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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8EZ1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00672

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245345**

2.STATE VENDOR OR MEDICAID NO.
(L2) **100182500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE**
(L4) **800 SECOND AVENUE NORTHWEST**
(L5) **PLAINVIEW, MN** (L6) **55964**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/11/2014** (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 **53** (L18)

13.Total Certified Beds **53** (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
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gary Nederhoff, Unit Supervisor — 02/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: MPM
Mark Meath, Enforcement Specialist — 04/23/2014 (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
09/01/1986
(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
03/18/2014
(L33)

DETERMINATION APPROVAL

CCN 24-5345

St Isidore Health Center of Greenwood Prairie was not in substantial compliance with Federal participation requirements at the time of the December 19, 2013 standard survey. February 3, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on February 11, 2014, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the December 19, 2013, effective January 28, 2014. Refer to the CMS-2567b for both health and life safety code.

Effective January 28, 2014, the facility is certified for 53 skilled nursing facility beds.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 26, 2014

Ms. Paula Lewis, Administrator
St Isidore Health Center Of Greenwood Prairie
800 Second Avenue Northwest
Plainview, MN 55964

RE: Project Number S5345023

Dear Ms. Lewis:

On January 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 11, 2014 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 December 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2013, effective January 28, 2014 and therefore remedies outlined in our letter to you dated January 16, 2014, 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,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245345	A. Building B. Wing	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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 **F0309** Reg. # **483.25** LSC	Correction Completed **01/28/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/28/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/28/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/28/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/28/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GN	02/26/2014	10160	02/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2013			

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 A. Building B. Wing	(Y3) Date of Revisit
245345	01 - MAIN BUILDING 01	2/11/2014

Name of Facility	Street Address, City, State, Zip Code
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	01/28/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	02/26/14	25822	02/11/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/18/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245345	A. Building B. Wing 02 - CHAPEL	2/11/2014

Name of Facility	Street Address, City, State, Zip Code
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	01/28/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	02/26/2014	10160	
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/18/2013

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: 8EZ1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00672

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245345**
2.STATE VENDOR OR MEDICAID NO.
(L2) **100182500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE**
(L4) **800 SECOND AVENUE NORTHWEST**
(L5) **PLAINVIEW, MN** (L6) **55964**

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 **12/19/2013** (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 **53** (L18)

13.Total Certified Beds **53** (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	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 01/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/18/2014 (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
09/01/1986
(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
03/18/2014
(L33)

DETERMINATION APPROVAL

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

CCN
24-5345

At the time of the Standard survey on December 19, 2013, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy
(Level E), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3902

January 16, 2014

Ms. Paula Lewis, Administrator
St Isidore Health Center Of Greenwood Prairie
800 Second Avenue Northwest
Plainview, Minnesota 55964

RE: Project Number S5345023

Dear Ms. Lewis:

On December 19, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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 55904-5506

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 January 28, 2014, 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 January 28, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 March 19, 2014 (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 June 19, 2014 (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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5345s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____ JAN 29 2014 MN Dept of Health Rochester	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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	The submission of this response and plan of correction is not to be construed as a legal admission that a deficiency exists or that this statement of deficiency was correctly cited. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility to the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Preparation and submission of this plan of correction has been done to comply with the requirements of state and federal law that mandate submission of a Plan of Correction within ten (10) days of the receipt of the statement of deficiencies as a condition of participation in Title 18 and Title 19 programs. The plan of correction is the facility's letter of credible allegation of compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a bruise for 1 of 3 residents (R36) and the facility failed to investigate, assess, and develop interventions to promote healing and prevent bruising from reoccurring for 1 of 3 residents (R6) reviewed for non-pressure related skin conditions. Findings include: R36 was observed on 12/16/13, at 3:50 p.m. to have a dark purple discolored area located on the	F 309	1/30/14 GPN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Klein | TITLE: Administrator | (X6) DATE: 1/20/2014

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.

Attachment 1

Regulation 483.25 Tag F309
Provide Care/Services for Highest Well-being

St. Isidore Health Center of Greenwood Prairie provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. A plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments.

The policies and procedures for reporting, investigating, and monitoring bruises and other skin lesions were reviewed and found appropriate. Facility policies require that the licensed nurses conduct a comprehensive skin audit at the time of admission, upon readmission from the hospital, and after falls and other incidents that put the resident at risk for injury. The nursing assistant bathing protocol includes observing and reporting open skin areas and bruises.

During the January 16, 2014 mandatory meetings, the licensed nurses were instructed on skin-related policies and procedures including 1) the procedures for investigating, documenting, and tracking bruises and 2) the need to mentor the nursing assistants to be alert to bruising and open areas and to appropriate reporting of findings to the licensed nurse. During the January 23, 2014 mandatory meetings, the certified nursing assistants were instructed to be observant for open skin lesions and bruises and to report findings to a licensed nurse in a timely manner.

Resident number 36 - The resident's skin was reassessed by a registered nurse. The bruise on the resident's temple has healed without complication. The January 10, 2014 registered nurse note indicated no temple tenderness when rubbing scalp or combing hair. The resident's skin-related plan of care was reviewed and found appropriate/updated.

Resident number 6 - The resident's skin was reassessed by a registered nurse including the discolored area on the resident's right hand. The cause of the bruise on the resident's was investigated by a licensed nurse and felt to be caused by the resident's hand-to-wrist orthotic used to prevent contractures and preserve functional range of motion. A physical therapy evaluation of the orthotic was requested. Occupational therapy has been working with the resident since admission and recently reeducated the staff on adjustment of the hand orthotic. The resident's related plan of care was reviewed and updated.

The resident has chronic skin discolorations/lesions related to frailty and has increased risk of bruising due to receiving aspirin on a daily basis. Routine skin assessments will continue; concerns will be reported to the attending physician. The care plan has been reviewed and updated.

Compliance will be monitored by the RN Clinical Manager/designee by conducting random skin audits for two weeks. If previously unreported bruises or other skin problems are observed, additional auditing and staff training/counseling will be done. The results of the audits will be reviewed during the January Quality Council meeting and ongoing.

Completion date: January 28, 2014

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JAN 29 2014
MN Dept of Health
Rochester

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F 309	Continued From page 1 skin of the right temple. The clinical record lacked documented evidence the discoloration had been identified, ongoing assessment for healing, and develop interventions based on a comprehensive assessment to prevent bruising from reoccurring. The annual Minimum Data Set dated 9/27/13, indicated R36 had diagnoses to include dementia, anxiety and heart disease. The MDS indicated R36 had severe cognitive impairment and a history of falls. R36's care plan dated 10/2/13 identified R36 as having a risk for bruising related to paper thin skin. The November 2013 nursing progress notes indicated on 11/29/13, R36 had sustained an unwitnessed fall. Although the progress note identified R36 had a bump on the right forehead and right side of head, the clinical record lacked documentation the bruise had been identified and the area monitored for healing without complications. On 12/19/13, at 9:25 a.m. the director of nursing (DON) verified the bruise located on the right temple of R36 and referred to R36's recent fall and confirmed R36 had bumped the right side of her head. DON verified the bruise from the fall had not been identified in R36's medical record. DON stated when a fall occurred which resulted in an injury, DON expected the nurse to "open a monitoring event" in the resident's clinical record to ensure monitoring of the injury was completed. DON verified the monitoring event had not been created nor was the bruise monitored. The Skin Risk Assessment policy dated 7/2013, directed staff to note and document the absence or presence of bruises.	F 309	**Please see attachment #1**	1/28/2014

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F 309	Continued From page 2 R6 had a bruise located on the right hand which had not been reported to licensed staff, assessed for causal factors, or interventions put in place to promote healing and prevent further bruising. R6 was observed on 12/16/13, at 6:05 p.m. to have a purple colored, quarter-sized bruise between the second finger and thumb on the right hand. R6 wore an orthotic device which covered the bruised area. R6 said he was not able to tell how and when the bruise happened. On 12/18/13, at 10:26 a.m. R6 was observed with the hand to wrist orthotic on the right hand. The bruise on the right hand was covered by the Velcro from the right hand orthotic. At the time of the observation, R6 stated the bruised area "hurt." The quarterly Minimum Data Set (MDS) dated 10/13/13, indicated R6's diagnoses included heart failure, hypertension, hyperlipidemia, aphasia, and hemiplegia of the right side. The Care Area Assessment (CAA) dated 1/13/13; identified R6's Braden score (a tool used to predict potential for skin breakdown) was 17, which indicated R6 was at risk for skin breakdown related to pressure. indicated R6's BIMS score was 11 which indicated R6 continued to have moderate cognitive impairment. The MDS indicated R6 required extensive assist with transfers of two staff, R6 did not walk, required a Hoyer lift (a mechanical lift) for transfers and R6 needed extensive assist of one staff with dressing. R6's physician's orders dated 12/19/13, indicated range of motion (ROM) was to be implemented before applying the orthotic in the morning. The	F 309		

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F 309	Continued From page 3 special instructions included staff were to have the orthotic on at night for about six hours and on during the day. The orthotic was to be off at meals and activities. The physician ' s orders also included medications that may cause bruising which include Coumadin and Aspirin daily. The plan of care dated 1/18/13, directed staff to apply the hand orthotic twice daily. The care plan identified R6 also had a foot brace and right arm brace. The care plan directed to observe the skin around the orthotic braces and during cares for redness or pressure areas, including bruises. On 12/18/13, at 10:41 a.m. registered nurse (RN)-A, licensed practical nurse (LPN)-C and DON were interviewed. RN-A, DON and LPN-C all verified they were not aware of the bruise and confirmed there was no monitoring event (electronic form for charting skin issues) or other charting completed concerning the bruise on R6's right hand. At the time of the interview, RN-A visually observed the bruise on the right hand between the thumb and the second finger and stated it did not look like an old bruise. RN-A loosened the orthotic and R6 stated it felt better now. At 10:45 a.m. LPN-C measured the bruise at 3.5 centimeter (cm) x 3.0 cm and stated the nursing assistants (NAs) applied the orthotic. The order was verified by LPN-C and RN-A stated they were not sure of the last time therapy had assessed the orthotic. RN-A and LPN-C stated the NA should have reported the bruise and a monitoring event form should have been started to monitor the bruise. A nurses' note written by LPN-C and after surveyor intervention on 12/18/13, at 11:17 a.m. indicated the bruise was noted on R6's right	F 309		

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F 309	Continued From page 4 hand, included the obtained measurements, identified R6 was on Coumadin, had thin skin and the strap on the orthotic hand brace may have been "too tight." LPN-C indicated staff would be instructed to make sure the strap was loose. A nurses' note written by RN-A after surveyor intervention on 12/19/13, at 8:28 a.m. noted R6's right hand orthotic was checked. RN-A noted the NA stated it was like an old bruise. On 12/19/13, at 8:35 a.m. DON stated she expected the NAs to report the bruise to the nurse. DON stated the nurse would then open a monitoring event in the clinical record. DON stated the nurse would also email the DON if the bruise was explainable or call the DON if it was not. The facility's Monitoring and Investigation of Incidents/Accidents policy dated 12/2011, directed nursing staff to record all incidents/accidents in the computerized medical record under "Events." The facility's Accident/Incident-unexplained injuries policy dated 2/2003, directed all bruises, skin tears, scratches and other injuries that were not the result of a specific event were to be reported to the nursing supervisor as soon as the injury was noted. The policy directed the licensed nurse would then evaluate the injury and interview the resident if appropriate. Details of the injury were to be documented in the resident's medical record and the care plan updated.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 5 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R28) was comprehensively assessed for safe use of side rails; failed to identify . Findings include: R28 was not comprehensively assessed for the safe use of half (½) side rail on the bed. R28's quarterly Minimum Data (MDS) dated 10/27/13, identified R28 was severely cognitively impaired, required extensive assist of one staff for bed mobility, transferring and ambulation; R28 had behaviors. Use of side rails was not triggered on the MDS. On 12/16/13, at 4:24 p.m. a one half-length side rail was observed on the right side of R28's low bed. The left side of the bed was pushed next to the wall. On 12/19/13, at 7:00 a.m. R28 was observed in the low bed sleeping on her back. The side rail was up and the bed remained next to the wall. At 7:30 a.m. R28 remained in bed sleeping and the side rail was up. R28's annual Assessment for Restraint/Adaptive Equipment--Side rails dated 7/23/13; identified	F 323	Please see attachment #2	1/28/2014

Attachment 2

483.25 (h)(1) Tag F323
Accidents and Supervision

St. Isidore Health Center of Greenwood Prairie staff ensure that the residents' environment remains safe and as free of accident hazards as possible. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues and implements procedures to prevent accidents and incidents.

The resident's use of and need for safety/enabling devices are assessed at admission and reassessed during the quarterly interdisciplinary care conferences and whenever there is a significant change in the resident's behavior, physical condition, and/or mental function. Side rails will only be used after a comprehensive assessment of the safety risks versus the benefits. The resident/family preference for side rail use will be taken into consideration during the assessment process. Education on the risks/ benefits will be provided to the family/resident as necessary.

The policies and procedures related to side rail use were reviewed and revised. An assessment of the appropriateness of side rails will continue to be done prior to use and a reassessment will be completed at least quarterly and with significant changes in condition. The safety of the side rail and the resident's ability to use the side rail to enable/improve independent bed mobility/transferring will be addressed in more detail. The resident's use of the side rail will be visualized as part of the assessment process. Side rail use will continue to be addressed in the resident's plan of care.

The policies and procedures related to investigation of the falls/incidents were reviewed and found appropriate. During the interdisciplinary team meetings Monday through Friday, the circumstances surrounding falls are reviewed, causal factors are investigated (need to toilet, pain, medication side effects, hunger/thirst, acute illnesses, etc.), the appropriateness and effectiveness of current safety interventions are reassessed, and the need for additional interventions is evaluated. The resident's care plan is modified as necessary to assure maximum safety and minimal risk of injury.

During the January 16, 2014 mandatory meetings, the licensed staff were instructed on 1) procedural changes including the need to address side rail safety/enablement during the assessment of the risks and benefits of assistive devices and 2) the need for comprehensive fall assessments which include a review of recent acute conditions that could be a contributing/causal factor of the fall.

During the January 23, 2013 mandatory meetings, the certified nursing assistants were instructed to be observant/cognizant of and report health changes and environmental factors that may increase of the risk of resident falls/injuries. The nursing assistants will also be instructed to be aware of and report any changes regarding the resident's use of rails to facilitate independent bed mobility/transferring.

Resident number 28 - The risks/benefits and safety of side rail use was comprehensively reassessed by a registered nurse. The resident was visualized using the rail to facilitate independent repositioning in bed and transferring from bed to chair. Since the resident does not exhibit behaviors or movement disorders that increase the risk of injury from rail use, use of assistive side rails on the side of the bed that is not against the wall will continue. The care plan has been reviewed and updated accordingly. Since the side rail does not meet the definition of a physical restraint, side rail use is appropriately not coded on the minimum data set (MDS).

Resident number 36 – The interdisciplinary team reinvestigated the resident's recent falls and the probability of recurring urinary tract infections being a contributing factor. The plan of care has been updated to include close monitoring of urinary symptoms and subsequent safety precautions. The direct care staff has been informed of the increased safety risks related to urinary tract infections and instructed to immediately report changes in bladder function/urinary-related symptoms to the charge nurse.

The safety/mobility risks and benefits of side rail use for current residents will be reassessed at the next care conference or sooner if there is a change in the resident's condition or circumstance that may impact the risks/benefits of rail use. The Clinical Manager/designee will monitor compliance by conducting random chart audits for the next four weeks to assure comprehensive assessments of the safety of side rail use and the investigation of acute conditions as a causal factor for falls. The results of the audits will be reviewed during the January Quality Council meeting and ongoing.

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F 323	Continued From page 6 R28 would use the top two half side rails. The medical symptom for use of the side rails was weakness and indicated the reason for the side rail was to assist R28 with transferring and bed mobility. The form indicated the risks and benefits were explained to R28 and their family on 7/28/13. The assessment did not address R28's safety and it did not include the alternative approaches attempted. A Quarterly Progress Note dated 10/27/13, indicated R28 "continues to use 2 upper half side rails for T&R [turning and repositioning]." On 12/18/13, at 9:57 a.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed regarding R28's use of side rail. Both indicated R28 had no incidents with the side rail and indicated every side rail was reviewed for resident safety, what they were used for and the appropriateness of the side rail. On 12/19/13, at 7:50 a.m. RN-A was interviewed regarding R28 ' s side rail assessment. RN-A stated staff goes in and checks for bed mobility, bed boundaries, or transfers. RN-A stated the assessment in the computer had not addressed safety and stated safety should have been added to the side rail assessment. RN-A stated the quarterly reviews were not changed unless there was a change in the resident. RN-A further verified nothing else had been documented in regards the safe use of the side rail for R28. Facility policy for Side Rail Usage dated 7/2013 indicated side rails were considered to be restraints and side rail use would be individually assessed for proper usage. The procedure directed, "Safety of the resident using side rails for bed mobility must be observed while the rails	F 323		

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F 323	Continued From page 7	F 323		

are in place." The procedure indicated nursing staff was expected to consider all alternative safety methods and care approaches before physical restraint was utilized, such as, but not limited to bolster pillows, floor bed mats, personal bed alarms, scheduled snacks and toileting, and adequate daily exercise.
R36 recurrent urinary tract infections (UTIs) were not identified as potential risk factor for falls.

R36's Current ICD-9 Diagnoses dated as printed 12/18/13 included chronic kidney disease with a history of urinary tract infections (UTI) and falls. Review of incident report documentation from 8/05/13, to 12/16/13, revealed R36 experienced falls on 8/5/13, 11/9/13, 11/24/13, 11/29/13, and 12/13/13. Of the five falls, three identified R36 had been treated for a UTI, and one identified R36 had been monitored for UTI symptoms.

The facility's "Fall Risk (Acuity)" assessment form dated 9/23/12 indicated R36 had a history of falls with risk factors that included incontinence. The assessment identified R36 as being at high risk for falls related to confusion and not always aware of safety.

The annual Minimum Data Set (MDS) dated 9/27/13, indicated R36 had a Brief Interview for Mental Status (BIMS, a tool used to determine cognitive loss) score of three out of 15, which indicated severe cognitive impairment. The MDS further indicated R36 required extensive assist of one staff for transfers and toileting, was frequently incontinent of urine and was not on a toileting program to manage urinary incontinence. The MDS identified R36 had experienced one fall with no injury since admission. The Care Area Assessment (CAA) identified R36 had been

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F 323	Continued From page 8 aware of the need to urinate and took self to the toilet. The care plan dated 10/2/13, identified R36 as being at high risk for falls however, did not include interventions based on history of previous falls which included R36 had UTIs at the time which may contribute to the falls and to prevent further falls and possible injuries. On 12/19/13, at 9:33 a.m. RN-A reported the fall precautions to include monitoring and interventions for UTIs were to be included on the care plan. RN-A verified R36's chronic UTIs had not been fully assessed in relation to R36 ' s fall history. On 12/19/13, at 9:35 a.m. the DON verified the fall risk documentation should have included chronic UTIs. DON verified R36 had been treated for and/or monitored for UTI symptoms which were present during four of the last five falls. The facility's Events/Accidents/Incidents policy dated 7/2013, identified the charge nurse was responsible for reviewing occurrences for risk factors and initiating appropriate interventions.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	Please see attachment #3	1/28/2014

Attachment 3

483.25(l) Tag F329
Unnecessary Drugs

St. Isidore Health Center of Greenwood Prairie staff ensures that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued.

St. Isidore Health Center of Greenwood Prairie staff ensures that 1) 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 2) residents who use antipsychotic drugs receive gradual dose reductions with attempts to manage behaviors using nonpharmacological interventions. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible.

The policies and procedures related to the administration of psychotropic medications were reviewed and found appropriate. Except in the event of resident behaviors that place them or others at high risk of injury/life threatening circumstances, initiation of PRN antipsychotic orders will be authorized by the Clinical Manager or Director of Nursing.

Use of the daily *Behavior Flowsheet* will continue. This tool is completed by the direct care staff and identifies target behaviors and tracks the frequency and the effectiveness of related medications for residents who receive antipsychotic and/or antianxiety medications.

Guidelines/parameters are developed when psychotropic medications are prescribed on an as needed (PRN) basis. At the time of the quarterly care conference and more often if needed, the resident's medications are reassessed by licensed nurses and the social worker. The medication type/dose and other related information are reviewed to assure that the record continues to reflect adequate indications for use, the consideration of dose reductions, and nonpharmacological interventions as appropriate. Psychotropic medication will continue to be reviewed monthly by the consultant pharmacist and during the routine 30/60 day visits by the attending physician/nurse practitioner.

During the January 16, 2014 mandatory meetings, the licensed nurses were instructed on behavior related policies and procedures including 1) the need to document the resident's target behaviors, nonpharmacological interventions, and the response to pharmacological and nonpharmacological interventions and 2) the need to follow the care plan and update the plan as needed.

During the January 23, 2014 mandatory meetings, the certified nursing assistants were instructed 1) to be observant for behaviors 2) to consistently use the *Behavior Flowsheet* to record the frequency of target behaviors, the interventions attempted to modify the behavior, and the effectiveness of the intervention and 3) on the necessity to report behaviors to the nurse.

Resident number 22 – The 101-year-old resident was admitted November 1, 2007 with a diagnosis of depression with an order for an antidepressant. On December 19, 2013, the progress notes from her attending physician state, "Patient has been on antidepressant medication, maintained her serotonin level for a number of years on Zoloft 50 mg daily . . . because of the current regulation, even though I feel this is totally wrong, will decrease her down to 25 mg and watch closely, because of her excellent cognitive status, for any changes. If patient does have any problem, will immediately take her back to the Zoloft 50 mg status . . . Approximately 30 minutes used with her on discussing the medication, discussing how the medicine works, discussing the patient's symptomatology. She is very hesitant to decrease but again was told we will watch closely. If patient can get by with 25 mg, this is excellent, but again, I am very hesitant to make changes as she is doing so well at 50 mg. Feeling adjusting the medicine with no side effects of concerns, just simply due to state regulation and not to symptomatology of the patient is not appropriate."

Two weeks after the dose reduction, the resident started to complain of insomnia with recurrent tearfulness and distressing thoughts related to past family issues. Subsequently, the physician increased the Zoloft back to 50 mg daily with Ativan .5 mg every night for thirty days to decrease the resident's anxiety until the maximum therapeutic effect of the increased Zoloft dose is reached. The resident's plan of care was reviewed and updated by the interdisciplinary team January 8, 2014. The resident's mood will continue to be monitored and the physician notified of changes if necessary.

Resident number 3 – The 90-year-old resident was admitted to the facility February 22, 2013. The July 18, 2013 notes from the psychiatric clinical nurse specialist indicate a chief compliant of "episodes of anxiety and fearfulness. Some reported visual hallucinations. She has not been eating right; poor appetite." According to the notes, the

resident stated, "What is that cat doing in here?" when no cat was present. Resident also asked the clinician, "Do you see that wine that is floating through the air? It kind of bends and twists in the air." The clinician further notes, "has had some outbursts of anxiety; demanding that staff leave the room . . . appears to be having more episodes of confusion . . . did appear anxious and had some difficulty engaging in conversation. She had a difficult time making eye contact. Seroquel 12.5 mg was increased from once per day to BID per Psychiatry recommendations."

The July 18, 2013 attending physician's note states, "Patient is quite confused today with flight of ideas, very agitated, patient at first wanted to leave the nursing home was redirected, sitting in a chair, felt that people around were talking about her, wanted to know what I wanted . . . I feel that this is a definite significant paranoia with her dementia, but also question a psychotic episode with this patient . . . Will increase patient's Seroquel for now to try and make patient more comfortable . . . Going through nursing records, patient has been quite agitated, it is very obvious that the Seroquel we have run at this low-dose is not causing any problems with sedation, and so will make a significant jump to see if this helps out with patient's paranoia and confusion." Another psychiatric consult was recommended.

The September 19, 2013 physician's note states, "Patient is quite anxious . . . will continue the Seroquel for her anxiety . . . Feel it would be wise to consider an increase on same as patient is definitely having a significant paranoia and agitation today. Will take the Seroquel up to 75 mg at bedtime. Will also add in a 50 mg every a.m. Will ask that the patient be given that now."

The November 20, 2013 attending physician's progress note states, "Most significant for anxious depression with features of psychoses and hallucinations. Hallucinations have responded nicely to dose adjustment of her sertraline and Seroquel, but it would be inappropriate to try dose reduction trials at this point, since symptoms have only been controlled for approximately 2 months. Since her September psychiatric medication changes and discontinuation of cardioactive medicines, the PRN Seroquel appears to have been rarely used . . . No dose reduction trials seem warranted. Medications are continued without an intended strategy change."

On December 20, 2013, the PRN Seroquel was discontinued. On January 13, 2014, the attending physician ordered routine Ativan 0.25 mg BID for increased anxiety exhibited by yelling, striking out, refusing cares, and attempting to leave the building.

The resident's target behaviors will continue to be monitored on a daily basis and reviewed periodically by a licensed nurse and quarterly by the interdisciplinary care team.

Any significant changes will be reported to the physician. The care plan was reviewed and updated.

Compliance with tracking target behaviors and monitoring effectiveness of interventions will be will monitored by the Director of Nursing and Clinical Manager by random record reviews for the month. If noncompliance is noted, additional tracking and staff training will be done. The Director of Nursing and Consultant Pharmacist will monitor the physician's justification for not tapering medications to assure regulatory compliance. Physician education will be done as necessary. The results of the audits will be reviewed during the January Quality Council meeting and ongoing.

Completion Date: January 28, 2014

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	245345	A. BUILDING _____ B. WING _____	12/19/2013

JAN 2 0 2014
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9 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: Surveyor: Lageson, Jennifer Based on observation, interview and document review, the facility failed to attempt to taper a psychotropic medication or provide a physician ' s justification as to why an attempt to taper was contraindicated at this time for 1 of 5 resident (R22) reviewed for unnecessary medication use and the facility failed to identify parameters for use of an as needed antipsychotic medication for 1 of 5 residents (R22, R3) reviewed for unnecessary medications. Findings include: R22's Zoloft (antidepressant) did not have a reduction attempt since 12/20/12. A review of R22's care plan dated 10/2/2013 indicated R22's diagnoses included history of insomnia, depressive disorder and congestive heart failure. The care plan indicated, "resident has alterations in moods; sad, worried facial expressions r/t dx of depression. Interventions:	F 329		

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F 329	Continued From page 10 included monitor adverse side effects, administer Zoloft as ordered, failed taper of Zoloft 11/2008-returned to 50 mg dose and failed. Dose increased to 75 mg daily 1/27/2011-effective dose." Review of the documentation in progress notes for R22's mood monitoring from 3/25/13, through 11/4/13, noted R22 to have minimal depression according to the PHQ9 score, and was social with no mood behaviors identified. Review of the pharmacist's recommendation to the physician dated 11/26/13, indicated R22's Zoloft (antidepressant) was decreased from 75 milligrams (mg) to 50 mg in 12/20/12, was successful. The note identified R22 required an annual assessment for another possible gradual dose reduction (GDR) attempt at that time. The physician response regarding the GDR was dated 12/9/13, and read, "Considered with RN [registered nurse] and patient [R22] in November. Deferred til Spring 2014." The clinical record lacked evidence a clinical rational was documented why a GDR of the antidepressant was contraindicated. On 12/18/13, at 10:00 a.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed regarding R22's lack of a gradual dose reduction (GDR) in Zoloft (antidepressant) medication since 12/12. RN-A stated the GDR was not considered because of mood changes seasonally and R22's tendency to get moody and depressed during different times of year. RN-A stated R22 had sleeping problems relating to a family issue and the resident did not want a dose reduction when the physician made a note of it on 11/20/2013. RN-A further stated R22 also had a room change a couple of months ago. RN-A stated this information was not documented related to the continued use and effectiveness of	F 329		

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F 329	Continued From page 11 the antidepressant. On 12/19/13, at 11:00 a.m. RN-A provided a physician's order dated 12/19/13, that showed a decrease to 25 mg in the R22's Zoloft medication. (This occurred after surveyor discussion regarding lack of GDR and justification). RN-An agreed the clinical justification identified on the pharmacy recommendation dated 11/26/13, was not specific enough. RN-A also stated any issues she knew about R22 should have been documented (seasonal mood swings, issues with family, and room change) in relation to the antidepressant use. R3 did not have parameters for use of a prn (as necessary) antipsychotic medication (Seroquel) and did not have developed individual specific target behaviors or individualized behavioral interventions for scheduled Seroquel. R3's Physician Order Report dated 12/18/13 indicated R3 had diagnoses to include dementia, symptom hallucinations, anxiety state, debility, and depressive disorder. The quarterly MDS on 11/24/13 indicated R3 continued to have severe cognitive loss; R3 had delusions, physical behavioral symptoms directed toward others 1 - 3 days, verbal behavioral symptoms directed toward others 4-6 days and other behavioral symptoms not directed toward others 4-6 days with rejection of care 4-6 days, but less than every day. On 12/19/13, at 7:34 a.m. R3 was observed to be in her wheelchair in her room with her call light within reach. Her eyes were closed. At 7:41 a.m. R3 began mumbling help me. RN-B came to R3's room at 7:44 a.m. to see what resident wanted. This scenario was repeated again within 14	F 329		

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F 329	Continued From page 12 minutes after nurse left. On 12/19/13, at 7:49 a.m. RN-B stated R3 was usually more anxious in the evenings and her morning anxiety had increased over the last couple of weeks. RN-B stated she had just given R3 the scheduled Seroquel and stated in an hour R3 would be calmer. At 7:55 a.m. R3 was heard to start yelling "help me" louder. RN-B stated she thought R3 may be needed to go to the bathroom. R3 was then taken to the bathroom and then taken to the dining room where she was observed to sit quietly at the table. The care plan dated 12/02/13 indicated R3 received antidepressant medication related to depression diagnosis and chronic pain may impact R3. The goal was that R3's use of medication will result in improvement in the resident's functional status as evidenced by: participating with her ADL's and decreased complaints of discomfort. The interventions included to administer medication as ordered and observe effects of Zoloft and Seroquel. The care plan directed to attempt non-pharmacological intervention such as: music, visiting with others, food, change in position, and toilet use. The care plan directed to monitor R3's mood and response to medication, include consultant pharmacy and RN review, provide educational material to resident/family and answer questions as they arise. A hand written statement dated 4/24/13, added to the end of the care plan, identified R3's diagnosis of hallucinations/paranoid/delusional. The care plan identified R3 used Seroquel. Physician ' s orders indicated on 4/24/13, to offer Seroquel 12.5 milligrams (mg) every day at bedtime. This was increased on 5/28/13. On	F 329		

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F 329	Continued From page 13 7/18/13 Seroquel 25 mg was ordered prn (as needed) every six hours for hallucinations/paranoia/agitation/delirium; in addition, R3 was offered scheduled Seroquel 75 mg at bedtime and 50 mg every morning. R3 also was offered Zoloft (an antidepressant) 125 mg every morning. Resident R3 received prn Seroquel 25 mg on the following dates: - On 9/26/13, at 3:15 p.m. for agitated behavior. A nurse ' s note for the same date and time indicated R3 was calling out and swinging at invisible things and was unable to be redirected with orientation to surroundings. No non-pharmacological charting was noted on other interventions used prior to giving the prn Seroquel. There was no documentation on the effectiveness of the prn medication. - On 9/28/13, at 3:44 a.m. for agitated and restless behavior. No documentation was noted regarding use of non-pharmacological interventions tried before giving the prn Seroquel or the effects of the prn given. - On 10/17/13, at 11:57 p.m. for restlessness and hollering out. There was no documentation regarding symptoms displayed or non-pharmacological interventions used prior to giving the prn Seroquel or the effectiveness of the prn given. - On 10/20/13, at 9:52 a.m. for hallucinations, agitation. A nurse's note for the same date and time indicated R3 refused medications in the morning and refused to eat breakfast. Staff documented they were able to get R3 to take her scheduled Seroquel and the prn dose. The note indicated R3's agitation improved, but was beginning to get worse again. No documentation regarding symptoms displayed or	F 329		

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F 329	Continued From page 14 non-pharmacological interventions used prior to prn dose were noted. - On 11/10/13, at 3:06 p.m. for agitation. No documentation regarding symptoms displayed or non-pharmacological interventions used prior to prn dose and no effectiveness of the prn were documented. - On 11/24/13, at 12:11 p.m. for anxiety. No documentation regarding symptoms displayed or non-pharmacological interventions used prior to prn dose. A nurses notes dated 11/24/13 at 3:18 p.m. indicated R3's daughter was at facility for lunch and she requested R3 to have a prn Seroquel for agitation and anxiety. Documentation on the prn medication form indicated at 10:30 p.m. the prn dose was not effective. - On 11/29/13, at 12:19 p.m. given for refusal of a.m. dose and increased anxiety. A nurse's notes dated 11/29/13 at 3:27 p.m. indicated R3 refused the morning medications, but agreed to prn Seroquel at 12:00 noon which was effective. No non-pharmacological interventions were documented. - On 12/07/13, at 1:31 a.m. for increased anxiety. No documentation regarding symptoms displayed or non-pharmacological interventions used prior to prn dose were documented. The Behavior Flow Sheets for R3 were reviewed for October, November, and December, 2013. The nursing assistants were to document how many times R3 exhibited anxiety: hallucinations/delusional behaviors and how many times R3 was agitated/paranoid. There were no specific target behaviors or targeted behavioral symptoms identified. Non-pharmacological interventions were to: #1, assure R3 staff was there to help her and #2 ask	F 329		

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F 329	Continued From page 15 R3 what it was she needed. These did not match up with the care plan interventions of music, visiting with others, food, change in position, and toilet use. Review of the psychotropic review dated 6/10/13, at 10:32 a.m. indicated R3's Seroquel was increased to 12.5 mg twice a day on 5/28/13 and noted R3's behaviors had increased. No documentation related to behavioral symptoms or effectiveness of non-pharmacological interventions was noted. Review of the facility's psychotropic review dated 9/04/13, noted a review of R3's medications, with increases of Seroquel noted. Quantitative charting was noted, but only related to delusions and paranoia; no documentation related to the effectiveness of non-pharmacological interventions was noted. Although the review indicated more interventions were to be added, no noted new interventions were added to the care plan. Review of the psychotropic review dated 11/15/13, at 10:29 a.m. indicated R3 was moved to a room where R3 would have a roommate. The review indicated there was an increase in agitation, hallucinations, and delusional behaviors on the day and evening shifts, none on night shift. The review indicated these behaviors were somewhat less and were managed by staff. The review indicated R3 received Seroquel 75 mg every day and had a prn 25 mg dose that has been used once in the last two weeks. The review indicated R3 had psychotic episodes of paranoia with confusion, agitation, hallucinations and R3 was delusional. No quantitative charting was noted and no documentation of the effectiveness	F 329		

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F 329	Continued From page 16 of non-pharmacological interventions was noted. On 12/18/13, at 9:30 a.m. RN-A stated she charted on behaviors/psychotropic medications at least quarterly in the chart. RN-A indicated staff would tell her in-between times if there were any changes. On 12/19/13, at 8:38 a.m. DON stated the parameters for R3 to receive prn Seroquel were hallucinations, paranoia, and agitation. DON stated staff was to try non-pharmacological things first and if R3 was not re-directable, then the prn Seroquel could be offered. DON stated the nurses were aware of the non-pharmacological interventions and the interventions would be located on the care plan. DON verified no direction related to prn Seroquel was on R3's care plan. The facility's Medication Monitoring and Management policy dated 2006, indicated that in order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist performed ongoing monitoring for appropriate, effective, and safe medication use. As needed (PRN) orders the resident was to be monitored for the effectiveness of the medication or possible adverse consequence.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	Please see attachment #4	1/28/2014

Attachment 4

Regulation 483.60(b, d, e) F431
Labeling of Drugs and Biologicals

St. Isidore Health Center of Greenwood Prairie provides pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services within the facility and to guide development and implementation of related procedures. The facility utilizes only persons authorized under state requirements to administer medications.

In accordance with State and federal law, the facility policy requires that drugs and biologicals are stored in a secure, locked location at the proper temperature with access only by authorized personnel.

The procedure for monitoring refrigerator temperatures was reviewed and found appropriate. A new refrigerator has been purchased for the storage of medications at the nurses' station. The staff will continue to record the refrigerator temperatures on a routine basis. Adjustments will be made if temperatures are outside the 36-46 degrees Fahrenheit range. The inability to maintain acceptable temperatures will be reported to the maintenance department for follow up.

To monitor compliance, the Director of Nurses will audit the refrigerator temperature logs for one month. Any deviation from the acceptable range will be investigated and corrective action taken.

Completion Date: January 28, 2014

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F 431	Continued From page 17 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a system to maintain the medication refrigerator within identified range of 36-40 degrees Fahrenheit (°F). This had the potential to affect all residents who required the use of refrigerated medication/s.	F 431		

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F 431	Continued From page 18 Findings include: On 12/19/13 at 10:53 a.m. noted medication refrigerator in the nurse ' s station to be at 36 °F. This was verified by licensed practical nurse (LPN)-D. LPN-D verified the St. Isidore Health Center temperature record of medication room refrigerator #3 indicated the normal refrigerator range should have been 36-40 °F. The refrigerator temperature log for the dates of 10/16/13 - 10/31/13, indicated temperatures from 24-28 °F. The refrigerator temperature log from 11/01/13 -11/20/13 indicated the temperature ranged from 28-30 °F. On 11/28 - 11/31, there were three days the temperatures were not recorded and on 11/29, the temperature was at 32 °F. From 12/7/13 - 12/19/13, the #3 refrigerator logged temperatures from 32 - 34 °F. On 12/19/13, at 10:53 a.m. LPN-D stated the refrigerator temperatures were logged in by night staff. On 12/19/13, at 12:40 p.m. with LPN-D present during the observation, the following medications were observed in refrigerator #3: Tylenol suppositories, biscolax, Bronovana inhalation solution, Pneumovac (which the label indicated should be refrigerator with temperatures between 36-46 °F). intravenous C-Ceftriazone, Novolog Insulin (label states keep in cold place, avoid freezing), Levemir (label stating 36-45 °F), Influenza vaccine (label states 36-46 °F), Novolin (keep in cold place, avoid freezing), Tuberculin vial, Bisocodyl, Ativan Liquids (label to be stored between 36-46 °F), and lorazepam injectables (do not freeze). LPN-D verified the above findings.	F 431		

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ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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F 431	Continued From page 19 On 12/19/13, at 11:18 a.m. the registered nurse (RN)-A and the medical records coordinator (MRC)-F were interviewed. RN-A stated she was not aware of the low temperature in refrigerator #3 and she was not aware if the pharmacy had been contacted. MRC-F stated some medications had been thrown out around 11/31/13, because of freezing and the refrigerator had been replaced twice. MRC-F verified they had not been contacted regarding the continued low temperatures. Both RN-A and MRC-F stated the staff should have adjusted the temperature of the refrigerator if it was too high or too low. Both stated staff needed to report the continued low temperatures to either MRC-F or maintenance staff. On 12/19/13, at 11:42 a.m. maintenance stated he was not aware of the low temperatures of the medication refrigerator. On 12/19/13, at 12:40 p.m. a policy and procedure for refrigerator temperatures was requested, but none was provided.	F 431		
F 465 SS=E	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 maintain resident care	F 465	Please see attachment #5	1/28/2014

Attachment 5

Regulation 483.70(h) Tag F465
Safe, Sanitary, Comfortable Environment

It is the policy of St. Isidore Health Center of Greenwood Prairie to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

As part of an ongoing process to provide a pleasant, home-like environment, St. Isidore Health Center of Greenwood Prairie has a schedule for routine cleaning, repairs, and maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/supervisory staff.

A maintenance check list will continue to be used for inspection of resident rooms at the time of discharge and at least yearly. The condition of the walls, ceilings, radiators, and doors will be checked; damaged equipment and furnishings will be repaired/replaced as needed. All wheelchairs/scooters have been inspected to assure intact, cleanable surfaces. Inspection of the condition of the wheelchair/scooter seat, back and arm vinyl will be done during the routine cleaning of the wheelchair/scooter.

The repair of the vinyl on the wheelchair/scooter and the repair of the ceiling tiles, wall beams, radiators, and door surfaces are in process with planned completion by January 28, 2014.

During the January 16 and 23, 2014 mandatory meetings, all staff was reminded to observe for resident equipment/furnishings/structures that need to be repaired or replaced. The procedures for reporting work items to the Director of Maintenance were reviewed.

Compliance will be monitored by the administrator through direct observation and review of the maintenance checklists.

Completion date: January 28, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 465	Continued From page 20 equipment in sanitary/good repair for 2 of 2 residents (R43, R32); failed to maintain physical environment in good repair for 8 of 24 resident rooms (R56, R54, R36, R19, R3, R1, R33, R32) reviewed. Findings Include: ELECTRIC SCOOTER AND WHEELCHAIR TORN VINYL: On 12/16/13, at 3:04 p.m. R43's wheelchair was observed to have broken vinyl on the left arm rest. On 12/18/13, at 10:30 a.m. environmental director and maintenance-A verified the left arm rest had broken vinyl and the arm rest was not a cleanable surface. On 12/16/13, at 5:02 p.m. R32's electric scooter was observed to have duct tape covering half of the right arm rest and to have a chunk of cushion missing from back corner of right arm rest. On 12/18/13, at 10:30 a.m. environmental director and maintenance-A verified the above and confirmed the arm rest was not a cleanable surface. The facility Wheelchair Washing report sheets dated for 11/25/13, 12/2/13, 12/9/13 and 12/16/13, had no documentation of repairs needed for R32's electric scooter or R43's wheelchair. The facility Maintenance Repair Request sheets dated from 8/25/13 through 12/15/13, had no documentation of repairs reported for R32's electric scooter or R43's wheelchair. On 12/18/13, at 10:30 a.m. environmental director stated when a resident had their own personal	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 465	Continued From page 21 equipment that needed repair, the facility needed to get parts and repair it. The director stated if the equipment was not able to be used until repairs were done, the facility would provide appropriate equipment for the resident. Environmental director stated housekeeping was responsible for cleaning wheelchairs and all wheelchairs were cleaned weekly. Environmental director stated housekeeping would fill out a wheelchair washing weekly report sheet, which had an area to write down repairs needed. Environmental director stated housekeeping should also have written down the repairs needed in the fix it report book located in the nurse report room. On 12/18/13, at 11:10 a.m. housekeeping director verified R32's electric scooter had duct tape covering half of right arm rest and a chunk of cushion was missing from back corner of right arm rest. The housekeeping director verified the surface was not a cleanable. Housekeeping director verified housekeeping was responsible for washing wheelchairs weekly and stated housekeeping staff should have reported the repairs needed on wheelchairs on the wheelchair washing report sheet. The housekeeping director further stated housekeeping staff needed to be retrained what write down for repairs. On 12/18/13, at 12:03 p.m. the director of nursing (DON) stated she would expect wheelchair repairs needed to be reported to maintenance and the repairs to be done. DON stated surfaces should be cleanable. DON stated the part for the personal scooter should be ordered, and if not able to replaced then look at other options. Document review of the facility policy for cleaning resident wheelchair and assisted devices	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 465	Continued From page 22 undated, read "Standard: There is an organized system to monitor and prevent the development and transmission of nosocomial infections thru proper cleaning and maintenance of equipment. Policy: The wheelchairs and assisted devices for each resident will be cleaned weekly and as needed to ensure cleanliness. Please notify maintenance if needed supplies." TILES, REGISTERS, WALLS AND WOODEN SURFACES NOT INTACT: The facility failed to maintain ceiling tiles, registers, wooden surfaces and walls in resident rooms/bathrooms in good repair. R56 and R54's shared room on 12/17/13, at 9:42 a.m. bathroom ceiling tile had discolored area appearing as water staining and wall beam above bed scraped area. R36's room on 12/17/13, at 9:31 a.m. bathroom ceiling tile had discolored areas appearing as water staining and wall beam above bed had large area that appeared as water staining . R19's room and R57's room on 12/16/13, at 4:06 p.m. radiator had multiple scratches and was broken. On 12/18/13, at 10:01 a.m., the same had been observed. R3's room on 12/16/13, at 2:36 p.m. radiator had multiple scratches. On 12/18/13, at 10:01 a.m., the same had been observed and the radiator had a missing piece over a split in the radiator. R1's room on 12/16/13, at 3:48 p.m. radiator had multiple scratches with rust noted and wooden bathroom door had multiple chips of wood missing.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	12/19/2013

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ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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F 465	Continued From page 23 R33's Room and R32's room on 12/17/13, at 9:44 a.m. wooden closet door had scratches. During environmental tour on 12/18/13, at 10:01 a.m., with environmental director and maintenance (maintenance-A) the above had been observed and verified. Environmental director stated he had not been aware of any of the above needing repair. Environmental director stated staff were to write repairs needed in the fix it report book located in the nurse report room and the fix it book was for all staff to report repairs needed. Environmental director stated maintenance was responsible for repairs and checked the book daily. Environmental director stated as preventive maintenance beyond the report book "we do rounds in the facility once per month" to identify any other repairs needed. Environmental director stated radiators and ceilings had not been items checked on rounds, would have to be added to the list. At 1:00 p.m. environmental director stated registers were painted as needed and they were not scheduled to be painted. The facility Maintenance Repair Request sheets dated from 8/25/13 through 12/15/13, had no documentation of observed repairs needed for the above mentioned resident rooms. The facility Maintenance Department Policies dated 9/09, read, "Maintenance and Repair Factors: The building is maintained in good repair and kept free of hazards such as those created by any damaged or defective parts of the building or operating systems such as plumbing, electrical, communications, heating and cooling, in compliance with state and local codes and	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	12/19/2013

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ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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F 465	Continued From page 24 regulations. Routine repair and maintenance services are to be performed in the following categories: Electrical systems, equipment and appliances. Mechanical repair of equipment, furniture, appliances. Wall cleaning, ceiling cleaning, and refinishing or redecorating; heavy duty floor cleaning and resurfacing."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Isidore Health Center of Greenwood Prairie was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	The submission of this response and plan of correction is not to be construed as a legal admission that a deficiency exists or that this statement of deficiency was correctly cited. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility to the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Preparation and submission of this plan of correction has been done to comply with the requirements of state and federal law that mandate submission of a Plan of Correction within ten (10) days of the receipt of the statement of deficiencies as a condition of participation in Title 18 and Title 19 programs. The plan of correction is the facility's letter of credible allegation of compliance. POC ok RB 2-7-14 RECEIVED FEB - 7 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Administrator 1/28/2014

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
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. St. Isidore Health Center of Greenwood Prairie is a 2-story building that was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1993, addition was constructed to the South that was determined to be of Type II(222) construction. Because these two buildings are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 49 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.1. The deficient practice could affect all 49 residents. Findings include: On facility tour between 1:30 PM and 3:30 PM on 12/18/2013, documentation review of the weekly visual inspection emergency generator testing log (December 2012 to December 2013), indicated that the weekly emergency generator visual inspection was missed for 02/04/2013. This deficient practice was confirmed by the facility maintenance staff (JL) at the time of	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	See Bldg 2 for POC	1/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING 02 - CHAPEL B. WING _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Isidore Health Center of Greenwood Prairie - Chapel Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	The submission of this response and plan of correction is not to be construed as a legal admission that a deficiency exists or that this statement of deficiency was correctly cited. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility to the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Preparation and submission of this plan of correction has been done to comply with the requirements of state and federal law that mandate submission of a Plan of Correction within ten (10) days of the receipt of the statement of deficiencies as a condition of participation in Title 18 and Title 19 programs. The plan of correction is the facility's letter of credible allegation of compliance. POC ok FB 2-7-14 RECEIVED FEB - 7 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Paula S Lewis | Administrator | 1/30/2014

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
	245345	A. BUILDING 02 - CHAPEL B. WING _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. St. Isidore Health Center of Greenwood Prairie, 2005 addition is a 2-story building. The 2005 addition was determined to be of Type II (222) construction. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 49 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING 02 - CHAPEL B. WING _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 2 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.1. The deficient practice could affect all 49 residents. Findings include: On facility tour between 1:30 PM and 3:30 PM on 12/18/2013, documentation review of the weekly visual inspection emergency generator testing log (December 2012 to December 2013), indicated that the weekly emergency generator visual inspection was missed for 02/04/2013. This deficient practice was confirmed by the facility maintenance staff (JL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	The emergency generator visual inspection will be completed weekly as required. Maintenance supervisor responsible. Administrator to monitor.	1/28/2014

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3902

January 16, 2014

Ms. Paula Lewis, Administrator
St Isidore Health Center Of Greenwood Prairie
800 Second Avenue Northwest
Plainview, Minnesota 55964

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5345023

Dear Ms. Lewis:

The above facility was surveyed on December 16, 2013 through December 19, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5345s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00672	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRA	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 16, 17, 18 and 19, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904. c/o Gary Nederhoff, Unit Supervisor 507-206-2731 Office	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		

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2 830	Continued From page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a bruise for 1 of 3 residents (R36) and the facility failed to investigate, assess, and develop interventions to promote healing and prevent bruising from reoccurring for 1 of 3 residents (R6) reviewed for non-pressure related skin conditions. Findings include: R36 was observed on 12/16/13, at 3:50 p.m. to have a dark purple discolored area located on the skin of the right temple. The clinical record lacked documented evidence the discoloration had been identified, ongoing assessment for healing, and develop interventions based on a comprehensive assessment to prevent bruising from reoccurring. The annual Minimum Data Set dated 9/27/13, indicated R36 had diagnoses to include dementia, anxiety and heart disease. The MDS indicated R36 had severe cognitive impairment and a history of falls. R36's care plan dated 10/2/13 identified R36 as having a risk for bruising related to paper thin skin. The November 2013 nursing progress notes indicated on 11/29/13, R36 had sustained an unwitnessed fall. Although the progress note identified R36 had a bump on the right forehead and right side of head, the clinical record lacked	2 830		

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2 830	Continued From page 3 documentation the bruise had been identified and the area monitored for healing without complications. On 12/19/13, at 9:25 a.m. the director of nursing (DON) verified the bruise located on the right temple of R36 and referred to R36's recent fall and confirmed R36 had bumped the right side of her head. DON verified the bruise from the fall had not been identified in R36's medical record. DON stated when a fall occurred which resulted in an injury, DON expected the nurse to "open a monitoring event" in the resident's clinical record to ensure monitoring of the injury was completed. DON verified the monitoring event had not been created nor was the bruise monitored. The Skin Risk Assessment policy dated 7/2013, directed staff to note and document the absence or presence of bruises. R6 had a bruise located on the right hand which had not been reported to licensed staff, assessed for causal factors, or interventions put in place to promote healing and prevent further bruising. R6 was observed on 12/16/13, at 6:05 p.m. to have a purple colored, quarter-sized bruise between the second finger and thumb on the right hand. R6 wore an orthotic device which covered the bruised area. R6 said he was not able to tell how and when the bruise happened. On 12/18/13, at 10:26 a.m. R6 was observed with the hand to wrist orthotic on the right hand. The bruise on the right hand was covered by the Velcro from the right hand orthotic. At the time of the observation, R6 stated the bruised area "hurt."	2 830		

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2 830	Continued From page 4 The quarterly Minimum Data Set (MDS) dated 10/13/13, indicated R6's diagnoses included heart failure, hypertension, hyperlipidemia, aphasia, and hemiplegia of the right side. The Care Area Assessment (CAA) dated 1/13/13; identified R6's Braden score (a tool used to predict potential for skin breakdown) was 17, which indicated R6 was at risk for skin breakdown related to pressure. indicated R6's BIMS score was 11 which indicated R6 continued to have moderate cognitive impairment. The MDS indicated R6 required extensive assist with transfers of two staff, R6 did not walk, required a Hoyer lift (a mechanical lift) for transfers and R6 needed extensive assist of one staff with dressing. R6's physician's orders dated 12/19/13, indicated range of motion (ROM) was to be implemented before applying the orthotic in the morning. The special instructions included staff were to have the orthotic on at night for about six hours and on during the day. The orthotic was to be off at meals and activities. The physician ' s orders also included medications that may cause bruising which include Coumadin and Aspirin daily. The plan of care dated 1/18/13, directed staff to apply the hand orthotic twice daily. The care plan identified R6 also had a foot brace and right arm brace. The care plan directed to observe the skin around the orthotic braces and during cares for redness or pressure areas, including bruises. On 12/18/13, at 10:41 a.m. registered nurse (RN)-A, licensed practical nurse (LPN)-C and DON were interviewed. RN-A, DON and LPN-C all verified they were not aware of the bruise and confirmed there was no monitoring event (electronic form for charting skin issues) or other	2 830		

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2 830	Continued From page 5	2 830		

charting completed concerning the bruise on R6's right hand. At the time of the interview, RN-A visually observed the bruise on the right hand between the thumb and the second finger and stated it did not look like an old bruise. RN-A loosened the orthotic and R6 stated it felt better now. At 10:45 a.m. LPN-C measured the bruise at 3.5 centimeter (cm) x 3.0 cm and stated the nursing assistants (NAs) applied the orthotic. The order was verified by LPN-C and RN-A stated they were not sure of the last time therapy had assessed the orthotic. RN-A and LPN-C stated the NA should have reported the bruise and a monitoring event form should have been started to monitor the bruise.

A nurses' note written by LPN-C and after surveyor intervention on 12/18/13, at 11:17 a.m. indicated the bruise was noted on R6's right hand, included the obtained measurements, identified R6 was on Coumadin, had thin skin and the strap on the orthotic hand brace may have been "too tight." LPN-C indicated staff would be instructed to make sure the strap was loose. A nurses' note written by RN-A after surveyor intervention on 12/19/13, at 8:28 a.m. noted R6's right hand orthotic was checked. RN-A noted the NA stated it was like an old bruise.

On 12/19/13, at 8:35 a.m. DON stated she expected the NAs to report the bruise to the nurse. DON stated the nurse would then open a monitoring event in the clinical record. DON stated the nurse would also email the DON if the bruise was explainable or call the DON if it was not.

The facility's Monitoring and Investigation of Incidents/Accidents policy dated 12/2011, directed nursing staff to record all

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2 830	Continued From page 6 incidents/accidents in the computerized medical record under "Events." The facility's Accident/Incident-unexplained injuries policy dated 2/2003, directed all bruises, skin tears, scratches and other injuries that were not the result of a specific event were to be reported to the nursing supervisor as soon as the injury was noted. The policy directed the licensed nurse would then evaluate the injury and interview the resident if appropriate. Details of the injury were to be documented in the resident's medical record and the care plan updated. SUGGEST METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess residents, and implement interventions to ensure residents are provided care in a manor to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs are completed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		

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21426	Continued From page 7 This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide Tuberculosis (TB) education for all staff. Findings include: On 12/18/13, at 3:30 p.m. licensed practical nurse (LPN)-B stated the last TB education for staff had been done in 7/2012. On 12/19/13, at 8:18 a.m. LPN-B stated, "We have not been doing all staff TB education, nursing assistants and licensed staff have been the only staff receiving education for TB." LPN-B verified facility policy identified all employees would receive annual education. Review of TB meeting attendance sheets dated 6/7/12, identified nursing assistants; the attendance sheets dated 6/21/13, identified only licensed staff had been educated regarding TB. The facility Infection Control TB Control Plan dated 7/31/13, read, "VI. HCW Education 1. All employees at this facility will receive annual education appropriate to their tasks regarding TB; additional in-services will be given as needed."	21426		

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21426	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for TB education to educate new hires and asess if there is a need to do annually. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by:	21535		

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21535	Continued From page 9	21535		

Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R28) was comprehensively assessed for safe use of side rails; failed to identify .

Findings include: R28 was not comprehensively assessed for the safe use of half (½) side rail on the bed.

R28's quarterly Minimum Data (MDS) dated 10/27/13, identified R28 was severely cognitively impaired, required extensive assist of one staff for bed mobility, transferring and ambulation; R28 had behaviors. Use of side rails was not triggered on the MDS.

On 12/16/13, at 4:24 p.m. a one half-length side rail was observed on the right side of R28's low bed. The left side of the bed was pushed next to the wall.

On 12/19/13, at 7:00 a.m. R28 was observed in the low bed sleeping on her back. The side rail was up and the bed remained next to the wall. At 7:30 a.m. R28 remained in bed sleeping and the side rail was up.

R28's annual Assessment for Restraint/Adaptive Equipment--Side rails dated 7/23/13; identified R28 would use the top two half side rails. The medical symptom for use of the side rails was weakness and indicated the reason for the side rail was to assist R28 with transferring and bed mobility. The form indicated the risks and benefits were explained to R28 and their family on 7/28/13. The assessment did not address R28's safety and it did not include the alternative approaches attempted. A Quarterly Progress Note dated 10/27/13, indicated R28 "continues to use 2 upper half side rails for T&R [turning and

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21535	Continued From page 10	21535		

repositioning]."

On 12/18/13, at 9:57 a.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed regarding R28's use of side rail. Both indicated R28 had no incidents with the side rail and indicated every side rail was reviewed for resident safety, what they were used for and the appropriateness of the side rail.

On 12/19/13, at 7:50 a.m. RN-A was interviewed regarding R28 ' s side rail assessment. RN-A stated staff goes in and checks for bed mobility, bed boundaries, or transfers. RN-A stated the assessment in the computer had not addressed safety and stated safety should have been added to the side rail assessment. RN-A stated the quarterly reviews were not changed unless there was a change in the resident. RN-A further verified nothing else had been documented in regards the safe use of the side rail for R28.

Facility policy for Side Rail Usage dated 7/2013 indicated side rails were considered to be restraints and side rail use would be individually assessed for proper usage. The procedure directed, "Safety of the resident using side rails for bed mobility must be observed while the rails are in place." The procedure indicated nursing staff was expected to consider all alternative safety methods and care approaches before physical restraint was utilized, such as, but not limited to bolster pillows, floor bed mats, personal bed alarms, scheduled snacks and toileting, and adequate daily exercise.

R36 recurrent urinary tract infections (UTIs) were not identified as potential risk factor for falls.

R36's Current ICD-9 Diagnoses dated as printed

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21535	Continued From page 11 12/18/13 included chronic kidney disease with a history of urinary tract infections (UTI) and falls. Review of incident report documentation from 8/05/13, to 12/16/13, revealed R36 experienced falls on 8/5/13, 11/9/13, 11/24/13, 11/29/13, and 12/13/13. Of the five falls, three identified R36 had been treated for a UTI, and one identified R36 had been monitored for UTI symptoms. The facility's "Fall Risk (Acuity)" assessment form dated 9/23/12 indicated R36 had a history of falls with risk factors that included incontinence. The assessment identified R36 as being at high risk for falls related to confusion and not always aware of safety. The annual Minimum Data Set (MDS) dated 9/27/13, indicated R36 had a Brief Interview for Mental Status (BIMS, a tool used to determine cognitive loss) score of three out of 15, which indicated severe cognitive impairment. The MDS further indicated R36 required extensive assist of one staff for transfers and toileting, was frequently incontinent of urine and was not on a toileting program to manage urinary incontinence. The MDS identified R36 had experienced one fall with no injury since admission. The Care Area Assessment (CAA) identified R36 had been aware of the need to urinate and took self to the toilet. The care plan dated 10/2/13, identified R36 as being at high risk for falls however, did not include interventions based on history of previous falls which included R36 had UTIs at the time which may contribute to the falls and to prevent further falls and possible injuries. On 12/19/13, at 9:33 a.m. RN-A reported the fall precautions to include monitoring and	21535		

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	00672	A. BUILDING: _____ B. WING _____	12/19/2013

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21535	Continued From page 12 interventions for UTIs were to be included on the care plan. RN-A verified R36's chronic UTIs had not been fully assessed in relation to R36 ' s fall history. On 12/19/13, at 9:35 a.m. the DON verified the fall risk documentation should have included chronic UTIs. DON verified R36 had been treated for and/or monitored for UTI symptoms which were present during four of the last five falls. The facility's Events/Accidents/Incidents policy dated 7/2013, identified the charge nurse was responsible for reviewing occurrences for risk factors and initiating appropriate interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21695		

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21695	Continued From page 13 review, the facility failed to maintain resident care equipment in sanitary/good repair for 2 of 2 residents (R43, R32); failed to maintain physical environment in good repair for 9 of 24 resident rooms (R56, R54, R36, R19, R57, R3, R1, R33, R32) reviewed. Findings Include: ELECTRIC SCOOTER AND WHEELCHAIR TORN VINYL: On 12/16/13, at 3:04 p.m. R43's wheelchair was observed to have broken vinyl on the left arm rest. On 12/18/13, at 10:30 a.m. environmental director and maintenance-A verified the left arm rest had broken vinyl and the arm rest was not a cleanable surface. On 12/16/13, at 5:02 p.m. R32's electric scooter was observed to have duct tape covering half of the right arm rest and to have a chunk of cushion missing from back corner of right arm rest. On 12/18/13, at 10:30 a.m. environmental director and maintenance-A verified the above and confirmed the arm rest was not a cleanable surface. The facility Wheelchair Washing report sheets dated for 11/25/13, 12/2/13, 12/9/13 and 12/16/13, had no documentation of repairs needed for R32's electric scooter or R43's wheelchair. The facility Maintenance Repair Request sheets dated from 8/25/13 through 12/15/13, had no documentation of repairs reported for R32's electric scooter or R43's wheelchair. On 12/18/13, at 10:30 a.m. environmental director stated when a resident had their own personal	21695		

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equipment that needed repair, the facility needed to get parts and repair it. The director stated if the equipment was not able to be used until repairs were done, the facility would provide appropriate equipment for the resident. Environmental director stated housekeeping was responsible for cleaning wheelchairs and all wheelchairs were cleaned weekly. Environmental director stated housekeeping would fill out a wheelchair washing weekly report sheet, which had an area to write down repairs needed. Environmental director stated housekeeping should also have written down the repairs needed in the fix it report book located in the nurse report room.

On 12/18/13, at 11:10 a.m. housekeeping director verified R32's electric scooter had duct tape covering half of right arm rest and a chunk of cushion was missing from back corner of right arm rest. The housekeeping director verified the surface was not a cleanable. Housekeeping director verified housekeeping was responsible for washing wheelchairs weekly and stated housekeeping staff should have reported the repairs needed on wheelchairs on the wheelchair washing report sheet. The housekeeping director further stated housekeeping staff needed to be retrained what write down for repairs.

On 12/18/13, at 12:03 p.m. the director of nursing (DON) stated she would expect wheelchair repairs needed to be reported to maintenance and the repairs to be done. DON stated surfaces should be cleanable. DON stated the part for the personal scooter should be ordered, and if not able to replaced then look at other options.

Document review of the facility policy for cleaning resident wheelchair and assisted devices undated, read "Standard: There is an organized

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system to monitor and prevent the development and transmission of nosocomial infections thru proper cleaning and maintenance of equipment. Policy: The wheelchairs and assisted devices for each resident will be cleaned weekly and as needed to ensure cleanliness. Please notify maintenance if needed supplies."

TILES, REGISTERS, WALLS AND WOODEN SURFACES NOT INTACT:
The facility failed to maintain ceiling tiles, registers, wooden surfaces and walls in resident rooms/bathrooms in good repair.

R56 and R54's shared room on 12/17/13, at 9:42 a.m. bathroom ceiling tile had discolored area appearing as water staining and wall beam above bed scraped area.

R36's room on 12/17/13, at 9:31 a.m. bathroom ceiling tile had discolored areas appearing as water staining and wall beam above bed had large area that appeared as water staining .

R19's room and R57's room on 12/16/13, at 4:06 p.m. radiator had multiple scratches and was broken. On 12/18/13, at 10:01 a.m., the same had been observed.

R3's room on 12/16/13, at 2:36 p.m. radiator had multiple scratches. On 12/18/13, at 10:01 a.m., the same had been observed and the radiator had a missing piece over a split in the radiator.

R1's room on 12/16/13, at 3:48 p.m. radiator had multiple scratches with rust noted and wooden bathroom door had multiple chips of wood missing.

R33's Room and R32's room on 12/17/13, at 9:44

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21695	Continued From page 16 a.m. wooden closet door had scratches. During environmental tour on 12/18/13, at 10:01 a.m., with environmental director and maintenance (maintenance-A) the above had been observed and verified. Environmental director stated he had not been aware of any of the above needing repair. Environmental director stated staff were to write repairs needed in the fix it report book located in the nurse report room and the fix it book was for all staff to report repairs needed. Environmental director stated maintenance was responsible for repairs and checked the book daily. Environmental director stated as preventive maintenance beyond the report book "we do rounds in the facility once per month" to identify any other repairs needed. Environmental director stated radiators and ceilings had not been items checked on rounds, would have to be added to the list. At 1:00 p.m. environmental director stated registers were painted as needed and they were not scheduled to be painted. The facility Maintenance Repair Request sheets dated from 8/25/13 through 12/15/13, had no documentation of observed repairs needed for the above mentioned resident rooms. The facility Maintenance Department Policies dated 9/09, read, "Maintenance and Repair Factors: The building is maintained in good repair and kept free of hazards such as those created by any damaged or defective parts of the building or operating systems such as plumbing, electrical, communications, heating and cooling, in compliance with state and local codes and regulations. Routine repair and maintenance services are to be performed in the following categories: Electrical systems, equipment and	21695		

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21695	Continued From page 17 appliances. Mechanical repair of equipment, furniture, appliances. Wall cleaning, ceiling cleaning, and refinishing or redecorating; heavy duty floor cleaning and resurfacing." SUGGESTED METHOD OF CORRECTION: The administrator, environmental director or designee (s) could revise policies and procedures to ensure that the environment for the residents is free from hazards, safe, functional, sanitary, and comfortable for the residents, staff and the public. The administrator, environmental director or designee (s) could provide in-servicing to all staff related how to ensure the environment the policies and procedures are followed. The administrator, environmental director or designee (s) could monitor the status of physical plant conditions periodically to ensure that a routine maintenance plan in place is being effectively instituted. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21695		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.	21942		

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21942	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to promote the development of a family council group on an annual basis. This had the potential to affect all 48 residents residing in the facility. Findings include: The facility failed to continue attempts to establish a family council. On 12/16/13, the survey team requested from the facility information regarding a family council group or attempts to establish a family council. The administrator provided a copy of an undated letter given to family members on admission. On 12/16/13, at 1:00 p.m. the administrator reported the facility admission packet included a letter which invited family members and friends of residents to join a family council. The administrator reported the family council had met once a month in the afternoon, and further reported housekeeping staff (HS)-A had been responsible for the family council and had attended the meetings. The administrator was unable to provide names of family members that had attended other then HS-A. The administrator stated family members and friends of residents had been invited to join family council during the admission process, however no attempts had been made after admission. On 12/19/13, at 10:15 a.m. HS-A verified the facility did not have an active family council and	21942		

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21942	Continued From page 19 further verified no attempts had been made to contact family members annually to establish a family council. SUGGESTED METHOD OF CORRECTION: The administrator and or designee could ensure that efforts to form a family council were completed annually for all resident family members and or representatives. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21942		