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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5XZB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00582

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/19/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Chris Campbell, Unit Supervisor 05/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/16/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 245283

On May 19, 2016, this Department conducted a Post Certification Revisit (PCR) by review of the plan of correction and on May 23, 2016 a PCR was conducted by the Department of Public safety. Based on the revisits , we have found the facility has achieved compliance, effective May 17, 2016.

Documentation supporting the facility's request for a continuing waiver involving life safety code deficiencies, K014, K038, K067 and K103. have been forwared to CMS Region V Office for final determination. Approval of the waivers were recommended.

Refer to the CMS 2567b forms for both health and life safety code.

Effective May 12, 2016, the facility is certified for 83 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245283

July 8, 2016

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

Dear Ms. High:

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

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

Effective May 12, 2016 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

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

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K014, K038, K067 and K103. have been forwared to CMS Region V Office for final determination. Approval of the waivers were recommended..

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 24, 2016

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

RE: Project Number S5283026

Dear Ms. High:

On April 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 7, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 23, 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 April 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 17, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 7, 2016, effective May 17, 2016 and therefore remedies outlined in our letter to you dated April 21, 2016, will not be imposed.

Your request for a continuing waiver involving the Life Safety Code (LSC) deficiences cited under K0014, K0038, K0067 and K0103 at the time of the April 7, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245283 Y1	A. Building B. Wing Y2	5/19/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0273	Correction	ID Prefix F0278	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.20(b)(2)(i)	Completed	Reg. # 483.20(g) - (j)	Completed
LSC	05/17/2016	LSC	05/17/2016	LSC	05/17/2016
ID Prefix F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0312	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	05/17/2016	LSC	05/17/2016	LSC	05/17/2016
ID Prefix F0314	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed
LSC	05/17/2016	LSC	05/17/2016	LSC	05/17/2016
ID Prefix F0411	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.55(a)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	05/17/2016	LSC	05/17/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	05/24/2016	34983	05/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/7/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245283 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/23/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	05/17/2016	LSC K0025	05/17/2016	LSC K0029	05/17/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	05/17/2016	LSC K0051	05/17/2016	LSC K0056	05/17/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	05/17/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	05/24/2016	27200	05/23/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/5/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5XZB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00582

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/07/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, HPR SWS 05/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist 05/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

A standard survey was completed at this facility to determined if the facility was in compliance with Federal certificatoin regulations. Deficiencies were cited with the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed.

Documentation supporting the facility's request for a continuing waiver involving life safety code deficiencies, K014, K038, K067 and K103. have been forwared to CMS Region V Office for determination. Approval of the waivers was recommended. Refer to the CMS 2786R Provision Number K84 Justification Pages for each deficiency for the details of the waiver request.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 21, 2016

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

RE: Project Number S5283026

Dear Ms. High:

On April 7, 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.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: chris.campbell@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 17, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 17, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 7, 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 October 7, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to honor resident preferences for frequency of bathing for 1 of 3 residents (R21) reviewed for choices. Findings include: R21's quarterly Minimum Data Set (MDS) dated 2/11/16, indicated R21 had moderately impaired cognition and required extensive assistance of	F 242	R21□s Care Plan will be updated to indicate the resident□s preference for bathing. Three (3) residents on each wing will have their PREFERENCE FOR CUSTOMARY ROUTINE AND ACTIVITIES OBSERVATION reviewed and asked their bathing preferences.	5/17/16

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

Electronically Signed | 04/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 two people for bathing. R21's Diagnoses Report printed on 4/7/16, included diabetes, muscle weakness, cellulitis (infection of the inner layers of the skin), edema (swelling) and paraplegia (paralysis of the legs and lower body). On 4/4/16, at 6:26 p.m., and again on 4/6/16, at 9:15 a.m., R21 stated she did not have a choice in the number of showers she got a week. R21 stated she only got one shower a week and she would like two. Review of R21's Care Conference Report dated 12/24/14, indicated she requested to shower twice a week. Review of hand written notes from R21's 11/16/15, Care Conference indicated R21 would like 1-2 showers a week. On 4/6/16, at 9:19 a.m., the Activities Director (AD) stated activity staff ask resident's their bathing frequency preference at admission and at each annual care conference. The AD will then email the registered nurses (RN)s the preferences so that they can schedule resident's baths or showers. In an interview on 4/7/16, at 8:54 a.m., the AD confirmed R21's preference for 1-2 showers a week was in the staff's hand written notes from the 11/16/15 care conference, but did not get put in R21's medical record. The AD could not say if she emailed the RN about R21's preferences. R21's Kardex indicated R21 was scheduled for one shower a week, on Mondays.	F 242	Newly Admitted residents will be asked their preferences during the PREFERENCE FOR CUSTOMARY ROUTINE AND ACTIVITIES OBSERVATION and preferences for bathing will be routed to the Clinical Managers to care plan for. Current residents will continue to be asked their preferences during the PREFERENCE FOR CUSTOMARY ROUTINE AND ACTIVITIES OBSERVATION completed with each Annual and Significant change MDS and changes in bathing preferences will be routed to the Clinical Manager for Care Plan updates. The Resident s Rights Policy has been reviewed and updated. Activities staff and Nursing will be trained on expectations. Audits will be completed weekly by the Clinical Manager or designee on residents who have requested more than one bath/shower per week to assure that the bath/showers are occurring as care planned for. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 2 In an interview on 4/7/16, at 9:14 a.m., registered nurse (RN)-A stated she hasn't heard lately that R21 would like more than one shower a week. RN-A stated there was no reason R21 couldn't have two showers a week. In an interview on 4/7/16, at 9:34 a.m., the director of nursing (DON) stated residents can have as many baths or showers as they want, but as R21 had edema and that required wrapping, perhaps she couldn't have more than one. Review of the facility policy on Resident Rights, effective 2/11/05, indicated resident's customary routines are asked at admission and at scheduled care conferences in order to accommodate the resident's past preferences and encourage choices.	F 242		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an admission comprehensive Minimum Data Set (MDS) assessment was completed for 1 of 16 residents	F 273	A COMPREHENSIVE ADMISSION ASSESSMENT (MDS) was completed for R117 on 4/18/16.	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 3 (R117) reviewed for comprehensive assessments. Findings include: R117's undated face sheet, indicated R117's current admission date was 2/1/16. R117's diagnoses report dated 3/1/16 through 3/31/16, indicated R117's diagnoses included physical deconditioning, diabetes with neuropathy (nerve pain), muscle weakness, difficulty walking, osteoarthritis, and amputation of two or more toes. R117's admission orders dated 10/13/16, indicated R117 was admitted for short term rehab and daily skilled services. R117's physician orders dated 1/19/16, directed R117 to be discharged to home on 1/20/16. The discharge summary dated 2/5/16, indicated R117 had been admitted on 10/13/15, for short term rehabilitation. R117 received physical and occupational therapies, and was discharged home with home care services on 1/20/16. Progress notes dated 1/20/16, indicated R117 was discharged home and was to receive home care services and family assistance. R117's admission orders dated 2/1/16, indicated R117 was admitted for extended care and daily skilled services. Progress notes dated 2/1/16, indicated R117 was re-admitted after having been discharged from the facility on 1/20/16. The progress note indicated R117 was unable to manage at home. Progress notes dated 2/3/16, indicated R117 had been discharged from the facility to home with	F 273	A list of DISCHARGE RETURN ANTICIPATED MDS will be reviewed from 1/1/16 to 4/15/16 to assure that they were coded correctly. If there was an error and the resident is still in house a COMPREHENSIVE ADMISSION ASSESSMENT (MDS) will be completed. The MDS Coordinator has been updated on when it is appropriate to use Discharge-Return Anticipated. Audits will be completed monthly by the Director of Nursing or designee to on MDS s from the previous month with Discharge Return-Anticipated to assure that they were coded correctly. Monitoring will be completed at a consistent level (Monthly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 4	F 273		

home care services. Upon discharge R117 was able to transfer independently at home, but upon re-admission, R117 was unable to stand to transfer and required a lift assist. The progress notes further indicated R117 was admitted with a pressure ulcer related to immobility at home.

A nurse practitioner's progress note dated 2/4/16, indicated R117 had been admitted several weeks previously for short term rehabilitation, then went home. R117 was unable to manage at home and was newly re-admitted to the facility with deconditioning and pressure sores on both heels and sores on both elbows.

R117's MDS's indicated a discharge MDS combined with a quarterly MDS was completed on 2/2/16. The assessment reference date for this assessment was 1/20/16. The MDS was coded as a discharge with return anticipated.

R117's medical record lacked a comprehensive admission assessment for the admission on 2/1/16.

On 4/7/16, at 9:03 a.m. registered nurse (RN)-A verified R117's return was not expected when discharged on 1/20/16.

On 4/7/16, at 9:46 a.m. RN-B verified R117's re-admission was not anticipated at the time of discharge and verified a comprehensive assessment was not done for this resident. RN-B stated the discharge MDS was coded with a return anticipated, due to the short time period R117 had been discharged. A new MDS had not been completed because there had been no change in the resident's condition since the discharge on 1/20/16. RN-B stated the next MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 5 was due in April. The facility policy and procedure for MDS Completion and Location dated 10/10, directed the MDS would be completed on a schedule following state and federal guidelines.	F 273		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 3 residents (R8, R94) reviewed for dental status. Findings include: R8's undated Face Sheet identified diagnoses that included osteoarthritis. R8's significant change MDS dated 1/6/16, identified R8 had no loose, broken natural teeth or tooth fragments. R8's nursing and physician progress notes records lacked documentation of any tooth loss or breakage. Observation on 4/5/16, 10:44 a.m. revealed R8 had multiple missing and broken front natural teeth. R94's undated Face Sheet indicated a diagnosis of intracranial hemorrhage (bleeding into the brain). R94's quarterly review MDS dated 12/21/16, indicated R94 was cognitively impaired and required staff assistance for oral cares. R94's care plan dated 5/8/14, directed oral cares after meals. The MDS had no documentation of oral and dental status. R94's nursing and physician progress notes contained no documentation since 12/21/15 of any tooth loss or damage. Observation on 4/5/16, at 11:42 a.m. revealed R94 had multiple missing broken and loose teeth. On 4/7/16, at 12:26 p.m. registered nurse (RN)-A was interviewed and stated oral assessments should be documented at least annually and residents' oral status assessed quarterly by	F 278	R8 has an ORAL ASSESSMENT completed. R8□s MDS of 1/6/16 was modified to reflect broken natural teeth. R94 has an ORAL ASSESSMENT completed. R94□s ANNUAL MDS of 3/18/16 was modified to reflect broken teeth, loose teeth, and mouth pain. R94□s Insurance Care Coordinator has been notified to make a referral for dental services. R94 has been set up with a dental appointment on June 13, 2016 which is the soonest that Delta Dental could arrange services. The facility will review five (5) MDS□s that were completed with ARD□s between 4/1/16 4/30/16 to determine accuracy of oral status coding of the MDS. The MDS will be modified if the coding was inaccurate. Nursing has been educated on how to accurately document oral assessments. The Assessments/Quarterly Reviews Policy has been reviewed and remains appropriate. The Oral Assessments Policy has been updated. Random Audits will be completed monthly by the Director of Nursing or designee to assure that oral/dental status has been addressed and accurate on comprehensive MDS□. Monitoring will be completed at a consistent level (Monthly) until compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 looking in the resident's mouth, under the tongue and asking the resident if their mouth hurt. RN-A further stated she could not find an assessment of R94's oral status since 2014. On 4/7/16, at 12:47 p.m., the director of nursing (DON) was interviewed and stated oral assessments must be completed annually, and this was a requirement. On 4/7/16, at 9:47 a.m. RN-B, minimum data set (MDS) coordinator, was interviewed and stated the MDS care area documentation was based upon what was documented in the resident's chart. She further stated that if nothing was documented in the chart, the corresponding care area could not be completed. The facility policy indicated quarterly assessments would include oral status.	F 278	is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included the monitoring of medication side effects for Coumadin use for 1 of 5 residents (R158) reviewed for unnecessary medications. Findings include: R158's Face Sheet identified diagnoses that included cerebral infarction (stroke), weakness, and long term (current) use of anticoagulants. R158's Admission Minimum Data Set (MDS) dated 3/14/16 indicated moderately impaired cognition. The MDS also indicated total assistance with transfers and impaired balance on one side. The MDS indicated R158 had had a fall with minor injury and was on an anticoagulant. The Physician Order Report for 3/29/16 - 4/1/16 ordered Coumadin by mouth every evening for the diagnoses of hemiplegia and hemiparesis following other cerebrovascular disease. A review of R158's Care Plan revealed no side effect monitoring for anticoagulant use. Review of R158's Kardex revealed no mention of monitoring for side effects of anticoagulant use. In an interview on 4/7/16, at 7:47 a.m., registered	F 279	R158□s Care Plan has been updated to address the risk of bleeding for Coumadin use. The Care Plan of all residents□ who are receiving anti-coagulant therapy will be reviewed and updated if necessary. The Anticoagulation-Monitoring for Potential Side Effects Policy has been reviewed and remains appropriate. Staff has been re-trained regarding facility protocol. A Order Report by Category Report will be run weekly and any resident with new anticoagulant therapy will have their Care Plan audited to assure that the care plan addresses monitoring for side effects. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 nurse (RN)-A stated if a resident is on Coumadin, the Care Plan would include monitoring for potential side effects of anticoagulation use, including excessive bruising, evidence of bleeding, etc. RN-A reviewed R158's Care Plan and confirmed there was not a care plan for side effects of anticoagulant use. In an interview on 4/7/16, at 8:13 a.m., the Director of Nursing (DON) stated residents on anticoagulants should be monitored for side effects. The 4/7/14, facility Anticoagulation Monitoring for Potential Side Effects Policy specified resident Care Plans will include monitoring for potential side effects of anticoagulation use.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services as directed by the care plan for 1 of 3 residents (R134) reviewed for pressure ulcers and urinary incontinence and 1 of 3 residents (R2) reviewed for side rail use. Findings include: R134's Face Sheet dated 4/8/16, indicated	F 282	R134□s SKIN RISK ASSESSMENT will be reviewed and updated as indicated. The Care Plan will be updated if indicated by the SKIN RISK ASSESSMENT. R134 has had BOWEL AND BLADDER ASSESSMENTS completed and Care Plan revised. A list of three (3) residents on each wing	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 R134's diagnoses included cerebral infarction (stroke), hemiplegia (weakness on one side of the body) affecting the right dominant side, depression, mild cognitive impairment, difficulty walking and falls. The pressure ulcer care plan dated 12/23/15, indicated R134 was at risk for pressure ulcers related to frequent incontinence and the need for assistance with activities of daily living (ADL). The care plan directed to see the Kardex for specific indications and approaches. The Kardex dated 12/10/15, directed staff to reposition R134 every two hours when in the wheelchair, recliner and bed. The Kardex was updated by the director of nursing (DON) on 4/6/16. The updated Kardex indicated R134 had a history of pressure ulcers and directed to offload R134 every two hours. The incontinence care plan dated 12/23/15 indicated R134 experienced bladder incontinence related to a decrease in functional mobility and cognitive awareness of the need to urinate. The care plan directed to provide incontinence care after each incontinent episode and see the Kardex for specific indications and approaches. The Kardex dated 12/10/15, indicated R134 was incontinent of bowel and bladder. The Kardex directed staff to check and change R134 every two hours during the day. On 4/6/16, R134 was continuously observed from 8:00 a.m. until 10:40 a.m. and repositioning was not provided. At 10:40 a.m. NA-A brought R134 to his room and transferred him onto the toilet. NA-A removed the brief and stated it was wet with urine. R134 did not urinate or have a bowel movement while on the toilet. At 10:53 a.m. R134's buttocks were observed with licensed	F 282	who are at risk for impaired skin integrity was developed by Clinical Mangers. These residents were reviewed for compliance with facility Skin Risk Assessments and Observations Policy, and appropriate interventions are care planned for. Revisions will be made to the Care Plan as indicated. A list of three (3) residents on each wing who rely on staff assistance for elimination needs was developed by Clinical Managers. These residents will have their BOWEL AND BLADDER ASSESSMENTS reviewed. Revisions will be made to the Care Plan as indicated. The Impaired Skin Tissue Documentation Policy, Incontinence Assessment and Management Policy have been reviewed. R2□s bed was replaced with a bed that has the ability to control the bed from the footboard. All residents with side rails will be reviewed for appropriate use of side rails. The Care Plan Process and Review Policy was reviewed and revised. Staff was trained on expectations of following the Plan of Care. Random audits will be completed weekly by Clinical Managers or designee to assure compliance with repositioning, elimination plan of care, and side rail use. Monitoring will be completed at a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11 practical nurse (LPN)-B. The coccyx area was slightly red and was blanchable by the LPN. On 4/6/16, at 10:35 a.m. NA-A verified R134 had not been repositioned, toileted, checked or changed since getting up. On 4/6/16, at 1:35 p.m. the DON stated R134 was to be repositioned, checked and changed every two hours and would expect staff to follow the care plan. In addition the DON verified she made an update to the Kardex on 4/6/16. The facility's Impaired Skin/Tissue policy revised 5/1/12, indicated the purpose of the policy was to promote healing, prevent infection and prevent new sores from developing. The facility's Incontinence Assessment and Management policy revised 7/17/13, indicated the purpose of the policy was to promote continence or the highest level of bowel and bladder function for the resident. R2's quarterly Minimum Data Set (MDS) dated 2/4/16, identified R2 had moderate cognitive impairment and was non-communicative. R2's MDS revealed R2 had diagnoses which included Parkinson's disease and chronic obstructive pulmonary disease. R2's MDS further revealed R2 total assistance with all activities of daily living (ADL's) and had limited functional range of motion on one side of her upper extremity. Review of R2's most recent quarterly note dated 11/10/15, revealed R2 was non-oriented and required total assistance with all ADL's and had a contracture of her right hand. The note further revealed R2's side rails were to remain down due	F 282	consistent level (weekly) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 12 to R2's non-use and did not need for repositioning. Review of R2's nursing assistant care sheet (kardex) undated, revealed R2's side rails were to be down at all times due to non-use. Review of R2's care plan revised 12/9/14, revealed R2 had impaired physical mobility related to Parkinson's dementia and referred facility staff to the kardex for specifics and approaches to bed mobility, side rail use, and repositioning schedule in bed. R2's care plan also identified R2 was susceptible to abuse related to impaired cognition and total dependence on others for ADL needs. R2's care plan directed facility staff to follow resident plan of care to ensure safety and to provide a safe environment. On 4/5/16, at 11:07 a.m. R2 was observed lying in bed on her back, eyes closed and blankets to mid torso. R2's right siderail (gray, hard plastic covered) was in the upright position. On 4/7/16, at 9:20 a.m. the director of nursing (DON) confirmed R2's care plan directing R2 was not supposed to have the siderail up, however the controls to R2's bed were on the right siderail of the bed. The DON stated she was unaware how long R2's bed with siderails had been in use.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide incontinence care and services for 1 of 3 residents (R134) reviewed for urinary incontinence. Findings include: R134's Face Sheet dated 4/8/16, indicated R134's diagnoses included cerebral infarction (stroke), hemiplegia (weakness on one side of the body) affecting the right dominant side, depression, mild cognitive impairment, difficulty walking and falls. A Progress Note dated 12/10/15, indicated R134 was admitted to the facility for rehabilitation after a left sided cardio vascular accident (CVA/stroke). R134 had right sided hemiparesis. R134 was able to answer yes/no questions, however R134 had dysphagia and could not always get the words out. R134 was unable to make needs known but could use the call light. R134 was incontinent of bowel and bladder. The 30 day Minimum Data Set (MDS) dated 12/21/15, indicated R134 had severe cognitive impairment with no behaviors or rejection of cares. R134 needed the total assistance of two staff with bed mobility and transferring and the extensive assistance of two staff with toilet use. The MDS further indicated R134 was frequently incontinent of bowel and bladder. The incontinence care plan dated 12/23/15 indicated R134 experienced bladder incontinence related to a decrease in functional mobility and	F 312	R134□s has had BOWEL AND BLADDER ASSESSMENTS completed and Care Plan revised. A list of three (3) residents on each wing who rely on staff assistance for elimination needs was developed by Clinical Managers. These residents will have their BOWEL AND BLADDER ASSESSMENTS reviewed. Revisions will be made to the Care Plan as indicated. The Incontinence Assessment and Management Policy has been reviewed. The Care Plan Process and Review Policy was reviewed and revised. Staff was trained on expectations of following the Plan of Care. Random audits will be completed weekly by Clinical Managers or designee to assure compliance with the elimination Plan of Care. Monitoring will be completed at a consistent level (weekly) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 14	F 312		

cognitive awareness of the need to urinate. The care plan directed staff to provide incontinence care after each incontinent episode and see the Kardex for specific indications and approaches. The Kardex dated 12/10/15, indicated R134 was incontinent of bowel and bladder and directed staff to check and change R134 every two hours during the day.

The Urinary Incontinence Care Area Assessment (CAA) dated 12/23/15, indicated R134 was frequent incontinent of urine, which could cause issues such as skin breakdown or urinary tract infections (UTI). The care plan was to be developed to address resident's incontinence and the need for additional care from staff to prevent adverse effects..

On 4/6/16, R134 was continuously observed from 8:00 a.m. until 10:40 a.m. and incontinence care was not provided. At 8:00 a.m. R134 was transferred from the bed into the wheelchair. R134 was then brought to the day room by nursing assistant (NA)-A and placed in front of the television. At 9:48 a.m. R134 was brought into the main dining room and was fed breakfast. At 10:40 a.m. NA-A brought R134 to his room and transferred him onto the toilet using the overhead lift. The NA removed the brief and stated it was wet with urine. R134 did not urinate or have a bowel movement while on the toilet.

On 4/6/16, at 10:35 a.m. NA-A stated she thought it was 8:30 a.m. when R134 got into the wheelchair. The NA stated R134 was to be toileted every two hours but would have to check her list. "Usually after [R134] eats." At 10:55 a.m. the NA checked the list and stated "I didn't write it down." The NA verified R134 had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 15 toileted, checked or changed since getting up. On 4/6/16, at 1:35 p.m. the director of nursing (DON) stated R134 was to be checked and changed every two hours and would expect staff to follow the care plan. In addition the DON stated there was not a bowel and bladder assessment, only the CAAs. The facility's Incontinence Assessment and Management policy revised 7/17/13, indicated the purpose of the policy was to promote continence or the highest level of bowel and bladder function for the resident.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure timely assistance with repositioning for 1 of 3 residents (R134) reviewed for pressure ulcers. Findings include: R134's Face Sheet dated 4/8/16, indicated	F 314	R134□s SKIN RISK ASSESSMENT will be reviewed and updated as indicated. The Care Plan will be updated if indicated by the SKIN RISK ASSESSMENT. A list of three (3) residents on each wing who are at risk for impaired skin integrity was developed by Clinical Mangers.	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 R134's diagnoses included cerebral infarction (stroke), hemiplegia (weakness on one side of the body) affecting the right dominant side, depression, mild cognitive impairment, difficulty walking and falls. A Progress Note dated 12/10/15, indicated R134 was admitted to the facility for rehabilitation after a left sided cardio vascular accident (CVA/stroke). R134 had right sided hemiparesis. R134 was able to answer yes/no questions, however R134 had dysphagia and could not always get the words out. R134 was unable to make needs known but could use the call light. R134 had a Braden score (a tool used for predicting pressure ulcer risk) of 12 which indicated R134 was at high risk for skin breakdown. R134 would be turned and repositioned every two hours and as needed. R134 was also incontinent of bowel and bladder. The accompanying Head to Toe Assessment dated 12/10/15, indicated R134 had a red coccyx and buttocks. An admission Skin Risk Assessment with a Braden Scale dated 12/10/15, indicated R134 was at risk for pressure ulcers and did not have any pressure ulcers. R134 transferred with the Hoyer (mechanical) lift and needed the assistance of two staff with bed mobility. R134 would be turned and repositioned every two hours and as needed. The 30 day Minimum Data Set (MDS) dated 12/21/15, indicated R134 had severe cognitive impairment with no behaviors or rejection of cares. R134 needed the total assistance of two staff with bed mobility and transferring. The MDS further indicated R134 was at risk for pressure ulcers and had one stage two pressure that was	F 314	These residents were reviewed for compliance with facility Skin Risk Assessments and Observations Policy, and appropriate interventions are care planned for. Revisions will be made to the Care Plan as indicated. The Impaired Skin Tissue Documentation Policy has been reviewed. The Care Plan Process and Review Policy was reviewed and revised. Staff was trained on expectations of following the Plan of Care. Random audits will be completed weekly by Clinical Managers or designee to assure compliance with repositioning. Monitoring will be completed at a consistent level (weekly) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17 not present since prior assessment. The pressure ulcer care plan dated 12/23/15, indicated R134 was at risk for pressure ulcers related to frequent incontinence and the need for assistance with activities of daily living (ADL). The care plan directed to see the Kardex for specific indications and approaches. The Kardex dated 12/10/15, directed staff to reposition R134 every two hours when in the wheelchair, recliner and bed. The Kardex was updated by the director of nursing (DON) on 4/6/16. The updated Kardex indicated R134 had a history of pressure ulcers and directed to offload R134 every two hours. The Pressure Ulcer Care Area Assessment (CAA) dated 12/23/15, indicated R134 was at risk for skin breakdown related to frequent incontinence of bowel and bladder, and needed help with ADL needs. Care plan was to be developed to reduce the risk of skin breakdown related to pressure on bony prominence or maceration. A Progress Note dated 12/28/15, indicated on 12/27/15, R134 had a 1 centimeter (cm) by 2 cm red area to the left buttock. On 12/28/15 the area remained but then appeared to have a 1 cm by 0.5 cm open area in the center. The area was described as missing a thin layer of skin. A Skin Ulcer Documentation dated 12/30/15, indicated the assessment revealed R134 had a stage two (a partial thickness loss of skin layers that presents as an abrasion, blister or a shallow crater) pressure sore on the left buttock. The ulcer measured 2 cm by 1 cm by 0 cm deep. R134 was totally dependent on staff for turning and repositioning. An alternating air flow mattress	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18	F 314		

was placed on the bed and R134 would be turned and repositioned every two hours. A foam dressing would be applied every three days. A Progress Note dated 12/31/15, indicated a facsimile (fax) was sent to the physician with an update regarding the pressure sore on the buttocks.
A Head to Toe Skin Assessment diagram dated 1/4/16, indicated R134 did not have a pressure ulcer.

On 4/6/16, R134 was continuously observed from 8:00 a.m. until 10:40 a.m. and repositioning was not provided. At 8:00 a.m. R134 was transferred from the bed into the wheelchair. R134 was then brought to the day room by nursing assistant (NA)-A and placed in front of the television. At 9:48 a.m. R134 was brought into the main dining room and was fed breakfast. At 10:40 a.m. NA-A brought R134 to his room, transferred him onto the toilet using the overhead lift and then transferred R134 onto his bed. At 10:53 a.m. R134's buttocks were observed with licensed practical nurse (LPN)-B. R134's buttocks did not have any open areas. The LPN stated there was possibly a scar on the left buttock and on the coccyx area. The coccyx area was slightly red and was blanchable by the LPN.

On 4/6/16, at 10:35 a.m. NA-A stated she thought it was 8:30 a.m. when R134 got into the wheelchair. The NA stated R134 was to be repositioned every two hours but would have to check her list. "Usually after [R134] eats." At 10:55 a.m. the NA checked the list and stated "I didn't write it down." The NA verified R134 had not been repositioned since getting up.

On 4/6/16, at 1:35 p.m. the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 (DON) stated R134 was to be repositioned every two hours and would expect staff to follow the care plan. In addition the DON verified she made an update to the Kardex on 4/6/16. The facility's Impaired Skin/Tissue policy revised 5/1/12, indicated the purpose of the policy was to promote healing, prevent infection and prevent new sores from developing.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess for the safe use of side rails which did not meet the Federal Drug Administration (FDA) guidelines to prevent entrapment for 3 of 3 residents (R2, R38, R93) reviewed for accidents and hazards related to a unsafe gaps of the side rails in zone 1 (within the rail itself). Findings include: Review of R2's quarterly Minimum Data Set (MDS) dated 2/4/16, identified R2 had moderate cognitive impairment and was non-communicative. R2's MDS revealed	F 323	R2, R38, and R93□s beds have been replaced with beds that have side rails that meet the FDA guidelines to prevent entrapment. All beds in the building that have side rails have been inspected to assure that side rails meet the FDA guidelines to prevent entrapment. The Personal and Donated Mechanical and Electric Bed Policy has been reviewed and updated regarding acceptance of donated beds to assure that they are in compliance with applicable	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 diagnoses which included Parkinson's disease and chronic obstructive pulmonary disease. R2's MDS further revealed R2's total assistance with all activities of daily living (ADL's) and limited functional range of motion on one side of her upper extremities. Review of R2's most recent quarterly note dated 11/10/15, revealed R2 was non-oriented and required total assistance with all ADL and had a contracture of her right hand. The note further revealed R2's side rails were to remain down due to R2's non-use and did not need for repositioning. Review of R2's medical record lacked a side rail safety assessment. Review of R2's undated nursing assistant care sheet (kardex), revealed R2's side rails were to be down at all times due to non-use. Review of R2's care plan revised 12/9/14, revealed R2 had impaired physical mobility related to Parkinson's dementia and referred facility staff to the kardex for specifics and approaches to bed mobility, side rail use, and repositioning schedule in bed. R2's care plan also identified R2 was susceptible to abuse related to impaired cognition and total dependence on others for ADL needs. R2's care plan directed facility staff to follow resident plan of care to ensure safety and to provide a safe environment. On 4/5/16, at 11:07 a.m. R2 was observed lying in bed on her back, eyes closed with blankets up to mid torso. R2's right siderail (gray, hard plastic covered) was in the upright position. R2's side rail was oblong shaped and approximately 21 inches long and 9 inches high. R2's side rail was observed to have 2 openings which measured 7	F 323	regulations prior to acceptance. Staff will be trained on the policy. The Administrator will have final approval of acceptance of any donated beds and will assure that the assessment has been completed. The Administrator is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 inches by 7.5 inches. The maintenance director (M-D) confirmed R2's side rail measurements and verified R2's side rail did not meet the FDA requirements for safe side rail measurements. M-D stated the bed had come from another facility that had closed and was unsure when the bed was given to R2. On 4/5/16, at 1:45 p.m. the M-D had removed the bed with the unsafe siderails from R2's room and had given R2 a new bed with no side rails. On 4/5/16, 3:34 p.m. R2 was observed lying in bed on her back, blanket covering up to mid torso with her eyes closed. R2's bed had no siderails on either side. On 4/7/16, at 9:20 a.m. the director of nursing (DON) confirmed R2's care plan and confirmed R2 was not supposed to have the siderail up, however the controls to R2's bed were on the right siderail of the bed. The DON stated the nurse managers were responsible for completing side rail assessments. The DON stated the M-D was responsible for ensuring all facility beds met the FDA requirements for safe siderails. The DON stated she was unaware how long R2's bed had been in use. R38's Face Sheet indicated diagnoses including muscle weakness, difficulty in walking, osteoarthritis and peripheral vascular disease. R38's quarterly MDS dated 1/27/16, indicated she was cognitively intact, and required extensive assistance with bed mobility, personal hygiene, and toileting. The MDS further indicated R38 was frequently incontinent of bladder. Review of R38's progress note, revealed an	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 11/5/15 note indicating R38 was independent with bed mobility using the side rails to reposition at night and that the side rails were to remain up for this purpose. R38's care plan dated 6/20/13, indicated impaired bed mobility and referred to the Kardex for specifics and approaches for bed mobility and transfers. R38's care plan also identified R38 was susceptible to abuse related to impaired mobility at times. R38's care plan directed facility staff to follow resident plan of care to ensure safety and to provide a safe environment. R38's 11/3/15, Kardex indicated R38 was independent to an assist of one with side to side bed mobility and an assist of two to be assisted to the head of the bed. The Kardex also indicated to have R38's side rails up at all times. An Observation Report dated 12/4/14 indicated side rails side rails were to be used on the top half of R38's bed in order to assist with turning side-to side. The Observation Report stated that the risks and benefits were explained to the resident only. In an observation on 4/5/16, at approximately 11:10 a.m., R38's side rails was observed to have 2 openings which measured 7 inches by 7.5 inches. The maintenance director (M-D) confirmed R38's side rail measurements and verified R38's side rail did not meet the FDA requirements for safe side rail measurements. M-D stated the bed had come from another facility that had closed and was unsure when the bed was given to R38.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 On 4/5/16, at approximately 1:45 p.m. the M-D had removed the bed with the unsafe siderails from R38's room and had given R38 a new bed with no side rails. R93's Face Sheet indicated diagnoses including chronic kidney disease, weakness and dementia. R93's quarterly MDS dated 2/8/16, indicated R93 was had severely impaired cognition, required extensive assistance with bed mobility and was totally dependent upon others for transfers. The MDS further indicated R93 was always incontinent of bladder and bowel, and received scheduled pain medications. Review of R93's progress notes revealed an 11/13/15 note that indicated R93 was to have the left side rail up for safety, comfort, and repositioning. R93's Skin Integrity Care Plan dated 4/17/14 directed staff to use a lifting device, such as a lift sheet, to move R93 in bed. R93's care plan also identified R93 was susceptible to abuse related to dependency on staff for mobility and dementia. R93's 6/25/14 Kardex indicated R93 was a total assist of one with side to side bed mobility and an assist of two to be assisted to the head of the bed. The Kardex also indicated to have R93's left side rail up. In an observation on 4/5/16, at approximately 11:10 a.m., R93's side rails was observed to have 2 openings which measured 7 inches by 7.5 inches. The maintenance director (M-D) confirmed R93's side rail measurements and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 verified R93's side rail did not meet the FDA requirements for safe side rail measurements. M-D stated the bed had come from another facility that had closed and was unsure when the bed was given to R93. On 4/5/16, at approximately 1:45 p.m. the M-D had removed the bed with the unsafe siderails from R93's room and had given R93 a new bed with no side rails. A side rail assessment for R93 was requested but not received. On 4/7/16, at 9:38 a.m. the facility administrator (A)-A stated the 3 beds the M-D had identified with unsafe side rails had been in the facility since 5/14, though had not been in use right away. The A-A stated it was the facility M-D responsibility to ensure all residents beds were safe to use. Review of a facility policy titled, Side Rails Policy dated 3/14/13, revealed a siderail definition of an apparatus that is attached adjacent to either side of the bed, and has the ability to be placed up or down along side of the bed. The policy directed facility staff to complete a side rail observation and side rail use was documented in NAR (nursing assistant registered) care plan sheet.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an assessment of antipsychotic medication side-effect movement disorder was completed for 1 of 5 residents (R117) reviewed for unnecessary medications. In addition, the facility failed to monitor for side effects of coumadin use for 1 of 5 residents (R158) reviewed for unnecessary medications. The facility also failed to ensure side effect monitoring for the use of an antidepressant for 1 of 5 residents (R94) reviewed for unnecessary medications. Findings include: R117's diagnoses report printed on 4/7/16, indicated R117's diagnoses included depressive	F 329	R117 has had an AIMS completed. The Consultant Pharmacist will review all residents with medications that require an AIMS to assure that one has been completed within the last six months. The Abnormal Involuntary Movement Observation policy has been reviewed and remains appropriate. Staff has been trained on the policy. The Consultant Pharmacist will complete audits with his monthly consultation visits to assure that AIMS are complete and current. Monitoring will be ongoing monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 26 episodes and generalized anxiety disorder. R117's physician orders for 4/1/16 through 4/30/16, included an order for Abilify (antipsychotic medication) 5 milligrams (mg) once daily (qd) for generalized anxiety disorder. R117's care plan for 2/1/16 through 4/7/16, indicated R117 received antipsychotic medications and directed nursing to monitor for side effects per facility protocol. R117's medical record lacked an Abnormal Involuntary Movement Scale (AIMS) which is used to measure involuntary movements known as tardive dyskinesia, a serious side effect of antipsychotic medications. On 4/7/16, at 9:02 a.m. during an interview, registered nurse (RN)-A verified R117 was receiving an antipsychotic medication. RN-A stated an AIMS was to be done every 6 months and verified an AIMS had not been done in the past 6 months, during R117's admission from 10/13/15 through 1/20/16, or this admission from 2/1/16 through the current date. On 4/7/16, at 1:03 p.m. the consultant pharmacist (CP) verified an AIMS would be expected to be done and verified he did not see that one had been done. The facility policy and procedure for Abnormal Involuntary Movement Observation (AIMS) dated 4/1/13, directed nursing to evaluate for tardive dyskinesia by completing an AIMS for residents admitted with an order for an antipsychotic medication. The facility policy and procedure further directed the AIMS would be completed a	F 329	The Consultant Pharmacist is responsible. *** R158□s Care Plan has been updated to address the risk of bleeding for Coumadin use. The Care Plan of all residents□ who are receiving anti-coagulant therapy will be reviewed and updated if necessary. The Anticoagulation-Monitoring for Potential Side Effects Policy has been reviewed and remains appropriate. Staff has been re-trained regarding facility protocol. A Order Report by Category Report will be run weekly and any resident with new anticoagulant therapy will have their Care Plan audited to assure that the care plan addresses monitoring for side effects. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible R94 has had a MEDICATION SIDE EFFECT AND MOOD AND BEHAVIOR MONITORING DOCUMENTATION completed. All residents who receive Psychoactive Medications will be reviewed to assure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 minimum of 6 month intervals. R158 was not monitored for side effects for use of Coumadin, an anticoagulant, or blood thinner. R158's Face Sheet identified diagnoses that included cerebral infarction (stroke), weakness, and long term (current) use of anticoagulants. R158's Admission Minimum Data Set (MDS) dated 3/14/16 indicated moderately impaired cognition. The MDS indicated R158 had had a fall with minor injury and was on an anticoagulant. The Physician Order Report for 3/29/16 -4/1/16 indicated Coumadin by mouth once an evening for the diagnoses of hemiplegia and hemiparesis following other cerebrovascular disease. The following doses/days were ordered: 4 mg on Mondays, Wednesdays, Saturdays and Sundays; 2 mg on Thursdays and Fridays; and 6 mg on Tuesdays. A review of R158's Care Plan revealed no side effect monitoring for anticoagulant use. Review of R158's Kardex revealed no mention of monitoring for side effects of anticoagulant use. Review of R158's progress notes indicated a fall from the wheelchair on 3/11/16, resulting in an abrasion with no swelling to R158's left forehead and a trip to the emergency department for evaluation. In an interview on 4/7/16, at 7:47 a.m., registered nurse (RN)-A stated if a resident is on Coumadin, the Care Plan will include monitoring for potential side effects of anticoagulation use, including excessive bruising, evidence of bleeding, etc. RN-A reviewed R158's Care Plan and confirmed	F 329	that a current MEDICATION SIDE EFFECT AND MOOD AND BEHAVIOR MONITORING DOCUMENTATION is completed. The Psychoactive Medication Side Effect Monitoring Policy has been reviewed and revised. Staff will be trained on this policy. Random audits will be completed monthly by the Director of Nursing or designee to assure that MEDICATION SIDE EFFECT AND MOOD AND BEHAVIOR MONITORING DOCUMENTATION IS completed per policy. Monitoring will be completed at a consistent level (Monthly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nurses is responsible for monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 28 there was not a care plan for side effects of anticoagulant use. In an interview on 4/7/16, at 8:13 a.m., the Director of Nursing (DON) stated residents on anticoagulants should be monitored for side effects. The 4/7/14, facility Anticoagulation Monitoring for Potential Side Effects Policy specified resident Care Plans would include monitoring for potential side effects of anticoagulation use. R94's Admission Record identified diagnoses that included intracranial hemorrhage and a major depressive disorder.The physician order set for 4/1/16 to 4/30/16, ordered Prozac (antidepressant) 30 mg qd. The care plan dated 3/30/16 indicated R94 was at risk for adverse consequences related to receiving antidepressant medications.Staff was to monitor R94 for signs of sedation, anticholinergic effects (dry mouth, blurred vision, sleepiness, confusion, delirium, decreased sweating and saliva) and extrapyramidal symptoms (tremor, anxiety, repetitive muscle movements), distress and paranoia. The care plan further directed staff to monitor for and report these side effects. On 4/7/16, at 12:36 p.m. registered nurse (RN)-A was interviewed, and stated the facility monitored for medication side effects quarterly. RN-A stated R94's records lacked medication side effects monitoring documentation. On 4/7/16, at 12:45 p.m. the director of nursing (DON) was interviewed and verified R94's records lacked side effect monitoring	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29 documentation. The DON stated she would expect the medication side effects monitoring sheet to be completed quarterly for R94.	F 329		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dental services for 1 of 3 residents (R94) reviewed for dental services. Findings include: R94's Face Sheet indicated a diagnosis of intracranial hemorrhage (bleeding into the brain.R94's quarterly review MDS dated 12/21/16, indicated R94 required extensive assistance for oral cares. The MDS lacked oral/dental status. R94's care plan dated 5/8/14, directed oral care after meals and follow up	F 411	R94□s Insurance Care Coordinator has been notified to make a referral for dental services and appointment has been made for dental services on June 13, 2016 which is the earliest that Delta Dental could obtain services. Ten other residents with the potential for needing dental services will be reviewed to see if dental referrals have been offered. If indicated, a referral will be made for dental services. The Resident Dental Services Policy has	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 411	Continued From page 30 dental visits as needed. An observation on 4/11/16, at 11:44 a.m. revealed R94 had multiple missing teeth, broken teeth and loose teeth. On 4/7/16, at 7:25 a.m., nursing assistant (NA)-D was interviewed and stated oral cares are performed once in morning. NA-D said R94 's gums would bleed with oral cares. NA-D further stated staff used toothettes (soft sponge like tooth brush) for oral care, but it usually took 2 caregivers as R94 would "swing" at staff. When R94 was asked, he stated his mouth hurt. On 4/7/17, 12:36 p.m. RN-A was interviewed and stated she was not able to find any documentation of oral assessments for R94 in the medical record since R94's admission in 2014. On 4/7/16,12:47 p.m. RN-D was interviewed and stated she was unable to recall when R94/family was offered dental appointment services. The facility Resident Dental Servicespolicy, dated 8/17/07, directed the facility to provide or obtain from an outside source, dental services to meet the needs of each resident.	F 411	been reviewed and revised. Staff was trained on the policy. Random Audits will be completed monthly by the Director of Nursing or designee to assure that oral/dental status has been addressed and a dental referral has been made if necessary. Monitoring will be completed at a consistent level, (monthly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible for compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 31 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper hand hygiene between glove changes. R8's Face Sheet identified diagnoses that included osteoarthritis. R8's significant change Minimum Data Set (MDS) dated 1/6/16, indicated	F 441	R8 has had no ill effects and remains at prior level of functioning. The Hand Washing Policy was reviewed and revised. Nursing Staff will be trained on Hand washing policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	04/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 32 R8 was moderately cognitively impaired. The MDS further indicated R8 was frequently incontinent and required assistance of one staff for toileting assistance. On 4/6/16, at 7:51 a.m. R8 was observed. Nursing assistant (NA)-H told R8 she was getting her up to the bathroom. At 7:54 a.m. N A-H told R8 she was going to wash R8's bottom. NA-H donned gloves and wiped R8's buttocks with a towel. NA-H entered R8's bathroom, removed her soiled gloves and donned new gloves. NA-H did not perform hand hygiene before applying a clean pair of gloves. NA-H continued to provide cares for R8. On 4/7/16, at 1:29 p.m.,the director of nursing (DON) was interviewed and stated it is expected that staff will perform hand hygiene when removing soiled gloves and donning clean gloves. The facility's Hand Washing policy, revised 4/29/10, directed hand hygiene was required before and after all personal cares are delivered to the resident, and after removal of gloves.	F 441	The Infection Preventionist or designee will complete daily audits of Nursing staff for compliance with infection control policies and procedures. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Infection Preventionist or designee will complete weekly audits of non-nursing staff for compliance with infection control policies and procedures. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Infection Preventionist is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Michael's Health and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000		

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

Electronically Signed | 04/29/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St Michael's Health and Rehab Center's is a one-story building constructed in 1967, that was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this inspection the building was inspected as a Type V(000), as one building, which meets the standard. The facility to include the original 1967 building and the two additions have a full basement. The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 open to the corridors. The facility has a capacity of 83 beds. At the time of the survey the census was 77. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 014 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2000 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient practice could effect all 40 of 77 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, it was observed that the facility has carpet applied to the corridor walls on both levels, within 12 inches of the floor. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on	K 014	Waivered tag: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 014	Continued From page 3 03/19/2013, and during the state agency inspection on 03/12/2014 and 02/10/2015. At the time of the inspection the facility had corrected this condition throughout the "C" wing, and has submitted an annual wavier dated 02/27/2015 stating that all of the carpeting would be removed in 2016, at the time of this inspection the removal has not been completed. This deficient practice was confirmed by the Maintenance Supervisor. Documentation supporting your request for a waiver of the life safety code (LSC) deficiency cited at K014 has been forwarded to the CMS Region V Office for their review and determination. Approval of the waiver request has been recommended.	K 014		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by	K 018		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 4 CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA Life Safety Code 101 2000 edition section 19.3.6.3.3. This deficient practice could affect 20 of 77 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, it was observed that the corridor door leading to the facility's kitchen on the main level has a kick down style of unapproved door hold open device attached to the door. The kick down style of door holds does not release the door upon a single push or pull action to close the door in the event of an emergency. This deficient practice was confirmed by the Maintenance Supervisor.	K 018	The Kick-down style door holder has been removed. An Audit of doors found three (3) other Kick-down style door holders on fire rated doors and they have been removed. The Director of Plant Operations is responsible to maintain compliance with the NFPA and Life Safety Code Standards.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 025	The penetration area in relation to the	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 5 facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA Life Safety Code 101 2000 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 77 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, observation revealed that there is a penetration found around a sprinkler pipe that is passing through the 1 hour smoke barrier above the ceiling tiles in the smoke barrier wall located in the chapel. This deficient practice was confirmed by the Maintenance Supervisor.	K 025	sprinker pipe near the Chapel and bundle of cables has been firestopped utilizing a listed caulk providing a fire resistance at least equivalent to that of the existing wall. The Director of Plant Operations is responsible to assure continued compliance by monitoring any future work that may cause penetrations and assure that they are properly firestopped.	
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous	K 029	The door on the dry storage on the lower level has been equipped with an approved Closer devise.	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 6 areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities of residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, observation revealed that the dry storage room on the lower level that is a combustible storage location that is greater than 100 square feet has a door that is not equipped with a self closing device at the time of the inspection. This deficient practice was confirmed by the Maintenance Supervisor.	K 029	An Audit of doors found no door out of compliance. The Director of Plant Operations is responsible to maintain compliance with the NFPA and Life Safety Code Standards.	
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to provided proper means of egress from the basement storage area under the "A" wing, in accordance with the NFPA Life Safety Code 101 2000 edition section 19-2-1. This deficient practice could effect all occupants as well as an undetermined number of staff, and visitors that would need to evacuate this area in	K 038	Waivered tag: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 7 an emergency. Note: residents are not allowed in this area. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, it was observed that the storage area in the basement, under the "A" wing, only has one exit. This area is approximately 7, 290 square feet in size. Rooms over 2,500 square feet require two remote exits. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on 03/19/2013, and during the state agency inspection on 03/12/2014 and 02/10/2015, and has been address through the issuance of an annual wavier for each inspection date. This deficient practice was confirmed by the Maintenance Supervisor. Documentation supporting your request for a waiver of the life safety code (LSC) deficiency cited at K038 has been forwarded to the CMS Region V Office for their review and determination. Approval of the waiver request has been recommended.	K 038		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent	K 050		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 8 persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2, during the last 12-month period. This deficient practice could affect 77 of 77 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had the following deficient conditions affecting the facility's fire drills: 1. The facility failed to vary the times of the fire drills by conducting 4 of 4 fire drills for the overnight shift in the 5 AM hour. 2. The facility failed to vary the times of the fire drills by conducting 4 of 4 fire drills for the evening shift in the 3 PM hour. This deficient practice was confirmed by the Maintenance Supervisor.	K 050	The FIRE DRILL PROCEDURE has been reviewed to assure that fire drill times will be varied. The Director of Plant Operations is responsible for assuring completion of the fire drills. The Administrator will audit the Fire Drill records to assure that the drill times are varied on each shift.	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 051		5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 9 A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to correctly install manually actuated alarm-initiating devices throughout the facility in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4.2 and 9.6.2, NFPA 72 National Fire Alarm Code (99), Sections 2-8.1 and 2-8.2, and the MN State Fire Code 907.3.3.1. This deficient condition could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces notification in the event of an emergency, thus negatively affecting 20 of 77 residents, as well as an undetermined number of staff, and visitors. .	K 051	K051 has been addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 10 Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, observation revealed that the Manual fire alarm boxes located in the main dining room and at the kitchen entry door that are 60 inches above the floor level which is higher than the maximum 54 inches as stated in NFPA 72 (99) This deficient practice was confirmed by the Maintenance Supervisor.	K 051		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect residents, as	K 056	The abandoned fire sprinkler head located in storage room 19-Z has been removed and replaced with a plug so that it does not interfere with the fire sprinkler head that is part of the facility□s complete fire sprinkler system that is tied to the facility□s fire alarm. A sprinkler head will be added to the	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 11 well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, observations reveled the following deficient conditions affecting the facility's fire sprinkler system: 1. There is a fire sprinkler head that is part of an abandoned domestic sprinkler system that is not tied to the fire alarm that is located in storage room 19-Z that is installed within 8 inches of a fire sprinkler head that is part of the facility's complete fire sprinkler system that is tied to the facility's fire alarm. 2. The alcove space that is located on the lower level across from the maintenance office is not protected by the facility's fire sprinkler system. This deficient practice was confirmed by the Maintenance Supervisor.	K 056	alcove space that is located on the lower leverl across for the maintenance office. An audit was completed of facility sprinkler heads and no other concerns were found. The Director of Plant Operations is responsible to maintain compliance with the NFPA and Life Safety Code Standards.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, that the facility has failed to install the facility's heating and ventilation in accordance with the NFPA Life Safety Code 101 2000 edition section 19-5.2.1	K 067	Waivered tag: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 12 and NFPA 90A 19.5.2.2. This deficient practice could effect all residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, it was observed and confirmed by interview, with the Director of Maintenance that there are corridors being used as a return air plenum in the "A & B" wings. This deficient practice was confirmed by the Maintenance Supervisor. Documentation supporting your request for a waiver of the life safety code (LSC) deficiency cited at K067 has been forwarded to the CMS Region V Office for their review and determination. Approval of the waiver request has been recommended.	K 067		
K 103 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install non-combustible framing, above the ceiling, in two locations in accordance with the NFPA Life Safety Code 101 2000 edition section 19.1.6.3. This deficient practice could effect 30 of the 77 residents as well as an undetermined number of staff, and visitors. Findings include:	K 103	Waivered tag: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 103	Continued From page 13 On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, it was observed that in two areas above the ceiling in tub rooms of "A & B" wings limited combustible framing material has been used. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on 03/19/2013, and during the state agency inspection on 03/12/2014 and 02/10/2015, and has been address through the issuance of an annual wavier for each inspection date. This deficient practice was confirmed by the Maintenance Supervisor. Documentation supporting your request for a waiver of the life safety code (LSC) deficiency cited at K103 has been forwarded to the CMS Region V Office for their review and determination. Approval of the waiver request has been recommended.	K 103		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect all residents, as well as an undetermined number of staff, and visitors.	K 147	All unapproved multiple plug adaptors will be removed. The extension Cord in the Board room was removed. The two power strips that were daisy chained together in the Rehab Office were removed.	5/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 14 Findings include: On facility tour between 11:00 AM and 3:00 PM on 04/05/2016, observations revealed the following deficient conditions: 1. There are an unapproved multiple plug adaptors found in all of the resident room that does not have a reset breaker on them, 2. There was a extension cord found in the board room, and 3. There were to power strips daisy chained in the rehab office.. This deficient practice was confirmed by the Maintenance Supervisor.	K 147	Training will be held with staff in regards to use of approved cords with reset breakers. Staff will also be trained to observe rooms so that family and residents are not bringing in unapproved cords or adapters. Safety Rounds are completed quarterly and unapproved devices will be removed if these inspections find any unapproved cords. A letter will be sent to Resident Responsible Parties that no extension cords are allowed. The Director of Plant Operations is responsible to maintain compliance with the NFPA and Life Safety Code Standards.	

Name of Facility

St. Michael's Health and Rehabilitation Center, Virginia, MN 55792 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
~~K014~~ K014	An annual/continuing waiver is being requested for K014 A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 4-19-13 for removing and replacing the carpet cove on the upper and lower floors is approximately $14000. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves. 2. Removal of the carpeting without replacement of some type of wall covering would make it aesthetically unappealing and could cause injury to residents due to rough surfaces. 3. The carpeting in the Large Dining Room and Lobby are to be replaced by the end of the 2016 calendar year. Gardens and Meadows wings and lower level is older and is due to be replaced before the end of calendar year 2017. The Foundation is currently attempting to raise funds for flooring but do not have adequate funds at this time. 4. The Minnesota Department of Public Safety, State Fire Marshall's Division has allowed installation of carpeting on walls up to a height of 12 inches when the building is fully sprinkled and the carpeting has a Class I rating, based on the Radiant Panel Test for carpeting. These conditions are met at this facility. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. 10. This annual/continuing waiver has been approved in the past. 4-29-16

	Title	Office	Date
Surveyor (Signature)	SUPERVISOR	STATE FIRE MARSHAL DIV	5-9-2016
Fire Authority Official (Signature)	Supervisor	State Fire Marshal Division	05-09-2016

Thomas Linhoff

Name of Facility 2000 CODE

St. Michael's Health and Rehabilitation Center, Virginia, MN 55792 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
~~K84~~ K038	An annual/continuing waiver is being requested for K038

A. Compliance with this provision will cause an unreasonable hardship because:
   1. The most recent cost estimate dated 4-8-13 for complying with a second means of egress from this wing is over $113,000.00. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves.
   2. There are concerns that penetrations of load bearing walls to install a second means of egress could adversely affect the structural integrity of the building.

B. There would be no adverse effect on the building occupants safety because:
   1. Residents do not have access to this area.
   2. Not more than two staff members occupy the area at any given time and then only for short periods of time (less than 15 minutes) to stock or retrieve supplies.
   3. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13.
   4. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system.
   5. The Building is equipped with corridor smoke detection.
   6. This area is equipped with smoke detection.
   7. The facility is smoke free and signs to that effect are prominently posted at all major entrances.
   8. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers).
   9. The building fire alarm system is monitored to provide automatic fire department notification.
   10. Fire Safety Training is provided for all employees annually and during orientation for all new hires.
   11. Fire Drills are conducted at least quarterly on each shift.
   12. The facility will decrease the combustible load of the space and monitor the area to keep combustible load reasonable for the storage space.

4-29-16

Surveyor (Signature)	Title	Office	Date
	SUPERVISOR	STATE FIRE MARSHAL	5-9-2016
Fire Authority Official (Signature)	Title	Office	Date
Thomas Linhoff	Supervisor	State Fire Marshal Division	05-09-2016

2000 CODE

Name of Facility

St. Michael's Health and Rehabilitation Center, Virginia, MN 55792 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
~~K64~~ K067	An annual/continuing waiver is being requested for K067 A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 4-10-13 for a complying ducted HVAC system is over $130000.00 excluding the required wiring. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves. 2. There are concerns that penetrations of load bearing walls to install required duct work could adversely affect the structural integrity of the building. 3. Installation of a ducted system may require asbestos abatement which would increase the costs. 4. LSC (00), Sec. 9.2.1 gives AHJ the authority to allow existing HVAC systems that do not comply with NFPA 90A to be continued in service. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. 10. This annual/continuing waiver has been approved in the past. 4-29-16

Surveyor *(Signature)*	Title	Office	Date
	SUPERVISOR	STATE FIRE MARSHAL	5-9-16
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff	Supervisor	State Fire Marshal Division	05-09-2016

Name of Facility

St. Michael's Health and Rehabilitation Center, Virginia, MN 55792 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
~~K84~~ K103	An annual/continuing waiver is being requested for K103. A. Compliance with this provision will cause an unreasonable hardship because: 1. The cost of removing the wood framing and replacing the ceilings at the Garden-Wing and Meadows-Wing tub rooms is estimated at roughly $10,000. 2. NFPA 101(00), Sec. 4.6.3 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical. St. Michael's Health & Rehab Center feels that it would be impractical to remove/replace the combustible wood framing at the ceilings because while not in literal compliance with the Code, the combustible wood framing at the ceilings does not represent a significant threat to the safety of the staff and residents and correction of this deficiency would cause the need for disproportionate effort, expense and disruption of services with little or no increase in life safety. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. 4/29/2016

Surveyor *(Signature)*	Title	Office	Date
	SUPERVISOR	STATE FIRE MARSHAL	5-9-2016
Fire Authority ~~Official~~ *(Signature)*	Title	Office	Date
Thomas Linhoff	Supervisor	State Fire Marshal Division	05-09-2016