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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7INF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00640

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245341**
2.STATE VENDOR OR MEDICAID NO.
(L2) **233847501**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HOSPITAL & NH**
(L4) **425 N ELM STREET**
(L5) **SAUK CENTRE, MN** (L6) **56378**

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 03/09/2012 (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	60			
(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):

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer the CMS 2567B for health. Effective February 14, 2012, the facility is certified for 60 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 03/20/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 03/20/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(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
Posted 4/4/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/23/2012
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5341 March 20, 2012

Mr. Delano Christianson, Administrator
St. Michael's Hospital & Nursing Home
425 North Elm Street
Sauk Centre, Minnesota 56378

Dear Mr. Christianson:

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

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

Effective February 14, 2011, the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900 , St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2012

Mr. Delano Christianson, Administrator
St. Michaels Hospital & Nursing Home
425 North Elm Street
Sauk Centre, Minnesota 56378

RE: Project Number S5341021

Dear Mr. Christianson:

On January 20, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 9, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 5, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 14, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2012, effective February 14, 2012 and therefore remedies outlined in our letter to you dated January 20, 2012, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245341	A. Building B. Wing	3/9/2012

Name of Facility	Street Address, City, State, Zip Code
ST MICHAELS HOSPITAL & NH	425 N ELM STREET SAUK CENTRE, MN 56378

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **01/06/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/14/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/14/2012**
ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **02/05/2012**	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** BF/cbl	**Date:** 03/20/2012	**Signature of Surveyor:** 10562	**Date:** 03/20/2012
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/5/2012

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: 7INF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00640

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245341**
2.STATE VENDOR OR MEDICAID NO.
(L2) **233847501**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HOSPITAL & NH**
(L4) **425 N ELM STREET**
(L5) **SAUK CENTRE, MN** (L6) **56378**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/05/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

At the time of the Standard survey, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post certification revisit to follow.

17. SURVEYOR SIGNATURE Date :
Timothy Rhonemus, HFE NEII 02/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/10/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(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
Posted 2/23/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8753

January 20, 2012

Mr. Delano Christianson, Administrator
St Michaels Hospital & Nursing Home
425 North Elm Street
Sauk Centre, Minnesota 56378

RE: Project Number S5341021

Dear Mr. Christianson:

On January 5, 2012, 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. 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;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 14, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 5, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 5, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

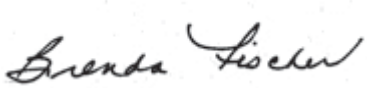
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HOSPITAL & NH	425 N ELM STREET SAUK CENTRE, MN 56378

(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. 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 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	Previous Action: On 10/20/11 a mandatory nurse meeting was held regarding R40. Meeting consisted of what needed to be reported regarding allegations of possible abuse. All RN/LPN's completed a mock report on line enabling any licensed staff to complete a report immediately. Prior to this session only DON/SS completed reports to agency. During this session new notification policy was also reviewed. Order of notification is as follows: 1. Contact Linda Strom, DON if unable to reach, 2. Contact Mary Waltzing, SS if unable to reach, 3. Contact Agnes Bearson, RN, ADON It will be the responsibility of person contacted to immediately notify the Administrator. Documentation of notification will be an incident report/VA report. 2/2/12 8:38 am T.C. Per Linda Strom DON authorized the changes on POC AA	1-6-12

2/2/12 AA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Christie — TITLE: Administrator — (X6) DATE: 1-27-12

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
	245341	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HOSPITAL & NH	425 N ELM STREET SAUK CENTRE, MN 56378

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all allegations of potential abuse and injuries of unknown source were immediately reported to the administrator and to the state agency for 2 of 15 residents (R40 & R54) in the sample reviewed for abuse. Findings include: R40 had an injury of unknown source which was not immediately reported to the administrator or state agency. R40 had diagnosis of dementia, hypertension and arthritis. The quarterly minimum data Set (MDS) dated 12/5/11, indicated R40 was cognitively impaired and needed extensive assistance with all areas of activities of daily living (ADL's). The facility submitted an online investigative report to the state agency on 10/17/11. The report indicated that at 6:00 a.m. on 10/15/11,	F 225	Each shift treatment nurse will review all incidnet reports with charge nurse. When there is no charge nurse the teratment nurse will review reports with team leader. Notation of reviews will be done on incident by nurse reviewing report. The nurse reviewing the incident report will be responsible to complete report to Agency as well as to initiate reporting to the Administrator. Education will be done to all nursing staff. DON will be responsible to review all incident reports to ensure that procedure is being followed. Reviews will be done Monday-Friday. Records of all reviewes will be kept and brought to monthly staff meetings as well as quarterly QA meeting.	

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F 225	Continued From page 2 staff had noted a large black area surrounding R40's left eye with reddened sclera. The report also indicated R40 was unable to state what happened. The facility's investigation further indicated the cause of the injury was unknown but felt it could have been from R40 "poked himself in the eye and then stabbed his eye. Resident does wear his watch to bed every night. The watch is on the left arm." At 3:00 p.m. on 1/4/12, the assistant director of nursing (ADON) stated she was aware of the incident with R40 and was aware the incident was not reported until 10/17/11. The ADON then stated "this incident happened over the weekend and the staff did not notify us until Monday, we had re-educated all the staff on 10/20/11 on reporting". The ADON verified that the facility did not report the incident to the state agency or notify the administrator until 10/17/11 when they were notified of the incident. R54 made allegations of abuse on 5/13/11 and was not reported to the facility administrator until 5/15/11 and the state agency was not notified until 5/16/11. R54's diagnoses included dementia, psychotic disorder with delusions and chronic back pain. His quarterly Minimum Data Set (MDS), dated 12/19/11, indicated he had physical and verbal behaviors as well as rejected cares 1-3 days out of the assessment period. He required extensive assistance with activities of daily living (ADL's). During interview at 2:35 p.m. on 1/3/11, R54's family member (FM)-A stated R54 had been held down in his wheel chair by a male staff member	F 225		

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F 225	Continued From page 3 in May 2011. FM-A stated R54's hands were scratched, bruised and R54 sustained a back injury due to the incident. FM-A indicated she had reported the incident to the facility, but there was no action completed by the facility. A letter dated 5/17/11 from the facility's director of nursing (DON) indicated that she had been notified of an incident involving R54 and NA-A on 5/15/11 and would report it to the state department the following day. An incident report to the state agency dated 5/16/11 (three days after the occurrence) indicated that on 5/13/11, an altercation between nursing assistant (NA)-A and R54 had occurred. An "investigative report" dated 5/19/11 indicated that NA-A was interviewed on 5/17/11. NA-A indicated he had responded to R54's room mates call light on 5/13/11 at 7:30 p.m., and as he was turning off the room mates call light, R54 punched him on the right side. R54 was swinging out at NA-A and NA-A held R54's right hand and left wrist telling R54 he would release him after R54 calmed down. NA-A reported the incident to an unnamed team leader. On 5/14/11 FM-A approached the unnamed charge nurse and asked what had happened to R54's hand. At this time the charge nurse noted bruising and a skin tear on R54's left hand. R54 told FM-A that NA-A was responsible for his injuries and FM-A reported this to the charge nurse. NA-A was instructed not to care for R54. On 5/15/11, FM-A again approached a charge nurse who held a family meeting and contacted the DON. NA-A was placed on administrative leave pending an investigation on 5/15/11.	F 225		

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F 225	Continued From page 4 During a phone interview with the facility's administrator at 11:44 a.m. on 1/5/12, he recalled being informed of the incident when the DON contacted him after she had been notified. This was on 5/15/11, two days after the incident and the incident was not reported to the state agency until 5-16-11, three days after the occurrence.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their abuse prevention policy regarding reporting alleged violations of abuse and injuries of unknown origin for 2 of 15 residents (R40 & R54). In addition, the facility abuse policy failed to address notifying the state agency immediately of allegations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of a resident's property. Findings include: The facility policy entitled "vulnerable adult" dated 2011 included under "reporting" "immediately ...within 24 hours if staff becomes aware of a situation that does not appear to require immediate police, emergency, or protective services." The policy further indicated under "procedure" the DON/designated staff	F 226	Policy manual will be revised to remove all areas that state within 24 hours. Policy will state all cases of allegations involving mistreatment, neglect or abuse will be reported to State Agency immediately. Revisions will also include new notification policy which is: 1. Contact Linda Strom, RN, DON, if unable to reach 2. Contact Mary Waltzing, SS, if unable to reach 3. Contact Agnes Bearson, RN, ADON It will be the responsibility of the person contacted to immediately notify the Administrator. Documentation of notification will be on the incident report/VA report. All staff will be educated on new policy. New hire orientation will consist of policy for all staff as well as hands on training of reporting online to State Agency for all licensed staff members. Refer to F225 for additional information	2-14-12

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F 226	Continued From page 5 were to report to the administrator immediately and "if not reported to MDH by nursing staff to complete report." During interview at 3:00 p.m. on 1/4/12, the assistant director of nursing (ADON) verified the policy does indicate the staff have up to 24 hours to report to the state agency and was not aware the policy needed to identify the state agency needed to be notified "immediately" and needed to change this in the policy. R40 had an injury of unknown origin, that was not reported to the administrator immediately as directed by the facility policy. Also the state agency was not notified immediately about R40's injury of unknown origin. R40 had diagnosis of dementia, hypertension and arthritis. The Quarterly minimum data set (MDS) dated 12/5/11 indicated R40 was cognitively impaired and needed extensive assistance with all areas of activities of daily living (ADL's). The facility's on line investigative report indicated that on 10/15/11 at 6:00 a.m., staff had noted a large black area surrounding R40's left eye with reddened sclera (white of the eye). The facility did not submit an online investigative report to the state agency until 10/17/11 (2 days after the occurrence). At 3:00 p.m. on 1/4/12 during interview the ADON stated she was aware of the incident with R40 and was aware that the incident was not reported until 10/17/11. The DON then stated "this incident happened over the weekend and the staff did not notify us until Monday, we had re-educated all the staff on 10/20/11 on	F 226		

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F 226	Continued From page 6 reporting". The ADON verified that the facility did not report the incident to the state agency or notify the administrator until 10/17/11 when they were notified of the incident. R54 made allegations of abuse and the facility did not notify the administrator as directed by the facility policy, also the state agency was not notified immediately about allegation of abuse. A letter dated 5/17/11 from the facility's director of nursing (DON) included she had been notified of an incident involving R54 and NA-A on 5/15/11 and would report it to the state department the following day. The incident had occurred 5/13/11. An incident report to the state agency dated 5/16/11 (3 days after) that indicated an altercation between nursing assistant (NA)-A and R54 had occurred on 5/13/11. An "investigative report" dated 5/19/11 included NA-A had reported an altercation to an unnamed team leader on 5/13/11. On 5/14/11 R54's family member (FM) -A had asked an unnamed charge nurse about bruising and a skin tear on R54's left hand. FM-A approached the charge nurse again later in the day and indicated R54 had accused NA-A of causing his injuries. On 5/15/11 FM-A again approached staff about the incident and the DON was notified at that time. During interview with the ADON at 7:45 a.m. on 1/5/12 she reviewed the incident report for R54 and verified the DON had not been notified of the incident until 5/15/11, even though the incident happened on 5/13/11. During a phone interview with the facility's	F 226		

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F 226	Continued From page 7 administrator at 11:44 p.m. on 1/5/12, he recalled being informed of the incident when the DON contacted him after she had been notified. This was on 5/15/11, two days after the incident. R54 received injuries from an altercation with NA-A on 5/13/11, this was not reported to the administrator until 5/15/11 and the state agency was not notified until 5/16/11.	F 226		
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. 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 document review, the facility failed to review and revise	F 280	A quarterly MDS was done with ARD of 1/15/12. Charge RN completed a new bowel and bladder assessment as well as updated Care Plan, Care Sheet, interdisciplinary notes.	1/26/12

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F 280	Continued From page 8 resident care plans for toileting needs for 1 of 3 residents (R15) in the sample who required assistance in toileting. Findings include: R15 had diagnoses of dementia, hypertonic (overactive) bladder, spinal stenosis of the lumbar spine and osteoarthritsis. The significant change Minimum Data Set (MDS) dated 10/25/11, indicated that R15 required extensive assistance of one staff for toileting. The Care Area Assessment (CAA) dated 10/19/11, indicted the following: "Is able to voice needs and requires help with toileting, needs assisted transfers hygiene, and clothing adjustment. Can have occasional urinary accident, has lasix (diuretic) usage with risk for urgency and her limited mobility is also a risk, wears a pull up for protection." During morning observations at 6:35 a.m. on 01/05/12, it was noted that R15 was already up, dressed for the day and sitting in her room. R15 stated she had been toileted about 20 minutes before. During interview, at this time nursing assistant (NA)-C stated R15 was toileted when she got up this morning and does tell staff when she needs to use the bathroom. R15 was toileted after breakfast at approximately 8:20 a.m. before she requested to lay down. At 9:05 a.m. on 01/05/2012, NA-D stated that they do not have a specific toileting schedule for R15 and stated "she is good in that way, she knows when she needs to go." The Bowel and Bladder Assessment Tool dated 10/20/11, indicated the toileting plan was the	F 280	2. Charge RN reviewed all current residents from most recent MDS. Updates were done as needed so all care plans, care sheets, interdisciplinary notes were the same. 3. New process will be developed to ensure continuity of information QA staff will now have read only access to MDS to review information already obtained. Meeting held with MDS/QA staff to review new procedure.	1/28/12 1/26/12

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F 280	Continued From page 9 following: assist to use toilet; upon arising, before and after meals, scheduled every 2 hours and provide assist to toilet as needed. The Interdisciplinary notes dated 10/20/11, indicated the plan of care was "continue to assist to the bathroom when resident requests, ask every two hours." The care plan last updated 11/22/11, indicted the following: "Please assist me as I request to the bathroom. Assist me with my pericares with elimination. I wear a panty-liner or pull-up for protection." The facility utilized two other forms which were part of R15's care plan: a nursing assistant (NA) care sheet by "Groups" that the NAs carried with them and a Resident Care Needs sheet, which were located in a pocket folder inside each resident closet door. R15's "Group 4" (dated 1-3-12) indicated that she "wears pull up". The Resident Care Needs sheet (dated 7-13-11) indicated that she was "continent". Neither form utilized by the nursing assistant indicated a frequency that R15 was to be offered toileting. At 9:30 a.m. on 01/05/12, the registered nurse (RN-A) verified that toileting frequency assessed on 10/20/11 did not match the care plan needed to be updated.	F 280	Bowel/bladder assessment forms will be changed to adopt better to MDS 3.0 Resident care needs list will also be changed to enable CNA's to know resident needs better. The new resident needs list will be brought to each care conference by responsible CNA so updates will be done in timely manner. CNA sheets will no longer have toileting needs on them. This will eliminate need to update two areas. Eduction of new procedure will be done to all nursing staff. 4. ADON will be responsible to ramdomly review one chart per week for 6 months, then will do 2 reviews per month times two months, then as needed. Results will be brought to PCC.	2-14-12
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	F 285	R14 was admited on 1/17/10 without Medicaid services. A DD Screening was completed. The case manager indicated no active treatment. Case management noted form Stearns County 3/9/10 indicated case management will not be provided per family request. Once MA was initiated in March 2011 the client received an ISP dated April 2011. A copy of the ISP dated April 2011 and	2/5/12

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F 285	Continued From page 10 A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.	F 285	December 2011 are currently in the R14. The ISP does not have an individual service plan but refers to the Nursing Home Care plan for complete list of goals and methods. The care plan for R14 indicates the ISP will be reviewed annually and will address individual resident needs appropriate for level of functioning. R38 was admitted to the facility on 2/11/09 Level 1 and Level 11 were completed and had a discrepancy. R38 had never been tested to determine the level of disability therefore does not have a recorded DX of MR in the state system per County caseworker. No further county involvement was indicated. R38 was dicharged to another SNF on 1/10/12 in another county. Per Stearns County they aremot able to alter the level 1 and level 11 documents. The attending physician for R38 would agree a diagnosis of learning disability or developmental delay may be more appropriate than an MR dx which is in her medical record since she was never tested. Since R38 was discharged she is no longer under the physician's primary care nothing will be done in this facility. The information regarding the discrepancy and possible suggestions were passed along to the facility social worker accepting R38. In the future St. Michael's Social Services will examine both the Level 1 and Level 11 PASRR documents for discrepancies and will address them as needed with the county and attending physician. Discrepancies will be addressed. Residents with Mental illness and Mental Retardation will have a copy of the ISP in the active chart and the Care Plan will correlate any recommendations from the ISP as it	

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F 285	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain an individual service plan (ISP) for 2 of 2 residents (R14 & R38) in the sample who were identified with mental retardation, in order to develop a plan to meet the identified active treatment needs. Findings include: R14 was admitted to the facility on 1/17/10 with a diagnosis of mild developmental disability. A Level I Preadmission Screening and Resident Review (PASRR) was completed on 1/15/10, which indicated the resident had a diagnosis of mental retardation or related condition and met criteria to have a Level II PASRR completed. The Level II PASRR was completed on 1/23/10, and noted the resident required active treatment. The Level II PASRR document directed that "The local agency assures that all active treatment needs have been specified in this person's Individual Support Plan (ISP) and will be met while this person resides in the nursing facility." When reviewed, the medical record did not contain the ISP plan from the local county agency. When interviewed at 9:15 a.m. on 1/5/12, the facility social worker (LSW) verified the medical record did not contain an ISP and stated the resident was not involved in any special active treatment, but was in many activity programs at the facility. She stated she would call the county to get the ISP. The LSW further stated that, because the ISP had not been available, it was not used to develop the plan of care and services for the resident. She stated that because R14	F 285	pertains to the individual plan of care. Social Services will coordinate the Care Plan as it relates to MI and MR residents with ISP's goals and methods on a quarterly basis. A report will be given to the QA team with resident's with receiving active treatment plans as identified by the ISP in the resident chart.	

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F 285	Continued From page 12 had been in the facility multiple times, the ISP may had been sent to them, but in a previous file. No further information was provided. When interviewed at 10:30 a.m. on 1/6/12, the LSW stated that she had spoken to the resident's case manager and he stated he felt the nursing facility's plan of care developed for the resident met all of the required active treatment needs. She provided a copy of a current ISP that was completed on 12/23/11, and faxed to her on 1/5/12 at 10:57 a.m.. She was unable to provide evidence that the nursing facility had ever received or inquired about the ISP since the resident's admission on 1/23/10, until 12/23/11 to indicate the facility had developed the plan of care to provide the active treatment needs as determined on the ISP. When interviewed (after survey exit) on 1/6/11 at 10:15 a.m., the resident's county case manager stated he was not the manager at the time of the resident's admission and could not explain why the facility did not have the ISP . He stated he had a copy of the facility's plan of care for the resident, and he "absolutely felt" it met all of her active treatment needs. R38 was admitted to the facility on 2/11/09 with a diagnosis of mild intellectual disabilities. When reviewed, the clinical record contained a Level I PASSR completed on 2/11/09 which indicated the resident had a diagnosis of mental retardation or a related condition and met the criteria to have a Level II PASSR completed. The Level II PASSR was completed on 2/13/09 and noted "This person does not have mental retardation, a related condition of mental illness." The PASSR	F 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HOSPITAL & NH	425 N ELM STREET SAUK CENTRE, MN 56378

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F 285	Continued From page 13 document directed that no further screening was required and the PASSR should be signed and forwarded to the facility to be filed. When interviewed at 10:57 a.m. on 1/5/12, the LSW was unable to explain the inconsistent information on the Level I and Level II PASSR reports. No information was provided to indicate the facility had ever contacted the county to get further clarification regarding the discrepancy. When interviewed at 10:15 a.m. on 1/6/11, a county case manager from R38's residing county was unable to explain the inconsistent information. He stated he could see from the computer notation that R38 had been "closed" because she did not qualify for services. He stated the case manager who had completed the form did not have the authority to change a diagnosis, and could have incorrectly completed the form. He indicated if the resident had a developmentally disabled diagnosis in place, the county should be reviewing the resident's needs annually.	F 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**01/05/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HOSPITAL & NH	**425 N ELM STREET** **SAUK CENTRE, MN 56378**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Michaels Nursing Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. St. Michaels Nursing Home is a 2 story building with no basement and is fully sprinklered. The building was constructed at 3 different times. The original building was constructed in 1973 and was determined to be of Type II(222) construction. In 1994, an addition was added to the east that was determined to be of Type II(111) construction. In 2008 the facility moved the 2 hr separation in the West wing adding 6 resident rooms to the Nursing Home. The addition was part of the original hospital constructed in 1949 and was determined to be of Type II (222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The resident room wardrobe closets are not sprinklered, but these closets have a small enough fuel load and are constructed in such a way that it would be impossible to provide proper	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**01/05/2012**

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K 000	Continued From page 1 coverage inside of them. There are sprinkler heads directly outside of each of the closets that could control a fire from within them. This meets the intent of CMS Regional Program Letter 93-19. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 58 at the time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building.	K 000		