERTRUDES HEALTH & REHABILITATION ((X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 560 Continued From page 3 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.			00459	B. WING		01/1	4/2016
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE 2 560 Continued From page 3 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.			FHARILITATION (1850 SAR	AZIN STREI	ET		
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.	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
risk, it is known to have a low sedation ratewill 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	2 560	A Psychotropic Side 11/22/15, revealed effects possibly relaincluding moderate and mild anxiety. The Minimum Data indicated R110 had but no mood indica resident's diagnose dementia and major recurrent. The MDS pounds with no wei pain management is pain. R110's correspondi (CAA) also dated 1 prescribed Zoloft for showed no signs on The CAA also noted risk, it is known to have not proceed to care medication use. She phy [prior to] admissing not exhibit any depit R110's care plan dainterventions related use, pain, a risk for between medication appetite/weight loss appetite and an unpon 12/10/15, the repounds. A progress daughter reported sinding practioner. In the care may be a progress daughter concerner [nurse practioner]." discontinued and of the care may be a progress daughter concerner [nurse practioner]."	e Effects Checklist dated some occurrences of side ated to R110's Zoloft use constipation, minimal diarrhea Set (MDS) dated 11/29/15, severely impaired cognition, tors were displayed. The is included Alzheimer's repressive disorder, onted her weight was 128 ght losses. The resident had interventions for indicators of mg Care Area Assessment 1/29/15, indicated R110 was or depression, however, resymptoms of depression. If all a low sedation ratewill in a low a low sedation ratewill in a low sedation rate and loss of losses o	2 560	education was documented. e. An audit will be conducted we four weeks and then monthly for to months for a total of three months presence of a care plan for antidepressants and monitoring for effectiveness. Audit results and a taken will be reported through the	ekly for wo more s on the or actions	

Minnesota Department of Health

STATE FORM 528811 If continuation sheet 4 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00459	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST GER	TRUDES HEALTH & R	REHABII ITATION (AZIN STREE EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	progress note indice recorded. Current down significantly in weight. UBW [usual [nurse practioner] a with daughter today likely beadmitting decline in status. Devening meal and for desire to eat have of the assistant direction interviewed regarding related to psychotronic and pstated, "Maybe it diplanning]No men see." ADON-A said the facility long endopsychotropic medicated nursing stated indicated nursing stated indicated nursing stated somnole SUGGESTED MET The facility could endevelopment are conceptable and indicated to plan audits could be brought to the quality.	ated, "Poor to fair intakes weight: 112.6 (1/11). Weight is a comparison to her admission body weight] 129 lbs. NP aware of weight status. Met y and she indicates she will her to hospice r/t [related to] aughter is here often with eels her intakes, appetite, and declined significantly." tor of nursing (ADON)-A was ng the lack of care planning opic drug use on 1/14/16, at riewing the care plans in both paper medical record she dn't trigger [to proceed to care tion of medications that I can the resident had resided at ough that a care plan related to eation use should have been and any adverse effects such as noce of functional decline." THOD OF CORRECTION: Insure policies for care plan arrent. Staff could be developing care plans. Care econducted and the results ity committee for review R CORRECTION: Twenty-one	2 560			

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00459		B. WING		01/1	4/2016
	PROVIDER OR SUPPLIER	EHABILITATION (1850 SAR	DRESS, CITY, S AZIN STREI EE, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 5		2 565			
2 565	Plan of Care; Use	5 Subp. 3 Comprehe		2 565			2/5/16
		omprehensive plan o I personnel involved i t.					
	by: Based on observatireview, the facility faccordance with the residents (R42) in the monitoring. Findings include: R42's care plan data for bruising/bleedin "anticoagulant there (thins the blood and The care plan identiany bleeding relate identified included resymptoms of bleed laboratory work as and physician if any noted. R42 was interviewed dark purple bruises the right thumb, right R42 explained the liblood draws." at the ago."	ent is not met as evicion, interview, and do ailed to provide servie resident's care plar he sample who required as a sample who required as a sample who required the goal as will do aspirin use." Interpretated the goal as "will do aspirin use." Interpretated the goal as "will do aspirin use." Interpretation or sign are ing and bruising, more ordered, notifying they bruising or bleeding and bruising or bleeding and the forearm and left in bruising was the results he hospital "couple of	d potential daily" uising). not have erventions and nitor e nurse I was		In order to comply with the regulat St. Gertrude s must provide servi accordance with each resident s plan of care as it relates to skin monitoring, St Gertrude s has do following: a. After the bruising was reported unit nurse for R42, documentation completed. b. Staff were reminded of the requirement to follow the plan of complicing monitor for skin integrity/bruising a report it to the unit nurse through education sessions and printed educational information. c. An audit will be conducted were four weeks and then monthly for the months for a total of three months check on staff compliance. d. All audits and information will reported through the Quality Coun	ices in written ne the d to the was are to and ekly for wo more to be	
	R42's medical reco	rd was reviewed on	11/19/15,				

6899

PRINTED: 05/24/2016 FORM APPROVED

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00459	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
ST GER	TRUDES HEALTH & R	REHARII ITATION (RAZIN STREI EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	at approximately 11 identified on R42's documentation in the R42's bruising on he progress note dated revealed that, "Reselhospital emergency note did not mention." A nursing assistant 1/13/16, at 11:31 a. bruise was identified reported to the nurse would will let us known reported. I should he confirmed that she when R42 was given NA-A explained she "the bruise looked or reported by now." A registered nurse 1/13/16, at 11:47 a. bruise was identified "event" and then it was treatment administration healed. RN-A explained R42's bruising. RN-documentation was record. RN-A explained that her expl	:00 a.m. No skin issues were medical records. None of the ne medical records revealed ler hand and arms. A nursing d 1/10/16, at 3:21 p.m. ident returned from ER y room] with paperwork." The				

Minnesota Department of Health

STATE FORM 528811 If continuation sheet 7 of 20

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` '	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		00459		B. WING		01/	14/2016
	PROVIDER OR SUPPLIER	EHABILITATION (1850 SAR	DRESS, CITY, S AZIN STREE EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	bruise incidents and notIf you identified have identified that A facility's Tub bath directed that, "Obs redness, broken sk reddish or blue-gray point, blisters, or sk changes to the unit SUGGESTED MET The facility could er care plans are curre related to following audits could be con are being followed, quality committee for	d determine if it's repd the bruise, my staff too." /shower policy dated erve the resident's sin, tender places, irriy area of skin over a in breakdown. Repo Nurse." THOD OF CORRECTISURE policies for follent. Staff could be eresident care plans. Inducted to ensure called and the results bround to ensure called the results bround the results bround the results to ensure called the results bround the results to ensure called the results the re	f should 2014, kin for any tation, pressure rt any FION: owing ducated Care re plans ght to the	2 565			
2 830	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident e and treatment, per supervision based of d preferences as ide resident assessmer scribed in parts 4658 ing home resident m possible unless the attending physicial in bed or the resident.	must sonal and nentified in and .0400 and ust be out re is a an that the	2 830			2/5/16

6899

Minnesota Department of Health STATE FORM

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00459	B. WING		01/14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
ST GERT	RUDES HEALTH & R	REHARII ITATION (RAZIN STRE EE, MN 553		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 830	Continued From pa	ige 8	2 830		
	by: Based on observatireview, the facility for care and services in for 1 of 3 residents as having non-presidents. R42 was interviewed dark purple bruises the right thumb, right R42 explained the bruised that in the bruised draws." at the ago." In a follow-up observation of the bruised that, "I think stated that, "I think stated that she had morning, but was we monitoring the bruised R42's quarterly Min 11/19/15, indicated physical assistance mobility and toilet under the assistance from one locomotion, dressing MDS also identified dependent of one probathing.	nimum Data Set (MDS) dated R42 required extensive from two persons with bed se and extensive physical e persons with transferring, ng, and personal hygiene. The I that R42 was totally person physical assist with		In order to comply with the regulat St. Gertrude s must provide serv accordance with each resident s plan of care as it relates to skin monitoring, St Gertrude s has do following: a. After the bruising was reported unit nurse for R42, documentation completed. b. Staff were reminded of the requirement to follow the plan of complicing monitor for skin integrity/bruising a report it to the unit nurse through education sessions and printed educational information. c. An audit will be conducted we four weeks and then monthly for the months for a total of three months check on staff compliance. d. All audits and information will reported through the Quality Countries.	ces in written ne the d to the was are to and ekly for wo more to be
	at approximately 11 identified on R42's	rd was reviewed on 11/19/15, 1:00 a.m. No skin issues were medical records. None of the medical records revealed			

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	00459	B. WING		01/	14/2016
PROVIDER OR SUPPLIER TRUDES HEALTH & R	FHABILITATION (1850 SAF	RAZIN STREE	т		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE
R42's bruising on h progress note dated revealed that, "Res [hospital emergenc note did not mention R42's care plan dated for bruising/bleeding "anticoagulant thera (thins the blood and The care plan identiany bleeding related identified included resymptoms of bleedil laboratory work as and physician if any noted. A nursing assistant 1/13/16, at 11:31 a. bruise was identified reported to the nursing assistant than the same planting assistant 1/13/16, at 11:31 a.	er hand and arms. A nursing d 1/10/16, at 3:21 p.m. ident returned from ER y room] with paperwork." The n any bruising. Ted 3/10/15, identified potential g related to need for apy, receives aspirin daily" d can contribute to bruising). ified the goal as "will not have d to aspirin use." Interventions monitoring for sign and ing and bruising, monitor ordered, notifying the nurse y bruising or bleeding was (NA)-A was interviewed on m. and explained that if a d, it was supposed to be se "immediately and the nurse	2 830			
reported. I should h confirmed that she when R42 was give NA-A explained she "the bruise looked oreported by now." A registered nurse 1/13/16, at 11:47 a. bruise was identifie "event" and then it treatment administr healed. RN-A expla R42's bruising. RN-documentation was	ave done that." NA-A had observed the bruising en a shower that morning. e did not report to the nurse as old and I thought someone had (RN)-A was interviewed on m. and explained that once a d, the nurse opened an was documented in the ration record (TAR) until ined that she was unaware of A confirmed no bruise s available in R42's medical				
	PROVIDER OR SUPPLIER TRUDES HEALTH & R SUMMARY STA (EACH DEFICIENCY REGULATORY OR L.) Continued From pa R42's bruising on h progress note date revealed that, "Res [hospital emergenc note did not mention." R42's care plan dat for bruising/bleedin." anticoagulant thera (thins the blood and The care plan ident any bleeding related identified included resymptoms of bleed laboratory work as and physician if any noted. A nursing assistant 1/13/16, at 11:31 a. bruise was identified reported to the nurse would will let us known reported. I should he confirmed that she when R42 was given NA-A explained she "the bruise looked or reported by now." A registered nurse 1/13/16, at 11:47 a. bruise was identified "event" and then it the treatment administration healed. RN-A explained R42's bruising. RN-documentation was identified.	PROVIDER OR SUPPLIER TRUDES HEALTH & REHABILITATION (SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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 "thought someone had"	PROVIDER OR SUPPLIER TRUDES HEALTH & REHABILITATION : SUMMARY STATEMENT OF DEFICIENCIES SHAKOPEE, MN 55378 SUMMARY STATEMENT OF DEFICIENCIES SHAKOPEE, MN 55378 SUMMARY STATEMENT OF DEFICIENCIES SHAKOPEE, MN 55378 Continued From page 9 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	PROVIDER OR SUPPLIER TRUDES HEALTH & REHABILITATION (SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER FOR DAY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. 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A registered nurse (RN)-A was interviewed on 1/13/16, at 11:47 a.m. and explained that once a truise was identified, the nurse opened an "event" and then it was documented in the treatment administration record (TRR) until healed. RN-A explained that she was unaware of R42's bruising. RN-A confirmed the swaliance of the confirmed that once a documentation was available in R42's medical	PROVIDER OR SUPPLIER TRUDES HEALTH & REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 1850 SARAZIN STREET SHAKOPEE, MN 55379 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: DENTIFYMG INFORMATION) DROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCITY ACTION SHOULD BE CROSS-REFERENCITY AND THAT AND THE PROPERTIES AND THE PR

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00459	B. WING		01/1	4/2016
	PROVIDER OR SUPPLIER	FHARILITATION (1850 SAR	DRESS, CITY, S AZIN STREE EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	on the NA's to let us R42's bruises shou The assistant direct interviewed on 1/13 explained that her ear or other skin condit The nurse then ope the bruising. ADON bruise incidents and notIf you identified have identified that A facility's Tub bath directed that, "Obsredness, broken sk reddish or blue-gray point, blisters, or sk changes to the unit SUGGESTED MET The facility could en non-pressure relate appropriate. Staff of the policy. Audits coresults brought to the review.	s know." RN-A stated that Id have been reported. tor of nursing (ADON)-A was Id-16, at 1:13 p.m. and expectations were for bruises ions be reported to the nurse. In and monitored Id-A stated that, "I review all determine if it's reportable or determine it is it i	2 830			
21540	MN Rule 4658.1318 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			2/5/16
	monitor each reside unnecessary drug u home's policies and	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00459	B. WING		01/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
ST GER	TRUDES HEALTH & R	FHARILITATION (AZIN STREE E, MN 5537			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
21540	resident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is the medical director physician does not the order and if the change the order, to the attending physician the attending physician the attending physician does not the order and if the change the order, to the attending physician does not the attending physician directly to the QAA. This MN Requirements on the physician does not be physician does not the order and if the change the order, to the attending physician directly to the QAA. This MN Requirements and on the physician does not be physician	physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the all director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not ne matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter	21540	In order to comply with the regulat	ion that	
	medication side effreviewed for unnective for unnective findings include: R110 was seated in on 1/12/16, 1:18 p.i although was not specified with the visitor. R110's physician or 11/22/15, included medication Zoloft 2 morning, as well as Ultram 25 mg three effects included los	ailed to monitor for potential ects for 1 of 5 residents (R110) essary medication use. In the dining area with a visitor m. The resident was alert and beaking, made eye contact of the use of the antidepressant 5 milligrams (mg) every three pain medications, times daily (potential side is of appetite), Extra Strength ree times daily, and a		St. Gertrude s must monitor the effectiveness of antidepressant medication, we have done the folloa. See the actions for 2560.	owing:	

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		00459	B. WING		01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST GERT	RUDES HEALTH & R	REHARII ITATION (AZIN STREE EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 12	21540			
	Lidoderm patch ever fracture.	ery 12 hours following a hip				
	11/22/15, revealed effects possibly rela	e Effects Checklist dated some occurrences of side ated to R110's Zoloft use constipation, minimal diarrhea				
	indicated R110 had but no mood indica resident's diagnose dementia and majo recurrent. The MDS pounds with no wei	Set (MDS) dated 11/29/15, I severely impaired cognition, tors were displayed. The es included Alzheimer's or depressive disorder, Sonoted her weight was 128 ght losses. The resident had interventions for indicators of				
	(CAA) also dated 1 prescribed Zoloft for showed no signs on The CAA also noted risk, it is known to have not proceed to care medication use. She p/t [prior to] admiss not exhibit any depica CAA did not indicated discontinuing the maconsidered. Progret the resident experies R110's care plan days.	ess notes 12/31/15, revealed enced an unwitnessed fall. ated 12/10/15, did not include				
	interventions relate use, pain, a risk for between medication appetite/weight loss	d to psychotropic medication falls, or potential correlation				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00459	B. WING		01/1	4/2016
	PROVIDER OR SUPPLIER	FHABILITATION (1850 SAF	DRESS, CITY, S RAZIN STREE EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	On 12/10/15, the repounds. A progress daughter reported s "Daughter concerne [nurse practioner]." discontinued and or was discontinued. progress note indicrecorded. Current down significantly in weight. UBW [usua [nurse practioner] a with daughter today likely beadmitting decline in status. Devening meal and for desire to eat have of the stated, "Maybe it diplanning]No ment stated, "Maybe it diplanning]No ment see." ADON-A said the facility long eno psychotropic medicated nursing stated of the stated of th	ge 13 sident's weight was 124 note revealed R110's she was not eating well at all. ed and would like to talk to NP On 1/4/16 Ultram was n 1/8/16, the Lidoderm patch On 1/11/16, a nutritional ated, "Poor to fair intakes weight: 112.6 (1/11). Weight is n comparison to her admission I body weight] 129 lbs. NP ware of weight status. Met and she indicates she will her to hospice r/t [related to] aughter is here often with eels her intakes, appetite, and declined significantly." for of nursing (ADON)-A was ng the lack of care planning opic drug use on 1/14/16, at iewing the care plans in both paper medical record she dn't trigger [to proceed to care tion of medications that I can the resident had resided at ugh that a care plan related to ation use should have been sychotropic Medication policy aff, "Monitors psychotropic g any adverse effects such as nce of functional decline." THOD OF CORRECTION: sing, resident primary rmacist could systematically	21540			
	review all resident r	nedication regimens to ensure edications are not used and				

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00459	B. WING		01/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST GERT	RUDES HEALTH & R	FHARILITATION (AZIN STREI E, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 14	21540			
	A quality tool could shared with the qua appropriate.	e medications are monitored. be developed and information ality committee for review as				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21855	MN St. Statute 144 Residents of HC Fa	.651 Subd. 15 Patients & ac.Bill of Rights	21855			2/5/16
	residents shall have and privacy as it rel personal care progressions. It rel consultation, exami confidential and sha Privacy shall be residential, and other a	nent privacy. Patients and e the right to respectfulness ates to their medical and ram. Case discussion, nation, and treatment are all be conducted discreetly. spected during toileting, activities of personal hygiene, or patient or resident safety or				
	by: Based on observative review the facility fac	on, interview, and document illed to provide personal esidents (R8, R42, R105) observed breached.		In order to comply with the regulat St. Gertrude s must ensure that a residents receive personal privacy maintains each resident s dignity	all that	
	on 1/11/16, at 6:05 wheeling himself fro room. A registered R105 and asked his insulin and R105 re	administration was conducted p.m. R105 was observed om his room to the dining nurse (RN)-B approached m if he was ready for his plied, "yes." RN-B handed ulin pen, R105 pulled his shirt		Gertrude s will do the following: a. Resident R105 has been infor the benefit of personal privacy and encouraged to do self-administrati insulin in his room. We will contin encourage him to do this. R105 c was revised for self-administration encouragement to go to his room injections. There are no other residents/patients that are doing	d ion of his ue to are plan and	

		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		` '	E CONSTRUCTION	(X3) DATE : COMPI	
ST GERTRUDES HEALTH & REHABILITATION 1850 SARAZIN STREET SHAKOPEE, MN 55379			00459		B. WING		01/1	4/2016
SHAKOPEE, MN 55379 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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-administration and explained R105 self-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 SHAKOPEE, MN 55379 ID PREFIX TAG PREFIX TAG PREFIX TAG 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	NAME OF	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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-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	ST GER	TRUDES HEALTH & R	KHARII II ATION (
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 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULI		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
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	21855	up and self-administic side of the abdome residents and staff the dining table. RN-B was interview administration and administered his intexplained that R100 dining table and sation the dining area." to offer to take him confirmed she had stated, "I guess I shad the shad stated, "I guess I shad the stated, "I guess I shad the shad stated, "I guess I shad the sh	stered the insulin to his rien. R105 was exposed to who were already seated wed following the explained R105 selfsulin after set-up. RN-B 5 usually administered it id, "he does not mind do RN-B said staff was sup to a private area, and not done so for R105. Fnould have asked him first esidents who shared a di 05. As prepared on 1/13/16, as prepared on 1/13/16, as prepared on the door to R8 nocking. R8 and his wife ime. Wed immediately after lead explained that staff was on each resident's room as before entering. RN-A did not knock on R8's do as did, "I forgot to knock, loor before entering." Enviewed later that morning the intervity of R42's room without apologized for interrupting resident's room. Wiew with R42 at approximas interviewed. She contact is selected to the contact interviewed. She contact in the contact is selected to the contact interviewed. She contact in the contact interviewed.	at the sing it oposed RN-B st." ining at 9:34 s's e were aving and oor but I mg at view ing the mately of irmed	21855	self-administration of insulin. b. Staff associates will be remine the importance of personal privace (knocking on the patient/resident providing for personal privacy dur procedures) through staff education Attendance will be documented. c. An audit will be conducted we four weeks and then monthly for the months for a total of three months monitor for personal privacy. d. All audits and information will	door and ing on. eekly for wo more is to	

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
		00459	B. WING		01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST GERT	RUDES HEALTH & R	REHARII ITATION (AZIN STREE EE, MN 5537			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21855	Continued From pa	ige 16	21855			
	guess I did not."					
	(ADON)-A was inte an expectation staff and wait for a responsive explained that staff regarding the expectation also explained nurse ensure insulin was Regarding R105, A was supposed to of "but he usually refut When questioned if care plan ADON-A A facility's Dignity po "Residents" private respected at all time request permission roomsStaff shall president privacy, incompared that the support of the property of the support of the supp	ssistant director of nursing rviewed, and explained it was f knock on a resident's door onse before entering. ADON-A had been provided education ctation. In addition, ADON-A sing staff was supposed to administered in a private area. DON-A explained that staff ffer to take him to his room, ses and we respect his rights." It was reflected in R105's replied, "I guess not." olicy dated 2012, directed that, space and property shall be es. Staff will knock and before entering a residents' promote, maintain and protect cluding bodily privacy during res."				
	SUGGESTED MET The facility could re resident rights to pr Audits could be cor respected for all res	THOD OF CORRECTION: e-educate staff regarding rivacy and appropriate policies. nducted to ensure privacy is sidents. The results could be ity committee for review.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
23010	MN Rule 4658.4639 Construction	5 A Nurse Call System; New	23010			2/5/16
	The nurses' station	must be equipped with a				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		00459	B. WING		01/14/2016
	PROVIDER OR SUPPLIER	FHABILITATION (1850 SAF	DRESS, CITY, RAZIN STREIEE, MN 553	= -	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
23010	from the resident a required by this par system, if electrical connected to the er Nurse calls and em of being inactivated central annunciator door is not visible for A. A nurse call resident's bed. Cal communication development are within reaction a resident mustation, activate a libedroom, and active medication room, noom, soiled utility multi-corridor nursi	tem designed to receive calls and nursing service areas to the communication by powered, must be mergency power supply. The capable only at the points of origin. A must be provided where the form the nurses' station. The communication by powered, must be capable only at the points of origin. A must be provided where the form the nurses' station. The cords, buttons, or other prices must be placed where the of each resident. A call st register at the nurses' ght outside the resident ate a duty signal in the ourishment area, clean utility froom, and sterilizing room. In the gunits, visible signal lights to corridor intersections.	23010		
	by: ased on observatio review, the facility f was properly function residents on the 30 environmental qual Findings include: R360's beside call 12:58 p.m. The light light, in which the c modular call light w bed. Pressing the b	ity. light was tested on 1/12/16 at hit was a gray bulb-type call ord was connected to an Arial all unit near the head of the bulb did not activate the light of e light of a call light display at		In order to comply with the regulation St. Gertrude is must ensure function 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 rest of the resident rooms. c. Staff were informed of this requirement through education sess and printed educational information d. An audit for compliance with this requirement will be conducted every times 3 months to check on staff compliance.	the sions . s

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LEAN OF COMMECTION	IDENTIFICATION NOMBER.	A. BUILDING:		O O IVIII	LLILD
	00459	B. WING		01/1	4/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST GERTRUDES HEALTH & RE	-HARII II ALION (AZIN STREE E, MN 5537			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
23010 Continued From pag	ge 18	23010			
NA-B was immediate informed of the probhad not activated an her walkie-talkie as i indicated the testing wall unit and the hall verified were not on. connector more tight wiggled it. She then bed, which then activhall display, and a remessage was heard carried. On 1/14/16 at 12:45 nursing (ADON)-A in light at night. Later a "I'm thinking he pulle functioninghe's a 'public did not routinely test maintenance staff ke system light activation Report registered who well at the time taken light. The report from no calls for R360 being and 1/12/16 at 12:56 there had been a gan non-use or potentiall the resident was adrangled 1/8/16, and the room arrival. When it was no use from 1/8 to 1/16 usages after 1/12/16 out all that time, or the meeting his needs to	ely called to the room and plem. She stated the testing automatic voice message on it should have. She also should have turned on the I display's lights, which she NA-B then pushed the cord tly into the wall unit and retested the call light on the vated the wall unit light and equest for assistance I over the walkie-talkie she p.m. the assistant director of adicated R360 utilized the call at 1:49 p.m. ADON-A stated, and it out. It wasn't call lights for function, but the play a record of the Arial cons. The Device Activity then a light was activated, as in for staff to answer the call in 1/16 revealed there were tween 1/6/16 at 12:07 p.m. Sp.m. The ADON clarified p of several days of call light ly non-function, but explained in that been empty prior to his spointed out the log indicated of the staff may have been the staff may have been to where he didn't need to use egarding R360's call light, "It	23010	e. All audit results will be reported through the Quality Council.	d	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

00459 B. WING 01/14/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE	B. WING 01/14	4/2016
01/14/20	101/14	
TWINE OF THOMBET ON OUT LIER STREET ADDRESS, OFFI, STATE, ZIF CODE	STREET ADDRESS, CITY, STATE, ZIP CODE	4/2010
ST GERTRUDES HEALTH & REHABILITATION (SHAKOPEE, MN 55379		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE MATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
23010 Continued From page 19 23010	23010	
The facility's 10/10, Call Lights policy indicated "Each resident is provided with a functioning, accessible call light or other appropriate signaling deviceReport 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 review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	indicated tioning, ate signaling that to plant CTION: m for ring the bed, and nclude could be eivew.	

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