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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6ZK5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245327**

2. STATE VENDOR OR MEDICAID NO. (L 2) **448415000**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE HEALTH CENTER**
(L4) **312 EAST GEORGE ST PO BOX 136**
(L5) **IVANHOE, MN** (L6) **56142**

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 **7/27/2016** (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) **09/30**

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

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 08/09/2016 (L19)
Christina Smith, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 08/09/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245327

August 9, 2016

Ms. Doris Derynck, Administrator
Divine Providence Health Center
312 East George St Po Box 136
Ivanhoe, MN 56142

Dear Ms. Derynck:

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 July 8, 2016 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 25 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
August 9, 2016

Ms. Doris Derynck, Administrator
Divine Providence Health Center
312 East George St PO Box 136
Ivanhoe, MN 56142

RE: Project Number S5327026

Dear Ms. Derynck:

On June 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 2, 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 June 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2016, effective July 8, 2016 and therefore remedies outlined in our letter to you dated June 30, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 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
245327 Y1	A. Building B. Wing Y2	7/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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 F0279	Correction	ID Prefix F0280	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25	Completed
LSC	07/08/2016	LSC	07/08/2016	LSC	07/08/2016
ID Prefix F0314	Correction	ID Prefix F0327	Correction	ID Prefix F0329	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(j)	Completed	Reg. # 483.25(l)	Completed
LSC	07/08/2016	LSC	07/08/2016	LSC	07/08/2016
ID Prefix F0334	Correction	ID Prefix F0425	Correction	ID Prefix F0441	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.65	Completed
LSC	07/08/2016	LSC	07/08/2016	LSC	07/08/2016
ID Prefix F0465	Correction	ID Prefix F0520	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. # 483.75(o)(1)	Completed	Reg. #	Completed
LSC	07/08/2016	LSC	07/08/2016	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) GPN/kfd	DATE 8/9/2016	SIGNATURE OF SURVEYOR 35567	DATE 7/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/9/2016

☐ 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

REVISED DOCUMENT

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245327	A. Building 01 - MAIN BUILDING 01 B. Wing	8/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 07/08/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 07/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 8/17/2016	SIGNATURE OF SURVEYOR 35482	DATE 8/2/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/9/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245327	A. Building 01 - MAIN BUILDING 01 B. Wing	8/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/30/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 07/01/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 8/9/2016	**SIGNATURE OF SURVEYOR** 35482	**DATE** 8/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/9/2016	☐ 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: 6ZK5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245327**

2. STATE VENDOR OR MEDICAID NO. (L 2) **448415000**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE HEALTH CENTER**
(L4) **312 EAST GEORGE ST PO BOX 136**
(L5) **IVANHOE, MN** (L6) **56142**

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 **06/09/2016** (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) **09/30**

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

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 07/11/2016 (L19)
Christina Smith, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 07/27/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 30, 2016

Ms. Mary Swanson, Administrator
Divine Providence Health Center
312 East George Street
PO Box 136
Ivanhoe, MN 56142

RE: Project Number S5327026

Dear Ms. Swanson:

On June 9, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 July 19, 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 July 19, 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your 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 September 9, 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 December 9, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
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Feel free to contact me if you have questions.

Sincerely,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		7/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2016

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

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a plan of care for treatment and prevention of chronic non-pressure and pressure related ulcers for 1 of 1 resident (R15) with multiple current ulcers on feet. Findings include: R15's care plan last revised 11/25/14 failed to identify R15's current pressure ulcers, risk for developing non-pressure and pressure related ulcers due to severe edema, refusal to wear socks and poor fitting shoes. R15's quarterly Minimum Date Set (MDS) dated 4/8/16 identified R15 had moderate cognitive impairment, was independent with walking, required supervision with dressing and required assistance with personal hygiene. The MDS further identified R15 was not at risk for pressure ulcers but had dressings to her feet and had diagnoses which included dementia, hypertension and anemia. . R15's care area assessment (CAA) dated 10/14/15 identified R15 had a decline in her condition overtime, had hypertension, swelling to her lower extremities, was unsteady and required limited assistance with walking. The CAA further identified R24 was at risk for pressure ulcers. On 6/08/16, at 9:22 a.m. R15 was asleep in her dining room chair. She had a black, rubber soled, Velcro closure slipper shoe on the floor and on her right foot. R15 had no sock or shoe on her	F 279	Corrective action as it applies to others: The policy and procedure of pressure ulcers was reviewed with all staff and will be reviewed with each new hire in their training. Immediate corrective action: The facility will be contracting with a wound care nurse to provide pressure ulcer staging wound care eduation for liscensed staff and CNA staff by August 30th, 2016. All staff will be updated on plan of correction and education plan on July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. On going documentation of any residents with presure ulcers. DON will audit on a weekly basis all documentaitn of residents with presure ulcers until resolved, then the audits will be completed on a bi-weekly basis. Minimal post resolved site monitoring will be documented on the body audit form. The DON will aduit the body audit forms weekly. The interdisciplinary team will review the care plans and audit updates 2 times weekly times 6, then 1 time weekly times six, then on a monthly basis to ensure accuracy of resident plan of care to confirm it reflects the current resident condition.	

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F 279	Continued From page 2 left foot, and both feet were grossly swollen and red. R15 woke up and walked slowly across the dining room. R15 walked more on her right side, her right slipper was worn down and misshapen and both feet spilled out over her shoes. On 6/08/16, at 7:00 p.m. registered nurse (RN)-A and two surveyors observed both R15's feet. After RN-A removed R15's socks from both feet she stated she had never seen R15's feet his bad before. R15's feet were both white from the antifungal powder from her toes to the top of both feet, there were no corn pads on R15's feet during observation. RN-A confirmed R15 had pressure areas on the outside of both of her great toes and little toes and numerous other impaired areas to R24's feet. RN-A confirmed all the broken blisters but stated she wasn't sure if the area on the outside of R15's right outer pinky toe was a broken blister or not because all of the surrounding skin had been rubbed off. RN-A stated open blisters were stage II pressure ulcers. R15 had an open area to her left pinky toe which measured 2.0 x 2.3 cm, with surrounding skin not intact, a 0.6 x 0.1 black scab to the top of her left 4th toe, and another 0.9 x 0.8 cm red area on the same toe, the tip of R15's left 3rd toe had a red area which measured 3.0 x 1.9 cm and her left great toe had an area of peeling skin which measured 1.5 x 2.0 cm. R15's right great toe had an area of peeling skin which measured 2.1 x 3.0 cm, her right 2nd toe had a crusty open 1.7 x 1.4 cm area and had a 4.0 x 2.1 cm area of peeling skin on the same toe, on the bottom of R15's right 4th toe was a 1.1 x 1.3 cm crusty area, on her right 5th pinky toe she had a 1.1 x 1.4 cm pink area characteristic of a popped blister with surrounding skin also rubbed off. RN-A stated they hadn't determined the cause of R15's	F 279	Recurrence will be prevented by: To contiune to educate the current staff and new hired staff on the policy and procedures with pressure ulcer staging wound care. Countinue to review procedure and policy at annual education; if any prodedure and policy changes are made; update all staff at the time of change prior to implication. Correction will be Monitored: Administrator and Director of Nursing	

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F 279	Continued From page 3 pressure ulcers yet and stated she felt the pressure ulcers were caused form R15's shoes over the last 2 months. She stated R15 walked using a walker and was supposed to elevate her legs to help with the swelling of her feet and they used corn pads as needed and anti-fungal powder between R15's toes. RN-A confirmed R15 had 4+ pitting edema to both feet and her shoes and socks were tight. RN-A then applied the same socks that were obviously too tight and short for her swollen feet and put R15's very same shoes back on which had just been identified as the cause for R15's pressure ulcers for the resident to ambulate to the dining room. On 6/09/16, at 11:35 a.m. director of nursing (DON) stated she expected a care plan to be developed after a pressure ulcer was identified which included assessment data and interventions. Review of the facility comprehensive resident care plan policy, undated identified each residents plan of care would be developed within 7 days after completion of the comprehensive assessment and prepared by the interdisciplinary team (physician, RN, Resident, Family or legal guardian, and other disciplines as determined by the residents needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		7/8/16

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F 280	Continued From page 4 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to review and revise the plan of care for 1 of 2 residents (R24) reviewed for hydration. Findings include: R24's care plan undated, was reviewed and only included the statement, "Diet as ordered: consistent carbohydrates" also "Monitor and record intake food/fluids." No mention of how much fluids will be divided between dietary for meals and for nursing (for medicaiton administration use) to prevent over hydration secondary to heart failure and history of fluid overload needing hospitalization. R24's diagnosis identified on the physician's Order Report dated 6/9/16 included edema, hypertension, heart failure and chronic kidney disease. The order report further identified R24	F 280	Corrective action as it applies to others: The policy and procedure of fuild intake was reviewed with all staff July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. Immediate corrective action: The Dietary Manager and dietary department will initiate and monitor the I/O forms. R24- I/O form initated immediatly. Will continued to be issued every 24 hours by charge nurse and dietary manager monitoring. IDT team will review any concerns on a weekly basis, and no more than a by weekly basis. Recurrence will be prevented by: The interdisciplinary team will review the care plans and audit updates 2 times	

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F 280	Continued From page 5 had orders for a "No Added Salt" diet and daily weights since hospital return on 5/26/16. R24's quarterly Minimum data Set (MDS) dated 5/15/16 identified R24 was cognitively intact, was independent with eating, was 64" tall, weighed 209 pounds, was not on a therapeutic diet and had no weight gain or loss. R24's care plan dated 5/1/16 identified R24 required set up assistance with eating and drinking, received a consistent carbohydrate diet and directed staff to monitor and record intake of food and fluids. R24's May and June 1 to 8, 2016 electronic medical record was revived and it lacked documentation of monitoring R24's daily fluid intake. R24's progress notes dated 6/1/16 completed by Certified dietary manager wrote they had a discussion on fluid consumed for the day. A plan was established to how much fluids was for meals, in between meals, with meds and it came to 2616 if totally consumed. A dietary diet order change form was completed for R24 to increase daily fluid consumption from 2500 to 1616 cubic centimeters (CC) per day. Review of R24's nursing assistant care sheet identified R24 was to have a large water mug and did not identify any fluid restrictions such as was agreed upon when the CDM interviewed the resident on 6/1/16. Review of R24's weights identified R24's current weight as of 6/6/16 was 195 pounds (#), down from 209# from most recent MDS dated 5/15/16.	F 280	weekly times 6, then 1 time weekly times six, then on a monthly basis to ensure accuracy of resident plan of care to confirm it reflects the current resident condition. Contiune to educate the current staff through staff meetings and in-service training. Educate the new hired staff in the new employee orientation. If any procedure and policy changes occur, the staff will be updated at the time of the change prior to implication. Correction will be monitored: Administrator and Director of Nursing Completion Date: July 12th, 2016.	

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F 280	Continued From page 6 On 6/7/16, at 12:07 p.m. R24 stated over the last 2 months she has woken up in the middle of night because she couldn't breathe good. R24 stated she didn't think the facility gave her her diuretic during that time because her leg was always swollen, and she had water around her heart when she went to the hospital last month. On 6/09/16, at 9:14 a.m. the dietary manager (DM) stated she wasn't sure why R24 had been hospitalized, but stated when R24 came back from the hospital on 5/26/16 she had orders for a 3500 ml's fluid restriction per day, low sodium, cardiac diet. DM stated then there was another order for a 2500 ml's fluid restriction per day, no added salt diet restriction. She stated R24 was on a 2500 ml's per day fluid restriction right now. DM confirmed R24's care plan and identified the fluid restriction was not indicated on R24's care plan. On 6/09/16, at 11:35 a.m. DON stated she expected the fluid restriction to be included in R24's care plan under dietary. Review of the facility comprehensive care plan policy, undated identified nursing staff would review and revise resident care plans monthly and as changes occurred.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		7/8/16

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to initiate dialysis interventions on admission to address fluid restriction, safety interventions in case of bleeding and monitoring fistula for patency for 1 of 1 resident (R32) receiving dialysis services for end stage renal disease. Findings include: R32's face sheet was reviewed and included admission on 5/31/16, indicated that the resident had a diagnosis of end stage renal disease. R32's physician order report, dated 5/31/16, indicated that the resident had been prescribed a renal diet. R32's Initial Care Plan no date of completion (this is the temporary care plan to follow until the comprehensive assessments and development of the comprehensive care plan is developed) stated that the resident had weekly dialysis on Mondays, Wednesdays and Fridays related to renal failure. Under Alteration in "FLUID VOLUME" it was checked for edema and monitor weight/edema. Under "NUTRITION" it was checked for cognitive impairment and reinforce diet restrictions however, there was no fluid restriction amount per day included. The temporary care plan also lacked any safety interventions which at a minimum would include management and care of fistula, and monitor for sign/symptoms of infection.	F 309	Corrective action as it applies to others: the policy and procedure for fulid intake and monitoring was reviewed on July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. Immediate corrective action: The facility now has a policy and procedure regarding the care of residents who receive dialysis services. The Dietary Manager and dietary staff will manage the intake and monitoring of fulid intake forms. The forms will be completed by all staff. The interdisciplinary team will review the plan of care, I/O forms, and audit updates 2 times weekly times 6, then 1 time weekly times six, then on a monthly basis to ensure accuracy of resident plan of care to confirm it reflects the current resident condition. Education of the new policy and prodcedures will be completed 1:1 by the director of nursing and/or administrator and again on July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. Recurrence will be prevented by: We will contiune to educate the current staff and any new hires on the dialysis services policy and procedures. This will	

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F 309	Continued From page 8 R32's progress notes, dated 5/31/16, indicated that the resident had a dialysis access site in her upper right chest. R32's progress notes, dated 6/3/16, indicated the facility had requested the dialysis clinic to advise on whether R32 was to be on any fluid restriction or not. R32's physician orders, dated 6/7/16 indicated that the resident was to be on a 32 ounce or 1000 cubic centimeter fluid restriction daily. During an observation of breakfast on 6/8/16 at 9:09 a.m., R32 was observed to be seated at the table. The resident had three cups in front of her. She had a cup of milk, apple juice and water. Nursing assistant (NA)-B stated that R32 was on a 32 oz. fluid restriction. The resident had drunk all three cups of liquid. Review of daily list of fluid dated 6/7/16 included, at breakfast to receive 4 ounces of water, and 4 ounces of apple juice (not a cup of milk). When interviewed on 6/8/16 at 12:32 p.m., registered nurse (RN)-A stated that the facility had not yet set up monitoring R32's fluid intake. When interviewed on 6/9/16 at 8:59 a.m., RN-B stated that the facility should have been monitoring R32's fluid intake since admission. She stated that the facility had to wait for orders. She stated that R32 had come with no orders from dialysis at all. She stated that the facility communicates with the dialysis clinic by fax or sending a note with R32. She stated that if there are any new orders from the clinic they would fax the facility and R32's primary care provider. She	F 309	be completed at new employee orientation and annual staff education. If any policy and procedure charges are made we will update all staff at the time of change prior to implication. The interdisciplinary team will review the care plans and audit updates 2 times weekly times 6, then 1 time weekly times six, then on a monthly basis to ensure accuracy of resident plan of care to confirm it reflects the current resident condition. Correction will be monitored: Administrator and Director of Nursing Completion Date: July 12th, 2016.	

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F 309	Continued From page 9	F 309		

stated that the staff were not checking for bleeding from the dialysis access site. She stated that the nurses were told by the dialysis clinic not to mess with the dialysis site as it is covered with gauze. She stated that if the site suddenly started bleeding then she would apply pressure and send the resident to the emergency department. She stated that coordinating care for emergency services in the event of bleeding from the access site should have been on the care plan.

When interviewed on 6/9/16 at 9:53 a.m., the director of nursing (DON) stated that the facility communicated with the dialysis clinic by fax. If there were to be any new orders then they would fax the facility and the primary care provider in order to coordinate care so there would be no overlap. The DON stated when R32 was admitted it was a mess trying to get her orders. She stated that she tried several times to get the orders from the assisted living where R32 had been residing. "Somewhere they dropped the ball on their end." She stated that the dialysis clinic wanted the staff to leave the dialysis access site alone as it was covered with gauze. She stated that all the nurses would know to apply pressure to the site if it started bleeding and then to send the resident to the emergency department. She acknowledged that the facility had not received any orders regarding fluid intake until 6/7/16 and that the facility had not been monitoring R32's fluid intake. The dietary manager was present for this interview. She stated that the facility should have been monitoring R32's fluid intake since admission. She stated that the dietary department should have been documenting fluid intake.

Policies and procedures regarding the care of residents who receive dialysis services were

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F 309	Continued From page 10 requested, however the facility stated they do not have any policies for this as they do not administer dialysis services in the facility.	F 309		
F 314 SS=G	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 record review, the facility failed to identify and treat current, recurring pressure ulcers for 1 of 1 resident (R15) which resulted in actual harm for R15. Findings include: R15 had been observed on 6/08/16, at 9:22 a.m. R15 was asleep in her dining room chair. She had a black, rubber soled, Velcro closure slipper shoe on the floor and on her right foot. R15 had no sock or shoe on her left foot, and both feet were grossly swollen and red. R15 woke up and walked slowly across the dining room. R15 walked more on her right side, her right slipper was worn down and misshapen and both feet spilled out over her shoes.	F 314	Corrective action as it applies to others: Policy and procedures for presure ulcers was reviewed with all staff on July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. and remains current with no changes. Immediate corrective action: The Direcotr of Nursing and the other department managrs were educated on the policy and procedure for and residents with presure ulcers 1:1 starting July 12th, 2016 and review again on July 19th or 21st general all staff mandatory meetings held at 10am and 2pm on both dates. with the respect of what a presure ulcer is and how it should be reported to the nursinh staff.	7/8/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 On 6/08/16, at 11:13 a.m. family member (FM)-A walked over to R15 at her dining room table and had an older, gray worn out pair of ankle-length socks in her hand. FM-A kneeled down under the table with the socks and told R15 to just be quiet and that she was going to wear those socks. She struggled to get the socks on as they were too tight and short for R15's swollen feet and didn't come up all the way to R15's ankle. FM-A stated, "Look here, you have a sore on your right foot too, those booties rub against toes." FM-A put R15's same slipper back on. On 6/08/16, at 7:00 p.m. registered nurse (RN)-A, and two surveyors observed both R15's feet. After RN-A removed R15's socks from both feet she stated she had never seen R15's feet his bad before. R15's feet were both white from the antifungal powder covering the toes to the top of both feet, there were no corn pads on R15's feet during this observation. RN-A confirmed R15 had pressure areas on the outside of both of her great toes and little toes and numerous other impaired areas to R24's feet. RN-A confirmed all the broken blisters but stated she wasn't sure if the area on the outside of R15's right outer pinky toe was a broken blister or not because all of the surrounding skin had been rubbed off. RN-A stated open blisters were stage II pressure ulcers. R15 had an open area to her left pinky toe which measured 2.0 x 2.3 centimeter (CM), with surrounding skin not intact, a 0.6 x 0.1 cm black scab to the top of her left 4th toe, and another 0.9 x 0.8 cm red area on the same toe, the tip of R15's left 3rd toe had a red area which measured 3.0 x 1.9 cm and her left great toe had an area of peeling skin which measured 1.5 x 2.0 cm. R15's right great toe had an area of peeling skin which measured 2.1 x 3.0 cm, her right 2nd toe had a	F 314	R-15 was reassessed and wound care documentation updated, family asked again to purchase new shoes but opted not to at this time. R-15 has discharged from faciliy. All the staff were educated on how to indentify and report any idecation of presure ulcers with any residents. Director of Nursing has contacted a certified wound care RN to join staff at this facility for bi-monthly or monthly skin checks with MDS review and care plan review to ensure accuracy and that all preventable measure are taken; also for wound care eduation for staff. Wound care inservice for the nursing department will be held August 2016. Recurrence will be prevented by: The Director of Nursing will audit the body audit forms weekly until issue is resolved and policy and procedures are hardwired with all staff. Certified wound care staff nurse will assess and audit all residents for skin concerns on a bi-monthly or monthly skin checks with MDS review and care plan review to ensure accuracy and that all preventable measure are taken; also for wound care eduation for staff. The IDT team will review all audit reports monthly at the quality assurance meetings. Correction will be monitored by: Administrator, the Director of Nursing and the IDT team Completion Date:	

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	245327	A. BUILDING _____ B. WING _____	06/09/2016

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F 314	Continued From page 12 crusty open 1.7 x 1.4 cm area and had a 4.0 x 2.1 cm area of peeling skin on the same toe, on the bottom of R15's right 4th toe was a 1.1 x 1.3 cm crusty area, on her right 5th pinky toe she had a 1.1 x 1.4 cm pink area characteristic of a popped blister with surrounding skin also rubbed off. RN-A stated they hadn't determined the cause of R15's pressure ulcers yet and stated she felt the pressure ulcers were caused form R15's shoes over the last 2 months. She stated R15 walked using a walker and was supposed to elevate her legs to help with the swelling of her feet and they used corn pads as needed and anti-fungal powder between R15's toes. RN-A confirmed R15 had 4+ pitting edema to both feet and her shoes and socks were tight. RN-A then applied the same socks that were visually too tight and short for her swollen feet and put R15's very same shoes back on which had just been identified as the cause for R15's pressure ulcers for the resident to ambulate to the dining room. R15's care plan last revised 11/25/14 failed to identify R15's current pressure ulcers, risk for developing pressure ulcers or problems with feet or shoes. R15's quarterly minimum set (MDS) dated 4/8/16 identified R15 had moderate cognitive impairment, was independent with walking, required supervision with dressing and required assistance with personal hygiene. The MDS further identified R15 was not at risk for pressure ulcers but had dressings to her feet and had diagnoses which included dementia, hypertension and anemia. . R15's care area assessment (CAA) dated 10/14/15 identified R15 had a decline in her	F 314	July 11th, 2016.	

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condition overtime, had hypertension, swelling to her lower extremities, was unsteady and required limited assistance with walking. The CAA further identified R24 was at risk for pressure ulcers.

R15's Braden Scale for prediction of pressure ulcer risk dated 4/14/16 identified occasional moisture, no mobility limitations, no skin problems and R15 was not at risk for pressure ulcers.

R15's Tissue Tolerance Test 6/9/16 did not identify any skin impairment and had no needs.

R15's weekly bath assessments were not completed weekly and did not identify any pressure related concerns, only swelling and scratches.

On 6/09/16, at 7:30 a.m. nursing assistant (NA)-B stated R15 had edema and problems off and on with her feet and stated she thought R15 had corns on the outside of her toes. She stated she did not do anything with R15's feet, but thought nursing used corn pads and antifungal spray on her feet. NA-B also stated R15 was supposed to elevate her feet. She stated she didn't know why R15 had problems with her feet and R15 had gotten new shoes over the past 1-2 months. NA-B stated she felt R15's feet did not get worse after she got new shoes.

On 6/09/16, at 7:45 a.m. NA-A stated R15 had always had some issues with her feet. NA-A stated R15 had blisters right now because of edema, sweat, not wearing socks, and not washing her feet and between her toes. NA-B stated there were no medical interventions for R15's feet. NA-B stated R15 always had edema and comfortable shoes were hard to find for her.

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F 314	Continued From page 14 She stated she felt these shoes seemed to be pretty good. On 6/09/16, at 7:54 a.m. registered nurse (RN)-B stated R15 was at risk for developing pressure ulcers. RN-B stated she didn't know what concerns R15 had with her feet and looked at R15's feet when she applied Band-Aid or antifungal spray. RN-B stated she looked at R15's feet today but couldn't remember what R15 had for skin concerns, and didn't know if R15 had any pressure areas or not. She stated R15 had never had blisters on her feet, but had bunions. RN-B stated R15 got new shoes 1-2 months ago and stated she didn't know if they caused pressure to R15's feet or not. RN-B stated R15 had different slippers before that were much softer. RN-B stated R15 couldn't wear shoes, and socks and shoes were hard to find for her because R15 had swollen feet. R15's socks and shoes didn't fit her right. RN-B stated anything that rubbed on R15's feet would be bad for her. RN-B confirmed R15's last skin assessment was done on 4/14/16 and indicated R15 was not at risk for pressure ulcers. She stated R15 had a history of swollen feet and they put the current shoes on her feet to prevent pressure ulcers. RN-B confirmed progress notes for R15 which identified blistering and open areas to R15's feet. She stated she would expect nurses to identify and stage pressure ulcers, and to call them what they are. She stated she considered blisters pressure ulcers and stated they could have developed from her shoes, sweaty feet and no socks. She stated over the last year they tried diabetic socks on R15 but because of her swelling they don't fit right and she didn't like them. RN-B stated she expected nursing to reassess R15 after identifying R15 had developed a pressure ulcer. RN-B confirmed	F 314		

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R15's care plan and stated there was nothing related to R15's risk for pressure ulcers, current pressure ulcers, shoes or feet. She stated the care plan did direct the nursing assistants to report any signs or symptoms of skin breakdown, but did not say who they were to report it to. She stated she would assume the NA's would report skin concerns to the nurse, and stated they were concerned awhile ago before we changed to R15's current shoes, but had not reported any issues with R15's current shoes or feet. RN-B confirmed R15 was wearing the very same slippers today as she had been wearing for the last 2 months which caused the pressure ulcers to R15's feet.

On 6/09/16, at 11:35 a.m. director of nursing (DON) stated she expected nurses to identify pressure ulcers and stated blisters were stage II pressure ulcers. She stated after a pressure ulcer(s) had been identified she expected nursing to reassess, determine interventions and monitor the pressure ulcer(s). She stated she expected a care plan to be developed after a pressure ulcer was identified which included assessment data and interventions.

On 6/10/16, at 12:43 p.m. DON stated their comprehensive skin assessment included weekly body audits on bath day, a tissue tolerance test and a Braden scale assessment. DON stated they also rely on NA's to report any skin concerns immediately to the nurse. DON stated RN-C fitted R15 for shoes and ordered them. DON stated she had not looked at R15's feet today but RN-C did this morning.
RN-C stated R15 used to wear canvas slip on shoes from Walmart. When she wore the canvas shoes her skin (from edema) were bulging over

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the shoes and they were too tight and didn't fit well. RN-C stated her family bought her the canvas shoes and they couldn't get them on her anymore because her feet were so swollen. RN-C continued to say that after the canvas shoes were noted to contribute to swelling, redness and pressure, I ordered her new shoes. RN-C stated after wearing the new shoes R15 had been having ongoing issues with her feet. RN-C stated R15 had problems with pressure from shoes in the past (shoes were exact same as current pair) because they had wore out. RN-C confirmed she ordered R15 the exact same pair again and podiatry agreed these were good for her. She stated podiatry didn't have any other resources for shoes that would fit her. RN-C said a big issue is that R15 doesn't wear socks. She stated she would need to have a good stretchy diabetic socks for her feet. RN-C stated they didn't have any diabetic socks at the facility right now and stated the pharmacy likely had some on hand and would order them today and receive tomorrow. RN-C stated she looked at R15's feet this morning and she had no open areas but had 2 bunions on each foot. She stated there had been an open area on her left foot and now the skin is coming off and had a red area to her right foot.. RN-C confirmed R15's only treatments for her feet were corn pads as needed on her toes and antifungal cream. DON confirmed resident had a history of blisters and pressure form her shoes. DON stated she did not know what the nurse practitioner did after she saw R15 on 6/4/16. She stated she would look for more documentation related to R15's toes and provide if she could find any.

Current physician's orders reviewed, 6/3/16 identified R15 had an order for as needed corn

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F 314	Continued From page 17 pad to left 5th lateral aspect to open blister/ulcer until healed and a small amount of anti-fungal powder between toes twice per day. Review of physician notes identified: -4/14/16 identified some edema of the legs, but no areas appeared tight or going to breakdown. -5/10/16 addressed only pulse and blood pressure medication. Review of nurse practitioner notes identified: -5/16/16 identified R15 had an ulcer on the left 5th toe on the lateral aspect measuring approximately 0.5 centimeter (cm) in diameter with a scant amount of sanguineous drainage. Opened blister surrounding ulcer area, scattered blisters on the bottoms of her toes on the right foot. New order to place protective pad to ulcer on the left lateral 5th toe, monitor daily and notify clinic if worsens. -6/4/16 identified R15 had an infection in toe a few months ago and had occasional blisters on her feet from rubbing on shoes. No new orders. Review of R15's progress notes identified: -3/25/16 4 millimeter (mm) diameter spongy white area left lateral little toe and had cottage cheese type discharge from tip of 3rd toe. See podiatrist next week. -3/30/16 saw podiatrist today, Keflex x 10 days, dressing change with Bactrim, Band-Aid to affected toes once daily. -3/31/16 power of attorney (POA) informed R15 of podiatry visit and that R15 needed new shoes. POA stated R15 likes the current style shoe she had and to order the same shoes again. -4/2/16 Band-Aid off left little toe, small open area with white center and pink perimeter. Right and third toe with pink open area, loose skin removed	F 314		

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and Band-Aid applied.
-4/4/16 new shoes ordered
-4/9/16 Antibiotics complete, new shoes came yesterday. R15 removed socks.
-5/10/16 R15 had bath today, no new skin issues noted.
-5/17/16 R15 had bath today, left leg quite swollen, 40 cm in circumference with 4+ pitting edema. Encouraged resident keep legs elevated. Also, she has an open bunion on the lateral side of her left foot. She also has a closed bunion on the medial side of her left foot and one on the bottom of her right foot at the base of the great toe.
-5/26/16 received communication from clinic R15 didn't meet criteria to be seen by NP regarding her feet and appointment made 6/3/16.
-6/3/16 nail care done by NP, order for corn pads for open blister left lateral little toe and antifungal between toes.
6/8/16-open area to left pinky toe 2.0 x 2.3 cm, surrounding skin also not intact, left top of 4th toe 0.6 x 0.1 black scab and 0.9 x 0.8 cm red area to same toe, tip of left 3rd toe 3.0 x 1.9 red area, left great toe medial aspect peeling skin 1.5 x 2.0, right great toe peeling skin on medial aspect 2.1 x 3.0, right toe #2 crusty open 1.7 x 1.4 area, lateral aspect of right 2nd toe 4.0 x 2.1 peeling area, bottom of right 4th toe 1.1 x 1.3 crusty area, right 5th pinky toe 1.1 x 1.4 pink area.

Review of the facility prevention of pressure ulcers policy, dated 9/16/07 identified based on a residents comprehensive assessment the facility ensured that a resident who entered the facility without pressure sores would not develop pressure sores unless they were unavoidable.

Review of the facility policy presence of pressure

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F 314	Continued From page 19 ulcers, dated 9/16/07 identified the facility would provide the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.	F 314		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor and evaluate fluid intake for 1 of 2 residents (R24) with a prescribed fluid restriction, to ensure sufficient fluid intake to maintain hydration. Findings include: R24's diagnosis identified on the physician's Order Report dated 6/9/16 included edema, hypertension, heart failure and chronic kidney disease. The order report further identified R24 had orders for a no added salt diet and daily weights since hospital return 5/26/16. R24's quarterly Minimum Data Set (MDS) dated 5/15/16 identified R24 was cognitively intact, was independent with eating, was 64" tall, weighed 209 pounds (#), was not on a therapeutic diet and had no weight gain or loss. R24's care plan dated 5/1/16 identified R24 required set up assistance with eating and drinking, received a consistent carbohydrate diet	F 327	Corrective action as it applies to others: The policy and procedure of fuild intake will be reviewed with all staff July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. Immediate corrective action: The Dietary Manager and charge nurse will initiate and monitor the I/O forms. R24-monitoring I/O form Q 24 hours with dietary manager and charge nurse. Education will be done at the upcoming staff meeting on July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. IDT team will review any concerns on a weekly basis, and no more than a by weekly basis. The facility has created a fluid restriction policy and procedures which will be finalized by July 12th, 2016. Director of nursing with 1:1 review and educate staff on policy and proceedure immediately and also at the mandatory general staff	7/8/16

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F 327	Continued From page 20 and directed staff to monitor and record intake of food and fluids. R24's electronic medical record was revived from May 1, 2016 to June 8, 2016, and lacked documentation of monitoring daily fluid intake. Review of R24's nursing assistant care sheet identified R24 was to have a large water mug and did not identify any fluid restrictions. Review of R24's dietary diet order change form dated 6/1/16 identified R24 was to get 2616 ml's a day versus the 2500 ml's restriction ordered on 5/26/16 by the doctor, and had no indications for recording or monitoring prescribed fluid intake. Review of R24's weights identified R24's current weight as of 6/6/16 was 195#, down from 209# from most recent MDS 5/15/16. On 6/7/16, at 12:07 p.m. R24 stated over the last 2 months she has woken up in the middle of night because she couldn't breathe good. R24 stated she didn't think the facility gave her her diuretic during that time because her leg was always swollen, and she had water around her heart when she went to the hospital last month. On 6/09/16, at 7:30 a.m. nursing assistant (NA-B) stated over the last couple of weeks they had been working on R24's diet since R24 had been in the hospital for congestive heart failure and breathing problems. NA-B stated she knew the Dr. had been considering a fluid restriction for R24, but stated she wasn't sure if she had one because there were so many fingers in the pot. NA-B confirmed R24 was currently retaining fluid.	F 327	meeting and survey follow up on July 19th and 21st with both meetings being offered @ 10am and 2pm. Recurrence will be prevented by: Contiune to educate the current staff through staff meetings and in-service training. Educate the new hired staff in the new employee orientation. If any procedure and policy changes occur, the staff will be updated at the time of the change prior to implication. Correction will be monitored: Administrator and Director of Nursing Completion Date: July 12th, 2016 with Policy and staff education 1:1 update/review. I/O form for R24 initated immediatly at this time.	

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On 6/09/16, at 7:45 a.m. NA-A stated R24 was on a special diet that started late last week or early this week. NA-A stated R24 was not on a specific fluid restriction. NA-A stated R24 had had problems with edema and had edema yesterday in her feet and stated she had not looked at R24's feet today yet.

On 6/09/16, at 7:54 a.m. registered nurse (RN-B) stated R24 was on a fluid restriction and dietary typed up a sheet that told them what fluid amounts R24 could have from nursing and dietary each day. RN-B stated she thought dietary was recording and monitoring R24's actual fluid intake. RN-B confirmed R24's meal intake record and percent of meal consumed was recorded, but did not identify fluid intake separately from fluid intake. RN-B stated nursing was not documenting R24's actual fluid intake. RN-B stated R24 was hospitalized last month for retaining fluid related to heart failure and had end-stage kidney disease. RN-B stated in the hospital they took about 10# of extra fluid off R24. RN-B stated she didn't know if R24's actual fluid intake was recorded, but stated it was not recorded anywhere that she knew it could be found.

On 6/09/16, at 9:12 a.m. dietary associate (DA-A) stated R24 was on a special diet, but stated he didn't know what the special diet was. DA-A stated they didn't record what R24 drank, only her overall meal intake (this included solids and fluids combined) percentage.

On 6/09/16, at 9:14 a.m. the dietary manager (DM) stated she wasn't sure why R24 had been hospitalized, but stated when R24 came back from the hospital on 5/26/16 she had orders for a 3500 ml's fluid restriction per day, low sodium,

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F 327	Continued From page 22 cardiac diet. The same day the fluid intake was reduced to 2500 ml's fluid restriction per day, no added salt diet restriction. She stated R24 was on a 2500 ml's per day fluid restriction right now. DM confirmed R24's care plan and identified the fluid restriction was not included on R24's comprehensive care plan. DM stated R24 had problems with edema in the past and wasn't sure if she had edema right now. She stated nursing was responsible for entering physician orders and R24's fluid restriction order was incorrect and should have been changed to the correct amount. DM stated dietary had not recorded R24's actual fluid intake, but stated it would make sense if they did at meals. DM stated nursing would need to record R24's water pass and supplement intake between meals to confirm R24's daily total fluid intake. DM stated there's a place for nursing to record fluid intake in the electronic medical record, and confirmed R24's fluid intake had not been recorded since 5/1/16. DM stated if nursing wasn't tracking, and dietary wasn't tracking R24's fluid intake there was no documenting or monitoring of R24's fluid restriction. On 6/09/16, at 11:35 a.m. DON stated she was not surprised nursing wasn't documenting R24's fluid intake in the electronic medical record, and stated she would expect them to accurately record, monitor fluid intake and document in the electronic medical record each shift. DON stated also expected the fluid restriction to be included in R24's care plan under dietary. A facility fluid restriction policy was requested, the administrator confirmed the facility did not have such a policy.	F 327		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		7/8/16

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F 329 SS=D	Continued From page 23 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a pulse rate was completed as ordered to monitor the effect of a cardiac medicaiton, also identify target behaviors to determine if antipsychotic is affective, and complete a comprehensive sleep assessment to determine if a sleep aide is affective to relieve insomnia for 1 of 4 residents (R27) and failed to monitor a cardiac medication	F 329	Corrective action as it applies to others: Immediate corrective action: Pulse and blood pressure checks daily initiated on resident R5 to her medication record for staff to check vitals prior to medication administration. Liscensed staff updated verbally in report per charge nurse of all digion medicaion	

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F 329	Continued From page 24 which causes low heart rate on a daily basis or receive a doctors order for not doing daily pulse rate for 1 of 4 residents (R5) who received daily digoxin. Findings include: R27's Physician Order Report revealed primary diagnoses of dementia with behavioral disturbance, hypertension (high blood pressure), and tachycardia (increased heart rate) with physician orders dated 5/3/16 to check pulse daily at supper, 5/4/16 Cardizem 180 mg extended release capsule daily, 5/6/16 Cardizem instant release 30 mg give two tablets give every six hours for tachycardia greater than 100 as needed, 4/29/16 Risperdal (antipsychotic medication) 2 mg daily daily for delusions/hallucinations, and 5/2/16 melatonin 2.5 mg give 2 capsules daily 7:00 p.m. - 9:00 p.m. for sleep. Vital sign documentation revealed R27's heart rate was obtained 21 of 39 opportunities from the date ordered of 5/3/16 through 6/9/16 even though the doctor ordered daily pulse at supper. R27's care plan dated 9/15/15 read, "Behavior-Resident at risk for wandering R/T [related to] diagnosis of dementia with deliriums" R27's care plan lacked identification of target behaviors. On 6/8/16 at 11:46 a.m. registered nurse (RN)-A stated, "We track if she is wandering because she is exit seeking at times. We will throw it in a progress note. I know in POC, the nursing assistants charting system, they also have a place where they document behaviors as well."	F 329	administration has to have a pulse and blood pressure check prior to administration. Care plan to reflect and identify target behaviors with interventions. R#27 did have a current sleep assessment completed in her record, one was not completed prior to starting Melotonin which the doctor had ordered for sleep even though nurses notes reflected resident sleep patterns and disturbances. Pharmacist educated on need to monitor and request assessments to review with monthly drug review. Providers educated on requesting sleep assessment and not only relying soly on progress notes in chart to determine sleep patterns and routine prior to ordering medications. Recurrence will be prevented by: Monthly pharmacy reviews. Nursing audits on medications records and care plan X 1 resident on a weekly basis @ IDT in conjunction with QAA. Correction will be monitored by: Director of nursing and or delagated RN, QAA committee, and Administrator.	

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F 329	Continued From page 25 On 6/8/16 at 12:44 p.m. the director of nursing (DON) stated, "They [nursing assistants] need to chart in POC [point of care] and the nurses should be doing a progress note." Adding "Wandering is the only behavior she [R27] has. When she first came in here she was hallucinating that was the reason she started the Risperdal. The Risperdal stopped the hallucinations. Last quarter we identified the only target behavior was wandering because the Risperdal is doing it's job." The DON reviewed target behavior documentation in POC. "If the MDS [minimum data set] questions cover them then we don't do anything more." On 6/8/16 at 4:22 p.m. DON stated, R27 did not have a sleep assessment completed when asked about the use of melatonin ordered by the physician. DON said the night nurses should be documenting on her sleep and for the most part R27 sleep would be discussed with the physician during rounds. On 6/9/16 at 10:14 a.m. the consultant pharmacist stated, "Yes, they should be tracking her sleep or making a notation if it has helped. They should contact the doctor to see if they want her to still have the [Cardizem] PRN [as needed]. My understanding was that she was put on the PRN until they knew the extended release [Cardizem] was working." Documentation regarding R27's sleep and target behaviors progress notes, and an assessment policy was requested but not provided. R5's Physician Order Report revealed a diagnosis	F 329		

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F 329	Continued From page 26 of atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating) with a physician order for Digoxin 0.125 mg 1 tab daily (cardiac medication used for treatment of atrial fibrillation). R5's physician orders did not specify when to obtain vital signs; including a heart rate. Review of R5's heart rate documentation revealed R5's heart rate was obtained 5 of 9 days in 6/2016, 15 of 31 days in 5/2016, 15 of 30 days in 4/2016, and 9 of 22 days reviewed for 3/216. On 6/8/16 at 5:23 p.m. the director of nursing (DON) stated, "Her doctor said we don't need to do the apical pulse anymore because she has been on it for so long. We have our weekly vitals we complete and he [R5's doctor] said that was ok." On 6/9/16 at 8:45 a.m. the Administrator stated, "I talked with [DON] and she said it was a verbal order that wasn't documented." On 6/9/16 at 10:12 a.m. the pharmacy consultant stated, "I thought they were doing vitals, I just assumed it was what the doctor said." Manufacturer recommendations for Digoxin included; "monitor and record their heart rate and blood pressure daily."	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the	F 334		7/8/16

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F 334	Continued From page 27 benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the	F 334		

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F 334	Continued From page 28 following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to document education had been provided prior to administering the influenza immunization for 3 of 5 residents (R6, R15, R21) and failed to offer the influenza immunization or provide documentation of decline, for an admission during the influenza season for 1 of 5 residents (R4) reviewed for influenza immunizations; in addition the facility failed to offer pneumococcal 23 (PPSV23) immunization to qualified residents. This had the potential to effect several of the 23 residents in the facility. Findings include: R6's influenza immunization was administered on 10/21/15. No documentation of education prior to	F 334	Corrective action as it applies to others: the facily the policy and procedures updated on or before July 18th, 2016 to include the items that we needed. Immediate corrective action: The facility updated the policy and procedure that include the following items: 1. Before offering the influenza immunization, each reasident, or the residents legal representative receives education regarding the benefits and potential side effects of the immunization. 2.Each resident is offered an influenza immunization October 1 -March 31 annually, unless the immunization is medically contraindicated or the resident	

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F 334	Continued From page 29 administration was found or provided. No documentation of administration or decline of PPSV23 was found or provided. R15's influenza immunization was adminsitered on 10/21/15. No documentation of education prior to administration was found or provided. No documentation of administration or decline of PPSV23 was found or provided. R21's influenza immunization was adminsitered on 10/21/15. No documentation of education prior to administration was found or provided. No documentation of administration or decline of PPSV23 was found or provided. R4 was admitted to the facility on 12/10/15. R4 did not have documentation adminsitration or decline of the influenza immunization for the 2015/2016 influenza season. No documentation of administration or decline of PPSV23 was found or provided. Centers for Disease Control's (CDC) Morbidity and Mortality Weekly Report dated 9/4/15 reads: "The Advisory Committee on Immunization Practices currently recommends that a dose of PCV13 [pneumococcal 13] be followed by a dose of PPSV23 [pneumococcal 23] in all adults 65 years and older..." On 6/9/16 at 8:22 a.m. the director of nursing (DON) stated regarding documentation of education provided; "I don't have documentation. This is how they have done it forever." At 9:09 a.m. the DON added, "Our medical director stopped in last week and informed us that we need to do it [use pneumococcal 23, PPSV23]. We are working on it." The DON verified the	F 334	has already been immunized durning this time period. 3. The resident or the resident's legal representative has the opportunity to refuse immunization. 4. The resident's medical record includes documentation that indicates the following items : a. That the residents or resident's legal representative was provided education regarding the benefits and potential side effects if the immunization. b. That the resident either received the immunization or did not receive the immunization due to medical contraindications or refusal. The policy and prodcures include both influenza and pneumococcal immunizations. The facility will track when letters are signed as acceptance of the policy, procdure and education for each resident. The staff will not administer until the signed accptance of the education and policy are signed by the resident or the legal representative for the resident. The facility will have the pneumococcal immunization to the reseidents by August 30th, 2016. The staff have been educated of the updated policy and procedures and documentation requirements on July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. Training will also in the new hire orientation and annual staff meetings for staff.	

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F 334	Continued From page 30 facility had not offered the PPSV23 to any of the residents. On 6/9/16 at 8:52 a.m. the adminstrator stated, "I was not aware of the new standards for pneumococcal." The DON provided a copy of the letter she mailed to families, dated 10/5/15 and read: "Dear Resident and/or Family Member, We are in the process of preparing for the flu vaccination season which runs October through March. To ensure understanding of the benefits and potential side effects of the immunization I have enclosed a copy of the Vaccination Information Statement for your review. Contradictions to the influenza vaccine include: Allergy to eggs or other components of the vaccine, e.g. Thimersol, Allergy to latex, Previous history of Gillian-Barre Syndrome, Allergy to Phenol (preservative). If you or your family member has one or more of the above contraindications, please notify nursing. We are encouraging all residents to become vaccinated with the Influenza Vaccine but we also give you the opportunity to refuse the vaccination. We will assume the at you are consenting to the vaccination unless you notify nursing prior to October 15th that you wish to refuse the vaccination. We will begin vaccinating residents October 15th. If you have any questions or wish to refuse the Influenza Vaccine please, call nurse's station or myself." Letter is signed by the DON. Facility Policy: Immunizations: Influenza and Pneumococcal revised 9-14-17 reads: "1. Divine Providence Health Center will provide education information to residents or their legal representative before offering the influenza	F 334	Recurrence will be prevented by: Contiune to educate new hires upon hire date in new employee orientation. Continue to review the policy and procedure at annual education. If any changes are made to the policy and procedure the staff will be updated at the time of change and prior to implication. IDT and DON will aduit the tracking system and documentaiton required for the immunizations. Correction will be monitored: Administrator, DON and IDT Completion Date: July 15th with policy/proceedure and letters to residents and family.	

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F 334	Continued From page 31 and/or Pneumococcal immunizations...2. Influenza Immunizations: a. Divine Providence Health Center will offer influenza immunization October 1 through March 31 annually to each resident unless the immunization is medically contraindicated or the resident has already been immunized during this time period....c. Documentation in the resident's medical record includes, at a minimum, that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization and that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. d. Documentation of the education provided and administration of the influenza immunization or reason for not administering the immunization will be completed on the resident's MAR [medication adminsitration record] and/or Influenza/Pneumococcal Immunization Assessment in Matrix [electronic medical record.]."	F 334		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		7/8/16

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F 425	Continued From page 32 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prime an insulin pen prior to administration for 1 of 1 resident (R24) who is insulin controlled diabetic; the facility failed to take a pulse prior to the administration of digoxin for 1 of 2 (R19) residents; the facility left 1 of 1 (R32) residents unattended with a medication. Findings include: LACK OF PRIMING INSULIN PEN: R24's face sheet, dated 5/26/16 (latest return), indicated that the resident had a diagnosis of type 2 diabetes mellitus. R24's physician order report, dated 2/1/16, indicated that the resident had an order for Humalog (a fast-acting insulin) Kwik pen solution; 100 units/mL to be administered subcutaneously per sliding scale (a way of administering varying increments of insulin based on a person's blood sugar). During an observation on 6/8/16 at 12:40 p.m., licensed practical nurse (LPN)-A prepared to administer insulin to R24. She stated that she had previously gotten a blood sugar reading of 253. LPN-A drew up 6 units of insulin based on the sliding scale. LPN-A then took R24 to her room	F 425	Corrective action as it applies to others: Policy and procedure for medication medication administration was reviewed on or by July 18th 2016 and remains current with no changes to policy and procedure. Immediate corrective action: All staff were educated on the medication administration policy and procedure on June 10th 2016, with reviewal on July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates. The facility created a policy and procedure on insulin needle and pen administration on June 10th, 2016. All staff were educated on the insulin needle/pen administration policy and procedure on June 10th, 2016. Recurrence will be prevented by : Audits of medication administration will be completed on a weekly basis X 1 at minimal per week with rotation of audits of all staff administering medciations.	

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F 425	Continued From page 33 and then proceeded to administer the 6 units of Humalog insulin. When interviewed on 6/8/16 at 1:04 p.m., licensed practical nurse (LPN)-A stated that the nursing staff at the facility did not prime insulin pens (a procedure intended to ensure a correct dose was to be administered) prior to administering insulin. Registered nurse (RN)-A who was also present for the interview stated that Humalog Kwik pens were not to be primed; only Levemir (a long-acting insulin) Kwik pen insulin were to be primed. RN-A stated that was the way the staff were doing it. When interviewed on 6/9/16 at 8:13 a.m., licensed practical nurse (LPN)-B stated that the facility did not prime insulin pens before administering insulin. She stated that the Kwik pens already primed automatically when insulin was drawn up. When interviewed on 6/9/16 at 8:43 a.m., the director of nursing (DON) stated that the nursing staff should be priming all insulin pens prior to administering insulin. She stated that she would have to initiate staff education on the administration of insulin pen administration. A copy was requested of the facility policy on administering insulin from a pen but was not provided. Review of the manufacturer's instructions for the Humalog KwikPen indicated that the Humalog insulin pen should be primed prior to each injection. It stated that priming the pen ensured the pen was ready to dose and it removed any air that may have collected in the cartridge during normal use. It also stated if the pen was not primed before each injection, the patient may get too much or too little insulin. LACK OF TAKING PULSE BEFORE	F 425	Correction will be monitored: Director of Nursing and or Administrator. Completion Date: July 15th, 2016.	

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F 425	Continued From page 34 ADMINISTERING DIGOXIN: R19's face sheet, dated 11/27/15, indicated that the resident had a diagnosis of hypertension and abdominal aortic aneurysm. R19's physician order report, dated 10/27/15, indicated that the physician had prescribed Digoxin (a drug which slows the heart rate) 125 mcg (micrograms) to be taken by mouth once daily. R19's medication administration record (MAR), reviewed from 6/1/16 through 6/8/16, indicated that the resident had been receiving this medication. During an observation on 6/8/16 at 10:07 a.m., licensed practical nurse (LPN)-A prepared R19's medications to administer. Included among R19's medications was the Digoxin. LPN-A then entered R19's room and introduced herself. LPN-A had brought a cup of water and R19 took all the medications two at a time. When interviewed after this exchange, LPN-A stated that the nursing staff did not take a pulse in the morning prior to administering her medications. Registered nurse (RN)-A who was present for the interview stated that R19 got a pulse taken weekly on her bath day. She stated, "We should probably be doing that," referring to taking a pulse prior to administering the digoxin daily. RN-A stated that she would hold digoxin if a resident's pulse was below 50. When interviewed on 6/9/16 at 8:43 a.m. the director of nursing (DON) stated that the facility did not have documentation that supported the fact that R19's physician had stated it was fine to only get weekly checks of her pulse. The DON	F 425		

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F 425	Continued From page 35	F 425		

stated that the nursing staff did not normally check the pulse prior to giving Digoxin. The doctor did not have any issues and was fine with just giving the Digoxin. "Its probably not best practice but that's the way it is."

LACK OF MONITORING MEDICATION CONSUMPTION:
R32's face sheet, dated 5/31/16, indicated that the resident had diagnoses of: Pick's disease (a form of progressive dementia), vascular dementia with behavioral disturbance and end stage renal (kidney) disease.

R32's physician order report, dated 6/2/16, indicated that the physician ordered Renvela (a medication used to treat kidney disease) 2400 mg (milligrams) to be taken by mouth in reconstituted form per packet instructions (added to water).

The resident was observed intermittently during supper on 6/8/16 from approximately 6:00 p.m. through 7:30 p.m. At 7:01 p.m., R32 was at the table with one other resident seated across from her. R32 was attempting to move away from the table in her wheelchair. In her hand was a cup of water with the reconstituted Renvela medication. At 7:38 p.m., R32 was at the table with the cup of water with reconstituted Renvela medication. The cup was approximately 3/4 full of reconstituted solution. The nurses station was located approximately ten feet away from the table. There were no nurses at the station, nor were there any within eyesight of R32 to monitor her. Two nurses were located in the medication room with the door closed. When interviewed about the Renvela medication in the cup of water, registered nurse (RN)-B stated that it was not routine practice to leave residents unattended with medications.

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F 425	Continued From page 36 Licensed practical nurse (LPN)-A then removed the cup with the Renvela from the table where R32 was seated. When interviewed on 6/8/16 at 7:42 p.m., registered nurse (RN)-A stated that it was not normal practice to leave medications unattended. She stated that a nurse should be present. When interviewed on 6/9/16 at 10:07 a.m., the director of nursing (DON) stated that it would not normally occur where the nursing staff would leave a resident unattended with medication. Policies and procedures for medication administration were requested but not provided.	F 425		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		7/8/16

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F 441	Continued From page 37 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 interview and document review, the facility failed TO develop an infection control program that included surveillance, tracking, and analyzing outbreaks of infection. In addition the facility failed to ensure laundry was handled to prevent the spread of infection. This had the potential to effect, staff, visitors, and all 23 residents residing in the facility. Findings include: Lack of analysis and surveillance of infections to prevent the spread of infection: On 6/8/16 at 3:40 p.m. the director of nursing (DON) was interviewed and indicated she was responsible for the infection control program, would trend different infections, and monitor the infections. She had a tracking and trending tool	F 441	Corrective action as it applies: QAA committee to further develop the infection control program with surveillance, tracking, and analzing outbreaks of infection in faciliy in conjunction with Maintenance and laundry department. Immediate corrective action: QAA committee to meet Thursday July 14th to review responsibliites, tracking form, and establish roles 3 deep in monitoring overall program in absences of committee members. A quality board with all information of QAA program will be on display for residents and staff. "3 deep" consists of #1- director of nursing, #2- administrator, #3 enviromental service manager. Tracking and surveillance forms	

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F 441	Continued From page 38 she would be using in the future, but currently did not have anything formally tracked currently. The DON identified that the facility needed a stronger system to track and trend. Adding, she was working the Quality Assurance committee to make a "3 deep" project so if someone is not there they can pick it up. Surveyor asked DON for a reproducible documentation in regards to the analysis of resident infections to determine if the analysis was effective to reduce the spread of infection was requested but none provided. Laundry: On 6/9/16 at 10:52 a.m. a laundry tour was conducted with Housekeeping (H)-A. H-A walked surveyor through the process of sorting laundry stating she wears gloves while sorting dirty laundry. "If we have infection control then we put clothes on [pointing to the personal protective equipment hanging on the wall]. We don't know what they have; they just tell us we need to gown up. At the end of the laundry tour H-A verified that she will only wear gloves to sort laundry, no other personal protective equipment. On 6/9/16 at 1:12 p.m. the housekeeping manager stated he would expect staff to both gown and glove for infection control. A facilty policy on the infection control program was requested but not provided. Facility policy Infectious Control Laundry/Housekeeping revised 2/3/10 reads: "...Procedures: All staff should be aware and follow general procedures for infection control. Staff should assume that all human and specified	F 441	will be reviewed with QAA committee with training and expectation of form completion. Facility staff will be educated on surveillance and tracking forms at a general staff meeting held July 19th and 21st @ 10am and 2pm both days. All staff is expected to attend. If an outbreak occurs, the charge nurse will notify all department managers and in their absence notify the employees that may come in contact with infectious materials. The direct floor staff will continue to bag linen as appropriate and the facily has ordered stickers to label the hazzardous bags for I.D. Laundry staff will DON and Duff PPE as appropriate. Recurrence will be prevented by the QAA committee will analyze all data for trend tracking on a weekly basis with Medical director present on a quarterly basis. Correction will be monitored by the Director of Nursing and Administrator with QAA committee also following up on a weekly basis. Correction completion date: July 15th, 2016	

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F 441	Continued From page 39 body are infected with infectious diseases. In addition to body fluids, all instruments, surfaces and materials that have been the potential to be contaminated with blood or other infectious materials should also be treated as if they are infectious. To provide proper protection against infectious diseases, staff must follow established guidelines for washing their hands and wearing protective clothing/equipment."	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide maintenance services and ongoing repairs to promote resident comfort and quality of life in regards to resident rooms numbered (3,12, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26) reviewed for environmental concerns. Findings include: On 6/09/16, at 1:30 PM a tour of the facility was completed with the maintenance manager (MM), who was also responsible for facility housekeeping and laundry services. In room 3, the recliner arm covers had large white stains on them, there was large paint chips and missing pain next to the bed against the wall and	F 465	Corrective action as it applys to others: Policy reviewed et updated per department manager and administrator. Immediate corrective action: Room 3 recliner arms with large white stains was removed from facily as resident was discharged. All of the bathroom sinks and toilet stains are being cleaned with a pummis stick which appears to be effective; housekeeping has intergrated this into their normal cleaning practices. All paint chips/scratches in the resident rooms and bathrooms will be repaired completely by August 1st 2016 per maintenance department with the Administrator doing a f/u audit to be completed by August 5th	7/8/16

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F 465	Continued From page 40 the toilet had black stains in the bowl drain exit. In room 12, the windows to the inside of the resident room were covered with debris. In room 15, the green heat register was chipped and scratched, the bathroom tile grout was dark brown and dirty, there was green lime scale on silver flush post, a green ring around the porcelain sink bowl and the hot water button was missing on the faucet and the bathroom wall was dirty and had missing paint. In room 16, the bathroom tile grout was dark brown and dirty, there was green lime scale on silver flush post, a green ring around the porcelain sink bowl and the hot water button was missing on the faucet, the bathroom wall was dirty and had missing paint and the windows to the inside of the resident room were dirty. In room 17, the toilet bowl drain exit was black, the base of the toilet was black, the grout and tile behind the toilet was dirty, the grout under the sink was dirty and both the hot and cold water buttons were missing on the faucet. In room 18, the wall behind the recliner was damaged and was missing paint, the closet door watch scratched , the toilet bowl drain exit was black, the base of the toilet was black, the grout and tile behind the toilet was dirty, the grout under the sink was dirty and both the hot and cold water buttons were missing on the faucet. In room 20, the bathroom wall had chipped paint, the back of the toilet was dirty, the tile and the grout was dirty under the sink and around the toilet, the bathroom walls had chipped paint and	F 465	2016 to ensure all painting needs were completed. Facility wide window washing will occur on a monthly basis with a checklist for monitoring and also as needed. Monthly check list includes washing of walls, dusting ceilings shelves and furniture, dusting of window blinds and washing of windows, moving furniture to sweep mop, cleaning sinks toilets with rust and lime remover (sink and toilet cleaning is also done daily per housekeeping staff). Hot and cold label buttons on the hot and cold sink handles were replaced upon surevy exit; department manager will replace as needed and housekeeping staff educated on reporting of any cosmetic or functional issues and concerns with in a timely manner (immediatly if effects resident care or places resident in harms way or within 24 hours). Stained areas noted on carpet in resident main dining room has been treated for spot removal and will continue on a monthly basis and at moment of spillage with monitoring completion per Enviromental Services manager. Audits will be performed by Enviromental services on a weekly to bi-weekly basis with QAA committe to reiew on a monthly basis. Correction will be monitored by Enviromental Services Manager and Administrator.	

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F 465	Continued From page 41 the door frames to the bathroom were chipped. In room 21, the wall by the recliner, the side of the bed and behind the headboard had chipped paint, the bathroom wall also had chipped paint, the back of the toilet was dirty, the tile and the grout was dirty under the sink and around the toilet, the bathroom walls had chipped paint and the door frames to the bathroom were chipped. In room 22, the bathroom sink had a green and brown ring around the inside of the porcelain bowl and had lime scale build up on the faucet and around the faucet handles. In room 23, the toilet seat was discolored in the back, the toilet bowl exit drain was black and the wall behind the toilet had chipped paint. In room 24, the toilet seat was discolored in the back, the toilet bowl exit drain was black and the wall behind the toilet had chipped paint. In room 25 the bathroom sink had a wide green ring around the porcelain inside of the bowl. In room 26, there was a stuffy, locker room type smell and the bathroom sink had a wide green ring around the porcelain inside of the bowl. There were also several extra large dark stains on the day area and the dining room carpet. On 06/07/16, at 10:32 a.m. R14 complained the windows had not been washed in the whole facility and stated he felt they had never been washed before. The windows appeared to be foggy.	F 465		

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F 465	Continued From page 42 On 6/07/16, at 11:12 a.m. R20 stated she had told staff last week that the windows need to be washed and she stated they told her they would check to see if they could find any volunteers to clean the windows. She stated she had told staff 3 different times about the dirty windows and stated she didn't know who was supposed to clean them. On 6/09/16, at 11:35 a.m. DON stated she expected the resident rooms to be free of chipped paint, lime scale, dirty toilets and sinks, dirty tiles and grout, and the facility to be cleaned every day. She stated she expected staff to fill out work orders for identified repairs and maintenance needs. On 6/09/16, at 1:12 p.m. MM stated maintenance was responsible for painting, removal of lime scale, maintaining sinks and toilets, cleaning facility owned resident recliners, cleaning carpets, maintaining the floors washing the windows and odor control. He stated resident rooms were repainted only when a resident is discharged. He stated he was aware that some of the resident rooms needed to be repainted or touched up, but hadn't painted or touched them up. MM confirmed some windows look bad because there was no gas left between widow pains causing discoloration and a foggy appearance on the windows. He stated there was no way to fix the windows and they would need to be replaced. He stated he hadn't brought up the need for window replacement to administrator. MM stated the bowls of the resident bathroom sinks were stained green and managed by a cleaning product. He stated there was no way to remove the stains or repair the damage to the bowls and they would need to be replaced. He stated	F 465		

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maintenance would have to take apart the flush posts and faucets to remove lime scale and water deposits that had built up over the years and replace the hot and cold identifier buttons on the faucet tops. He stated the floors and carpets in the facility were bad and cleaning the carpets, stripping and waxing the floors were on his list. He stated he wasn't sure of the last time the floors were done. He stated he expected resident rooms and common areas would be cleaned and maintained. He stated they have a paper work order system that staff can fill out a form and he collects them from the designated location in the morning when he collects trash at the nurses station. He stated there just wasn't a good system in place for maintaining the facility and he would need to start over. He also stated basically all the bathrooms needed to be redone.

On 6/9/16, at 2:20 p.m. during follow up interview MM stated he reviewed all facility work orders which had been completed and confirmed there were no work order requested for the environment concerns identified on our tour.

Review of the facility policy maintenance work order, dated 11/19/06 identified equipment used by residents were to be repaired and service provided within 24 hours or less to provide the best possible service.

Review of the policy common area cleaning, dated 2/2/10 identified all carpeted areas would be cleaned once per month or as needed and all tile floors would be cleaned on a weekly basis with a buffering every other week or as needed by maintenance. The policy also identified that housekeeping would look throughout the facility for possible repairs and report to maintenance.

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F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance and Assessment (QA&A) effectively sustained ongoing compliance related to repeat citations form past surveys in regards to unnecessary medications, which were identified during the recertification survey exited 8/12/15. This had the potential to effect several residents who received psychoactive medications.	F 520	Corrective Action as it applies to others: The policy and proceedure for the QAA is being developed by July 18th, 2016. Immediate Corrective Action: Action format developed by Administrator. QAA meeting with medical director held July 7th, 2016 to form a concreate plan of documentation and tracking tools for	7/8/16

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F 520	Continued From page 45 Findings include: During interview on 6/9/16 at 11:37 a.m. the director of nursing (DON) and administrator verified the QA&A met quarterly. The administrator stated would be starting an action plan format for the upcoming meeting scheduled 7/7/16. See F329: facility failed to ensure target behaviors were care planned for use of an antipsychotic medication, ensure a sleep assessment was completed prior to the initiation of sleep medication, and a heart rate was obtained daily per physician orders for the use of scheduled and as needed cardiac medication for 2 of 5 residents (R27, R5) reviewed for unnecessary medications. A memo was provided from the DON which read, "...Each meeting information and topic review consists of the following: QA dashboard. Report card. Risk management: Falls, medication errors, unusual occurrences, employee injuries; Human resources: staffing needs/goal met. Strategies to maintain full staffing with consistency. Infection control: HAI [hospital acquired infections], Employee infections, hand hygiene. Pharmacy: reviews, medication and dose reductions, ongoing monitoring. Nursing: any changes in flow, concerns, documentation. Behaviors. Routine MD [medical doctor] visits." A facility policy for the QA&A committee was requested but none provided.	F 520	measureable outcomes with forms being created for tracking and trending which will be completed by July 12th, 2016. Target behavior paper form is being devoloped by the Director of Nursing which will be completed on July 12th, 2016. July 19th and 21st general all staff mandatory meetings held at 10am and 2pm on both dates for staff education and training on proper completion of each audit for the QAA committe. Recurrance will be prevented by: Monthly QAA forms and data reviewed at monthly staff meetings per nursing department. If any changes to policy and proceedure, staff will be updated and educated on change prior to rolling out change of policy to staff. New hires will be provided education during their orientation process. Audit forms will be completed and reviewed within their specified time frames and followed up by the QAA committee to sustain solutions. Correction will be monitored by: Director of nursing and Administrator.	

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DIVINE PROVIDENCE HEALTH CENTER	**312 EAST GEORGE ST PO BOX 136** **IVANHOE, MN 56142**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 09, 2016. At the time of this survey, Divine Providence Health Center was found not to be 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2016

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
	245327	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/09/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto: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. Divine Providence Health Center is a one-story building, constructed in 1967. It has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an outpatient medical clinic and an assisted living facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching 90-minute fire-rated door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with battery-operated smoke alarms. The facility has a capacity of 25 beds and had a census of 23 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 050 SS=E	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 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: 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 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 FINDINGS INCLUDE: During Facility Inspection on June 09, 2016, between 10:30 AM and 12:30 PM, uring documentation review, it was revealed that fire drill documentation could not be located to indicate that a fire drill was conducted on 2nd shift (3pm-11pm) during the 4th quarter 2015	K 050	Corrective action as it applies to others: The policy and procedure of fire drills was reviewed with all staff on 6/15/16. Immediate corrective action: The schedule and documentation of the fire drills was reviewed with the management team. The documentation is located in the life safety code book and also scheduled on the calendars of the Administrator and the Maintenance Manager. Recurrence will be prevented by: Contiune to review the policy and procedure for fire drils at annual education. The Administrator and Maintenance Manager will aduit the doumentation of the fire drills on a monthly basis. Correction will be monitored by: Administrator and Maintenance Manager	7/8/16

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K 050	Continued From page 3 (Oct-Dec). These deficient practices were observed by the Maintenance Director.	K 050	Completion Date: June 30, 2016	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) FINDINGS INCLUDE: During Facility Inspection on June 09, 2016, between 10:00 AM and 6:30 PM, during documentation review, it was revealed that the cool down time was not being documented on the monthly generator test report. This deficient practice was observed by the Maintenance Director.	K 144	Corrective action as it applies to others: The policy and procedure of generators was reviewed with all staff on 6/22/16. Immediate corrective action: The schedule and documentation of the generators was reviewed with the management team. The documentation is located in the life safety code book and also scheduled on the calendars of the Administrator and the Maintenance Manager. Recurrence will be prevented by: Contiune to review the policy and procedure for generators at annual education. The Administrator and Maintenance Manager will aduit the doumentation of the geneators on a monthly basis. Correction will be monitored by: Administrator and Maintenance Manager Completion Date: July 1, 2016	7/8/16