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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 921G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**
2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **12/19/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (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
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 02/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/01/2017 (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
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
12/20/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245277

February 1, 2017

Mr. Michael Schultz, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

Dear Mr. Schultz:

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

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

Effective December 5, 2016 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 1, 2017

Mr. Michael Schultz, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number S5277026

Dear Mr. Schultz:

On November 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 4, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On December 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 5, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 4, 2016, effective December 5, 2016 and therefore remedies outlined in our letter to you dated November 19, 2016, will not be imposed.

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

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245277 Y1	A. Building B. Wing Y2	12/19/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0225	Correction	ID Prefix	F0226	Correction	ID Prefix	F0309	Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed	Reg. #	483.25	Completed
LSC		12/05/2016	LSC		12/05/2016	LSC		12/05/2016
ID Prefix	F0334	Correction	ID Prefix	F0441	Correction	ID Prefix		Correction
Reg. #	483.25(n)	Completed	Reg. #	483.65	Completed	Reg. #		Completed
LSC		12/05/2016	LSC		12/05/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TA/mm	02/01/2017	29433	12/19/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/4/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245277	A. Building 01 - MAIN BUILDING 01 B. Wing	12/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0271	Correction Completed 11/17/2016	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 11/17/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	02/01/2017	19251	12/13/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/8/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 921G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**
2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **11/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR SWS 12/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 19, 2016

Mr. Michael Schultz, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number S5277026

Dear Mr. Schultz:

On November 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 13, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 3, 2017 (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 May 3, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		12/5/16

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

Electronically Signed | 11/28/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential mistreatment to the State Agency (SA) and thoroughly investigate allegations of potential mistreatment for 2 of 4 residents (R17, R25) reviewed for potential mistreatment. Findings include: R17's annual Minimum Data Set (MDS) dated 8/13/16, identified diagnoses of Alzheimer's disease, psychosis, and depression. The MDS also identified R17 had severely impaired cognition, and required extensive staff assistance with toileting, personal hygiene, bathing, and transfers. The care plan dated 8/13/16, indicated R17 rejected cares at times, could be verbally abusive toward staff, and exhibited short tempered behavior (slap, hit, strike out, pinch, and punch).	F 225	F225 investigation and report… R17 was noted to have bruise to periorbital area… R17 had a bruise identified on 9-25-16, on 9-28-16, staff were interviewed and it was determined that R17 obtained the bruise from sleeping on her fist…immediate corrective action for R17 was done; including , reminders to staff to utilize non-pharmacological interventions with resident behaviors and to offer/encourage rest in bed when resident appears sleepy. Chart reviewed, resident care plan updated …R 17 has not received any other bruises to eye area…Staff to encourage use of travel pillow to support her head on 11-23-16… R25 had attempted to elope on 10-15-16…on 10-17-16, the elopement was reported to the state agency… immediate corrective action was done for	

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F 225	Continued From page 2 A facility Event Report dated 9/25/16, indicated that R17's right eye was black, blue, and puffy, and this was an injury of unknown origin. On 9/28/16, at 4:21 p.m. a progress note identified a bruise near R17's right eye. The progress note also indicated R17 denied being hurt by anyone, she had a history of being resistive and combative with cares, and she would had a history of scratching herself. On 9/28/16, the progress notes identified the interdisciplinary team (IDT) met and determined R17's resting position was to sit with her hand by her eye as she rests her head on her hand. The IDT determined this caused pressure to her periorbital (around the eye) area. The IDT indicated R17 will not sit in any other position while she rests in her wheelchair and often refused to lay down. The IDT note indicated the facility intervention to prevent future reoccurrence of similar incident was to have resident wear soft gloves or cloth in hand when up in wheelchair to protect face and hands from excess pressure and reduce potential for bruising. On 11/2/16, at 9:47 a.m. nursing assistant (NA)-I and NA-J stated they are to report any bruising to the licensed practical nurse (LPN) immediately. On 11/4/16, at 8:58 a.m. LPN-B stated NAs are to use a facility specific body observation sheet during weekly skin observation. The NA would complete the form and report all skin conditions to the LPN, as well as turn in this sheet to the LPN. The LPN would then document weekly and update registered nurse (RN) if indicated. The LPN would open and complete a skin event if indicated and update the RN if an event is opened. The LPN would monitor the bruises until	F 225	R25 including; elopement assessment by RN, relocation to more secure unit, wandergaurd in place, and care plan was updated on 10-17-16…R25 has not had any successful elopement attempts since this corrective measure was initiated. In order to identify other residents who were possibly affected, all events occurring after 11-4-16 have been reviewed by IDT to assure that policies were followed and reporting requirements were met Systemic changes to prevent similar occurrence include: *review of the VA reporting policy which was found to be appropriate; * a weekend call list has been generated and made available for staff to contact management for clarification of reportable events * the care providers algorithms for reporting and the necessity of immediate investigation and reporting has been re-enforced as the tool to determine when to report… *additionally, staff received education on the abuse prevention plan and mandatory reporters… *the event reporting policy has been reviewed and remains appropriate *all nursing staff will be trained on the above measures on 12-1-16. Monitoring to assure compliance has been initiated and entails: a weekend review each week for 4 weeks will be completed by the CM for any events opened to assure appropriate investigation and reporting has been completed; and Monday through Fridays	

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F 225	Continued From page 3 healed in treatment administration record (TAR) or medication administration record (MAR). LPN-B also stated when bruises are identified, staff are to measure the area, complete an event report, and document in progress notes. If a bruise was of unknown origin, in a suspicious area (face, peri area, breast), a vulnerable adult (VA) report was to be filed. LPN-B also stated they are to report to the nurse manager immediately, fax the report to the (SA), initiate the facility investigation, and interview all staff caring for the resident during the past 24 hours. LPN-B was unsure of the time to report to the SA, but stated it is a very short time window. On 11/4/16, at 9:55 a.m. the director of nursing (DON) stated she did not know why R17's black, blue, and puffy right eye wasn't reported immediately to the state agency. The DON confirmed it should have been reported at the time it was discovered. The DON stated if the facility was unable to determine the origin of bruise, they have to report within 1 to 2 hours. The DON stated staff has been trained on VA reporting. The facility Abuse Prevention Plan dated 7/1/15, directed staff to notify the facility charge of building immediately of all incidents who would notify the administrator, DON, and director of social services. The Abuse Prevention Plan defined injuries of unknown source as the source of the injury was not observed by any person or the source of the injury could not be explained, and the injury was suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma). The policy further directed the director of social services and DON to	F 225	this review will be completed by the IDT after morning meeting…the weekend events reviewed will be submitted with actions to the DON or designee every Monday…the audits results are to be reviewed at quality council for the need on ongoing audits…the DON/designee is responsible for the completion of these audits and compliance will be achieved by 12-5-16. The Social Service designee or designee will compile monthly VA reports and present to quality council...the social service designee is responsible for the reports and compliance will be achieved by 12-5-16.	

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F 225	Continued From page 4 investigate all accidents and incidents. The policy further directed the charge of building, administrator, DON, and director of social services are responsible for reporting suspected abuse or neglect immediately. R25's quarterly Minimum Data Set (MDS) dated 9/23/16, identified a diagnosis of heart failure. The MDS also indicated R25 was cognitively intact and had no behaviors, rejection on cares or wandering. The MDS further identified R25 required staff assistance for wheelchair mobility on and off the unit. An Safety Events-Elopement form dated 10/15/16, indicated R25 eloped three times on 10/15/16, between 5:45 p.m. and 6:15 p.m. R25 was found wheeling himself down the front ramp and also towards the outside front steps. The incident was not reported to the State Agency (SA) until 10/17/16. The Elopement Risk Assessment dated 10/18/16, indicate R25 had unsuccessful elopement attempts in the past, and had verbalized statements about leaving. R25 was at moderate risk for elopement. The SA Incident Report-Submission Completed form indicated the state agency received the elopement report on 10/17/16. On 11/4/16, at 9:40 a.m. the director of nursing (DON) verified the elopement was not reported until 11/17/16, and should have been reported on 11/15/16. The DON stated the elopement happened on a Saturday and she was not made aware of it until she came in on Monday. The DON stated licensed practical nurses (LPN) and registered (RN) could also report to the state	F 225		

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F 225	Continued From page 5 agency. The DON further stated she had a LPN meeting on 10/27/16, and reviewed vulnerable adult reporting and the elopement incident to try to avoid this from happening again.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential mistreatment to the State Agency (SA) and thoroughly investigate allegations of potential mistreatment for 2 of 4 residents (R17, R25) reviewed for potential mistreatment. Findings include: R17's annual Minimum Data Set (MDS) dated 8/13/16, identified diagnoses of Alzheimer's disease, psychosis, and depression. The MDS also identified R17 had severely impaired cognition, and required extensive staff assistance with toileting, personal hygiene, bathing, and transfers. The care plan dated 8/13/16, indicated R17 rejected cares at times, could be verbally abusive toward staff, and exhibited short tempered behavior (slap, hit, strike out, pinch, and punch). A facility Event Report dated 9/25/16, indicated	F 226	F226&abuse and neglect& R17 was noted to have bruise to periorbital area& R17 had a bruise identified on 9-25-16, on 9-28-16, staff were interviewed and it was determined that R17 obtained the bruise from sleeping on her fist&immediate corrective action for R17 was done; including , reminders to staff to utilize non-pharmacological interventions with resident behaviors and to offer/encourage rest in bed when resident appears sleepy. Chart reviewed, resident care plan updated &R 17 has not received any other bruises to eye area&Staff to encourage use of travel pillow to support her head on 11-23-16& R25 had attempted to elope on 10-15-16&on 10-17-16, the elopement was reported to the state agency&immediate corrective action was done for R25 including; elopement	12/5/16

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F 226	Continued From page 6 that R17's right eye was black, blue, and puffy, and this was an injury of unknown origin. On 9/28/16, at 4:21 p.m. a progress note identified a bruise near R17's right eye. The progress note also indicated R17 denied being hurt by anyone, she had a history of being resistive and combative with cares, and she would had a history of scratching herself. On 9/28/16, the progress notes identified the interdisciplinary team (IDT) met and determined R17's resting position was to sit with her hand by her eye as she rests her head on her hand. The IDT determined this caused pressure to her periorbital (around the eye) area. The IDT indicated R17 will not sit in any other position while she rests in her wheelchair and often refused to lay down. The IDT note indicated the facility intervention to prevent future reoccurrence of similar incident was to have resident wear soft gloves or cloth in hand when up in wheelchair to protect face and hands from excess pressure and reduce potential for bruising. On 11/2/16, at 9:47 a.m. nursing assistant (NA)-I and NA-J stated they are to report any bruising to the licensed practical nurse (LPN) immediately. On 11/4/16, at 8:58 a.m. LPN-B stated NAs are to use a facility specific body observation sheet during weekly skin observation. The NA would complete the form and report all skin conditions to the LPN, as well as turn in this sheet to the LPN. The LPN would then document weekly and update registered nurse (RN) if indicated. The LPN would open and complete a skin event if indicated and update the RN if an event is opened. The LPN would monitor the bruises until healed in treatment administration record (TAR)	F 226	assessment by RN, relocation to more secure unit, wandergaurd in place, and care plan was updated on 10-17-16&R25 has not had any successful elopement attempts since this corrective measure was initiated. In order to identify other residents who were possibly affected, all events occurring after 11-4-16 have been reviewed by IDT to assure that policies were followed and reporting requirements were met Systemic changes to prevent similar occurrence include: *review of the VA reporting policy which was found to be appropriate; * a weekend call list has been generated and made available for staff to contact management for clarification of reportable events * the care providers algorithms for reporting and the necessity of immediate investigation and reporting has been re-enforced as the tool to determine when to report& *additionally, staff received education on the abuse prevention plan and mandatory reporters& *the event reporting policy has been reviewed and remains appropriate *all nursing staff will be trained on the above measures on 12-1-16. Monitoring to assure compliance has been initiated and entails:, a weekend review will be completed by the CM for any events opened to assure appropriate investigation and reporting has been completed each week for 4 weeks and Monday through Friday this will be done	

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F 226	Continued From page 7 or medication administration record (MAR). LPN-B also stated when bruises are identified, staff are to measure the area, complete an event report, and document in progress notes. If a bruise was of unknown origin, in a suspicious area (face, peri area, breast), a vulnerable adult (VA) report was to be filed. LPN-B also stated they are to report to the nurse manager immediately, fax the report to the (SA), initiate the facility investigation, and interview all staff caring for the resident during the past 24 hours. LPN-B was unsure of the time to report to the SA, but stated it is a very short time window. On 11/4/16, at 9:55 a.m. the director of nursing (DON) stated she did not know why R17's black, blue, and puffy right eye wasn't reported immediately to the state agency. The DON confirmed it should have been reported at the time it was discovered. The DON stated if the facility was unable to determine the origin of bruise, they have to report within 1 to 2 hours. The DON stated staff has been trained on VA reporting. The facility Abuse Prevention Plan dated 7/1/15, directed staff to notify the facility charge of building immediately of all incidents who would notify the administrator, DON, and director of social services. The Abuse Prevention Plan defined injuries of unknown source as the source of the injury was not observed by any person or the source of the injury could not be explained, and the injury was suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma). The policy further directed the director of social services and DON to investigate all accidents and incidents. The policy	F 226	with IDT after morning meeting&the weekend events reviewed will be submitted with actions to the DON/designee every Monday&the audits results are to be reviewed at quality council for the need on ongoing audits&the DON/designee is responsible for the completion of these audits and compliance will be achieved by 12-5-16. The Social Service designee/designee will compile monthly VA reports and present to quality council...the social service designee is responsible for the reports and compliance will be achieved by 12-5-16.	

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F 226	Continued From page 8 further directed the charge of building, administrator, DON, and director of social services are responsible for reporting suspected abuse or neglect immediately. R25's quarterly Minimum Data Set (MDS) dated 9/23/16, identified a diagnosis of heart failure. The MDS also indicated R25 was cognitively intact and had no behaviors, rejection on cares or wandering. The MDS further identified R25 required staff assistance for wheelchair mobility on and off the unit. An Safety Events-Elopement form dated 10/15/16, indicated R25 eloped three times on 10/15/16, between 5:45 p.m. and 6:15 p.m. R25 was found wheeling himself down the front ramp and also towards the outside front steps. The incident was not reported to the State Agency (SA) until 10/17/16. The Elopement Risk Assessment dated 10/18/16, indicate R25 had unsuccessful elopement attempts in the past, and had verbalized statements about leaving. R25 was at moderate risk for elopement. The SA Incident Report-Submission Completed form indicated the state agency received the elopement report on 10/17/16. On 11/4/16, at 9:40 a.m. the director of nursing (DON) verified the elopement was not reported until 11/17/16, and should have been reported on 11/15/16. The DON stated the elopement happened on a Saturday and she was not made aware of it until she came in on Monday. The DON stated licensed practical nurses (LPN) and registered (RN) could also report to the state agency. The DON further stated she had a LPN meeting on 10/27/16, and reviewed vulnerable	F 226		

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F 226	Continued From page 9 adult reporting and the elopement incident to try to avoid this from happening again.	F 226		
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 ensure bruises were assessed, monitored, and interventions were implemented to prevent further bruising for for 2 of 3 residents (R17, R20) who were reviewed for non-pressure related skin conditions. Findings include: R17's Annual Minimum Data Set (MDS) dated 8/13/16, identified diagnoses that included Alzheimer's disease, and anemia. The MDS also identified R17 had severely impaired cognitive status and required staff assistance with activities of daily living (ADLs). R17's care plan dated 8/13/16, indicted R17 could reject cares at times, be verbally abusive toward staff, and exhibit short tempered behavior (slap, hit, strike out, pinch, and punch). The care plan also directed staff to observe skin with cares, and report any changes to a licensed nurse.	F 309	F309…investigation and report- same adjustments to R17 as noted above. R20 has passed away...R20 was noted to have bruising to her upper arm and the back of her right hand…*** R17 was noted to have bruise to periorbital area… R17 had a bruise identified on 9-25-16, on 9-28-16, staff were interviewed and it was determined that R17 obtained the bruise from sleeping on her fist…immediate corrective action for R17 was done; including , reminders to staff to utilize non-pharmacological interventions with resident behaviors and to offer/encourage rest in bed when resident appears sleepy. Chart reviewed, resident care plan updated …R 17 has not received any other bruises to eye area…Staff to encourage use of travel pillow to support her head on 11-23-16…	12/5/16

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F 309	Continued From page 10 On 10/31/16, at 8:58 a.m. R20 was observed to have a pale, purplish, pink bruise on the back of her right hand. On 11/1/16, at 1:23 p.m. R20's right upper, inner arm was observed to have a reddish purple discoloration. On 11/4/16, at 8:58 a.m. licensed practical nurse (LPN)-B verified a pale, purplish, pink bruise on back of R17's right hand. LPN-B stated she was not previously aware of the bruise, and verified their was no documentation in R17's electronic medical record (EMR) regarding the bruise. R20's annual MDS on 8/13/16, identified diagnoses that included schizophrenia, generalized muscle weakness, type I diabetes, and transischemic attacks (TIA's or mini strokes). The MDS also identified R20 had severely impaired cognition, and was short tempered and easily annoyed. In addition, the MDS stated R20 required staff assist with ADLs. R20's care plan dated 11/7/15, directed staff to observe skin with cares and report any changes to a licensed nurse. At 9:09 a.m. LPN-B verified a bruise on R20's right upper, inner arm which she described as light purplish in color. LPN-B also verified there was no documentation in R20's EMR. On 10/29/16, at 4:07 p.m. R20's weekly skin check was done and no bruising or other issues were noted. On 11/4/16, at 8:58 a.m. LPN-B stated nursing assistants (NAs) are to use a facility specific body observation sheet during weekly skin observation.	F 309	In order to identify other residents with the potential to be affected by bruising, All residents have had a head to toe skin inspection completed by 11-23-16 and documented on the facility bath skin sheet, and events or VA reports completed per facility policy. Systemic changes to prevent recurrence include: *The skin tool has been updated to include LPN observation of all reported skin issues and the policy has been reviewed and remains appropriate… *the bruise policy has been reviewed and updated to include any bruises resembling fingerprints as reportable… *stop and watch tool use will be reinforced during staff education on 12-1-16. *event policy and required investigation have been reviewed and remain appropriate *the care provider algorithm for reporting VA incidents as well as mandated reporters policy has been reviewed an deemed appropriate to use as a reporting guideline *Staff will receive education on all of the above on 12-1-16. Monitoring has been put in place to assure that these processes are followed. The Clinical Managers/designee will complete a weekly audit for 4 weeks totaling 10% of the residents on the skin observation tool use, documentation, and appropriate action with events and reporting; these audits will be submitted to the DON/designee. The DON/designee will submit monthly reports to the Quality Council for	

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	245277	A. BUILDING _____ B. WING _____	11/03/2016

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F 309	Continued From page 11 The NA would complete the form and report all skin conditions to the LPN, as well as turn in this sheet to the LPN. The LPN would then document weekly and update the registered nurse (RN) if indicated. The LPN would open and complete a skin event if indicated and update the RN if an event is opened. The LPN would monitor the bruises until healed in treatment administration record (TAR) or medication administration record (MAR). LPN-B also stated when bruises are identified, staff are to measure the area, complete an event report, and document in progress notes. The facility Bruises policy dated 1/15/16, directed guidelines and protocol for monitoring and reporting of bruising, which included monitoring bruises of unknown origin and bruises in suspicious areas (arms, wrist, finger prints, breasts, face, peri area). In addition, the facility policy Skin Integrity Assessment/Documentation dated 2/2011, specifically directed assessments of skin tissue to include inspection and observance of body surfaces for observation of bruises.	F 309	determination of ongoing need for audits. Future frequencies of the report will be determined by the Quality Council. The DON/designee is responsible for auditing…correction will be achieved by 12-5-16.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 334		12/5/16

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F 334	Continued From page 12	F 334		

immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the

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F 334	Continued From page 13 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer either pneumococcal 23-valent polysaccharide vaccine 23 (PPSV, also known as the Pneumovax23) or Pneumococcal Polysaccharide Vaccine 13 (PPV, also known as the Prevnar 13) for two of five residents (R70, R84), and provide risk/benefit information for the PPV13 vaccine for 2 of 5 residents (R70, R84) reviewed for vaccinations. Findings include: R70 was a 97 year old resident admitted to the facility in 4/16. R70's Vaccine Administration Record revealed no risk/benefit for the PPSV23 or PCV13 had been offered to the resident or their representative. R84 was an 84 year old resident admitted to the facility in 9/16. R84's Vaccine Administration Record revealed no risk/benefit for the PPSV23 or PCV13 had been offered to the resident or their representative.	F 334	F334…influenza and pneumococcal immunization. R70 has declined the pneumococcal vaccination and declinations have been filed in the medical record. R84 has passed away. In order to identify others with this potential, all residents in the facility have been reviewed for consents/declinations for the pneumococcal 23 and 13 on 11-15-16…as consents are obtained the vaccinations are being administered Systemic changes to prevent recurrence include: • Revision to the consent / declination form to include signature of the administering LN, date of vaccination and then the uploading of this consent / declination form upon completion of vaccination, unless declined. • The Admission Pre-admission screen has been updated to include pnueomococcal vaccine history.	

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F 334	Continued From page 14 On 11/3/16, at 1:48 p.m. the assistant director of nursing (ADON) stated the facility had no record or documentation indicating R70 or R84 had been offered pneumococcal vaccination, nor was there evidence R70 and R84 had been provided information regarding the risk and benefit of vaccination. The facility's Pneumococcal Vaccinations Policy dated 6/1/14, directed "PPSV23 and PCV13 is recommended for all adults age 65 or older .Documentation in the medical record and/or the electronic medical record will include; education provided and to whom it was discussed, signed consent that education was provided, determination of accepting or refusal of vaccination, reason for refusal."	F 334	• An admission checklist has been updated to include vaccinations recommended. • Staff will receive education on all revision to processes as above on 12-1-16 Monitoring for compliance has been put in place and the Admissions coordinator/designee will complete a weekly audit of admissions for 4 weeks to assure that new processes are followed and report concerns to the ICN/designee. The ICN/designee will report monthly to Quality Council for determination of ongoing need for audits. Reports will be completed monthly for 3 months and then at a frequency to be determined by the Quality Council. The infection control RN/designee is responsible for audits and the date certain is 12-5-16.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		12/5/16

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F 441	Continued From page 15 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were properly stored to prevent cross contamination for 6 of 6 residents (R8, R28, R40, R42, R54, R61) who utilized insulin pens. In addition, the facility failed to to ensure proper infection control practices were maintained during glucometer (portable monitor that measure blood glucose levels) checks for 3 of 3 observations. This had the potential to affect 38 residents who received medication from 2 of 3 medication carts during observation of medication administration. Findings include:	F 441	F441…insulin and glucometers. Immediate correction has been implemented for R8, R28, R40, R42, R54, R61 by placing their disinfected insulin pens in a zip lock baggie on November 2, 2016 Immediate correction has been implemented for R8, R28, R40, R42, R54, R61 by issuing a plastic container to store their personal glucometer on 11-2-2016 in…glucometers were disinfected prior to being placed in the issued container… Other residents with this potential have been identified and pens and glucometers	

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F 441	Continued From page 16 On 11/3/16, at 1:24 p.m. unboxed, unbagged insulin pens were observed to be stored all together in one compartment of the first drawer of the medication cart. Licensed practical nurse (LPN)-C verified that all insulin pens are stored in the same compartment. R8's physician orders dated 10/3/16, indicated R8 had orders for Humulin N insulin. R8 had Humulin N insulin pen in medication cart. R28's physician orders dated 10/3/16, indicated R28 had orders for Lantus insulin. R28 had Lantus insulin pen in medication cart. R40's physician orders dated 10/3/16, indicated R40 had orders for Humalog and Lantus insulin. R40 had Humulog and Lantus insulin pens in medication cart. R42's physician orders dated 10/3/16, indicated R42 had orders for Lantus and Novolog insulin. R42 had Lantus and Novolog insulin pens in medication cart. R54's physicians orders dated 10/3/16, indicated R54 had orders for Lantus insulin. R54 had Lantus pen in medication cart. R61's physician orders dated 10/3/16, indicated R61 had orders for Novolog and Lantus insulin. R61 had Novolog and Lantus pens in the medication cart. On 11/1/16,at 7:14 p.m. LPN-B was observed to perform a blood glucose check on R19 with R19's dedicated glucometer. Glucometers were	F 441	placed in individual containers as stated above. Systematic changes to prevent recurrence include revising the Blood Glucose Monitor policy to include storage containers and use. The hand washing policy was also updated for increase in specifics with regard to medication administration. All above stated changes will be presented in the 12-1-16 staff education Medication cart audits will completed 3 times a week by an LN for 2 weeks to assure compliance with storage of insulin pens and glucometers. Audits of glucometer or pen use, (including handwashing and infection control) will be done daily by CM/designee for a week at alternating times/shifts and then to be done weekly on day and afternoon shift for an additional 3 weeks with results to quality council for determination of ongoing audits… Audits will also be completed by the CM/designee on handwashing with medication administration, glucometer use and during meal times…these will be done daily at alternating times/shifts for one week, then weekly for an additional 3 weeks in order to determine compliance with infection control regulations for medication pass and mealtimes...audit results to quality council for determination of ongoing audits. Audits will be submitted to the DON/designee upon completion. The DON/designee will report to the Quality to assure compliance and then at a frequency as determined by the Quality	

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F 441	Continued From page 17 observed to be stored in the first drawer of the medication cart in plastic baggies with residents names on them. Upon completion of obtaining the sample in R19's room, LPN-B removed gloves, left R19's room, and placed the glucometer on top of the medication cart prior to opening the drawer and placing the uncleaned glucometer in R19's plastic baggie, which had the potential to contaminate the medication cart. LPN-B then disinfected hands with sani-wipes on medication cart. On 11/2/16, at 11:05 a.m. LPN-D was observed to perform a blood glucose check on R19 with R19's dedicated glucometer. Upon completion of obtaining the sample in R19's room, LPN-D removed gloves without washing or disinfecting hands, left R19's room and placed the uncleaned glucometer on top of the medication cart prior to opening drawer. LPN-D then placed the glucometer in R19's plastic baggie, which had the potential to contaminate the medication cart. On 11/2/16, at 11:16 a.m. LPN-D was observed to perform a blood glucose check on R13 with R13's dedicated glucometer. Upon completion of obtaining a sample in residents room, LPN-D placed glucometer on top of medication cart, opened the drawer, and placed the unclean glucometer in resident's plastic baggie, which had the potential to contaminate the medcation cart. In addition, LPN-D then removed gloves. LPN-D did not wash or disinfect hands after completing task. On 11/3/16, at 1:37 p.m. the assistant director of nursing (ADON) confirmed that the top of medication cart should have been decontaminated after placement of glucometer,	F 441	Council. The DON/designee is responsible for audits. Compliance will be achieved by 12-5-16	

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F 441	Continued From page 18 and glucometers will be placed in plastic, covered individual containers. The ADON also verified there was a risk of cross contamination with insulin pens being stored together. They should have been in individually labeled bags. On 11/4/2016, at 9:42 a.m. ADON stated glucometers and pens were disinfected yesterday and placed in covered, plastic individual containers. In addition, gloves should have been removed and hands washed or disinfected immediately after removal. The undated facility policy and procedure for standard precautions directed staff to remove gloves before touching non-contaminated items or environmental surfaces and wash hands immediately after removing gloves. In addition, the policy directed the staff to avoid contamination and prevent transfer of microorganisms to residents and environmental surfaces.	F 441		

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	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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, Fire Marshal Division on November 8, 2016. At the time of this survey, St. Raphael's Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Raphaels Health & Rehabilitation Center is a 2-story building with a full basement. The original building was constructed in 1954 with an addition constructed in 1974. The 1954 building is of type II(111) construction and the 1974 building is type II(111) construction. Therefore, the nursing home was inspected as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271	NFPA 101 Discharge from Exits	K 271		11/17/16

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K 271 SS=E	Continued From page 2 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain the exit discharge in accordance with 7.7, 19.2.7. This deficient practice could affect 20 residents. Findings include: On facility tour between the hours of 11:30 AM and 3:30 PM on 11/08/2016, it was observed that the south entry stairwell had several boxes, computer equipment and 10 metal chairs stored under the stairs not in accordance with LSC (12) section 19.2.7. This deficient practice was verified by the Maintenance Supervisor at the time of inspection.	K 271	All items identified will be removed from stairwell and stored appropriately elsewhere on the campus. The Plant Operations Manager and/or his designee will monitor for compliance in the issue. This was completed November 17, 2016.	
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be	K 321		11/17/16

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ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE EVELETH, MN 55734**

(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 321	Continued From page 3 self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain 1 out of 4 hazardous area rooms not in accordance with LSC (12) edition section 19.3.2.1. This deficient practice can affect 3 to 5 residents. Findings include: On facility tour between the hours of 11:30 AM and 3:30 PM on 11/08/2016, it was observed that the laundry soiled lined room door did not self-closed and positively latch in accordance with 19.3.2.1. This deficient practice was verified by the Maintenance Supervisor at the time of inspection.	K 321	A door closer will be installed to correct deficient practice on 11/17/2016. This will be monitored by the Plant Operations Manager and or Designee.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
November 19, 2016

Mr. Michael Schultz, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5277026

Dear Mr. Schultz:

The above facility was surveyed on October 31, 2016 through November 3, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Teresa Ament at: (218) 302-6151 or email: teresa.ament@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00583	A. BUILDING: _____ B. WING _____	11/03/2016

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/31/16-11/3/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 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 ensure bruises were assessed, monitored, and interventions were implemented to prevent further bruising for for 2 of 3 residents (R17, R20) who were reviewed for non-pressure related skin conditions. Findings include: R17's Annual Minimum Data Set (MDS) dated 8/13/16, identified diagnoses that included Alzheimer's disease, and anemia. The MDS also identified R17 had severely impaired cognitive status and required staff assistance with activities	2 830	Tag 2830 Corrected	12/5/16

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2 830	Continued From page 3 of daily living (ADLs). R17's care plan dated 8/13/16, indicted R17 could reject cares at times, be verbally abusive toward staff, and exhibit short tempered behavior (slap, hit, strike out, pinch, and punch). The care plan also directed staff to observe skin with cares, and report any changes to a licensed nurse. On 10/31/16, at 8:58 a.m. R20 was observed to have a pale, purplish, pink bruise on the back of her right hand. On 11/1/16, at 1:23 p.m. R20's right upper, inner arm was observed to have a reddish purple discoloration. On 11/4/16, at 8:58 a.m. licensed practical nurse (LPN)-B verified a pale, purplish, pink bruise on back of R17's right hand. LPN-B stated she was not previously aware of the bruise, and verified their was no documentation in R17's electronic medical record (EMR) regarding the bruise. R20's annual MDS on 8/13/16, identified diagnoses that included schizophrenia, generalized muscle weakness, type I diabetes, and transischemic attacks (TIA's or mini strokes). The MDS also identified R20 had severely impaired cognition, and was short tempered and easily annoyed. In addition, the MDS stated R20 required staff assist with ADLs. R20's care plan dated 11/7/15, directed staff to observe skin with cares and report any changes to a licensed nurse. At 9:09 a.m. LPN-B verified a bruise on R20's right upper, inner arm which she described as light purplish in color. LPN-B also verified there was no documentation in R20's EMR.	2 830		

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2 830	Continued From page 4 On 10/29/16, at 4:07 p.m. R20's weekly skin check was done and no bruising or other issues were noted. On 11/4/16, at 8:58 a.m. LPN-B stated nursing assistants (NAs) are to use a facility specific body observation sheet during weekly skin observation. The NA would complete the form and report all skin conditions to the LPN, as well as turn in this sheet to the LPN. The LPN would then document weekly and update the registered nurse (RN) if indicated. The LPN would open and complete a skin event if indicated and update the RN if an event is opened. The LPN would monitor the bruises until healed in treatment administration record (TAR) or medication administration record (MAR). LPN-B also stated when bruises are identified, staff are to measure the area, complete an event report, and document in progress notes. The facility Bruises policy dated 1/15/16, directed guidelines and protocol for monitoring and reporting of bruising, which included monitoring bruises of unknown origin and bruises in suspicious areas (arms, wrist, finger prints, breasts, face, peri area). In addition, the facility policy Skin Integrity Assessment/Documentation dated 2/2011, specifically directed assessments of skin tissue to include inspection and observance of body surfaces for observation of bruises. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to identify and assess not-pressure related skin issues, such as bruises, are implemented, assessed and revised as needed for all residents. The Director of Nursing or designee could educate all appropriate staff on	2 830		

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2 830	Continued From page 5 the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were properly stored to prevent cross contamination for 6 of 6 residents (R8, R28, R40, R42, R54, R61) who utilized insulin pens. In addition, the facility failed to to ensure proper infection control practices were maintained during glucometer (portable monitor that measure blood glucose levels) checks for 3 of 3 observations. This had the potential to affect 38 residents who received medication from 2 of 3 medication carts during observation of medication administration. Findings include: On 11/3/16, at 1:24 p.m. unboxed, unbagged insulin pens were observed to be stored all together in one compartment of the first drawer of the medication cart. Licensed practical nurse (LPN)-C verified that all insulin pens are stored in	21375	Tag 21375 Corrected	12/5/16

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21375	Continued From page 6 the same compartment. R8's physician orders dated 10/3/16, indicated R8 had orders for Humulin N insulin. R8 had Humulin N insulin pen in medication cart. R28's physician orders dated 10/3/16, indicated R28 had orders for Lantus insulin. R28 had Lantus insulin pen in medication cart. R40's physician orders dated 10/3/16, indicated R40 had orders for Humalog and Lantus insulin. R40 had Humulog and Lantus insulin pens in medication cart. R42's physician orders dated 10/3/16, indicated R42 had orders for Lantus and Novolog insulin. R42 had Lantus and Novolog insulin pens in medication cart. R54's physicians orders dated 10/3/16, indicated R54 had orders for Lantus insulin. R54 had Lantus pen in medication cart. R61's physician orders dated 10/3/16, indicated R61 had orders for Novolog and Lantus insulin. R61 had Novolog and Lantus pens in the medication cart. On 11/1/16,at 7:14 p.m. LPN-B was observed to perform a blood glucose check on R19 with R19's dedicated glucometer. Glucometers were observed to be stored in the first drawer of the medication cart in plastic baggies with residents names on them. Upon completion of obtaining the sample in R19's room, LPN-B removed gloves, left R19's room, and placed the glucometer on top of the medication cart prior to opening the drawer and placing the uncleaned	21375		

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21375	Continued From page 7	21375		

glucometer in R19's plastic baggie, which had the potential to contaminate the medication cart. LPN-B then disinfected hands with sani-wipes on medication cart.

On 11/2/16, at 11:05 a.m. LPN-D was observed to perform a blood glucose check on R19 with R19's dedicated glucometer. Upon completion of obtaining the sample in R19's room, LPN-D removed gloves without washing or disinfecting hands, left R19's room and placed the uncleaned glucometer on top of the medication cart prior to opening drawer. LPN-D then placed the glucometer in R19's plastic baggie, which had the potential to contaminate the medication cart.

On 11/2/16, at 11:16 a.m. LPN-D was observed to perform a blood glucose check on R13 with R13's dedicated glucometer. Upon completion of obtaining a sample in residents room, LPN-D placed glucometer on top of medication cart, opened the drawer, and placed the unclean glucometer in resident's plastic baggie, which had the potential to contaminate the medcation cart. In addition, LPN-D then removed gloves. LPN-D did not wash or disinfect hands after completing task.

On 11/3/16, at 1:37 p.m. the assistant director of nursing (ADON) confirmed that the top of medication cart should have been decontaminated after placement of glucometer, and glucometers will be placed in plastic, covered individual containers. The ADON also verified there was a risk of cross contamination with insulin pens being stored together. They should have been in individually labeled bags.

On 11/4/2016, at 9:42 a.m. ADON stated glucometers and pens were disinfected yesterday

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21375	Continued From page 8 and placed in covered, plastic individual containers. In addition, gloves should have been removed and hands washed or disinfected immediately after removal. The undated facility policy and procedure for standard precautions directed staff to remove gloves before touching non-contaminated items or environmental surfaces and wash hands immediately after removing gloves. In addition, the policy directed the staff to avoid contamination and prevent transfer of microorganisms to residents and environmental surfaces. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure an infection control program that includes medication administration and hand hygiene is appropriately implemented for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21375		
21426	MN St. Statute 144A.04 Subd. 3 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	21426		12/5/16

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21426	Continued From page 9 Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). 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 ensure 2 of 5 employees (E-1 and E-2) received a second step Mantoux and/or had the second step Mantoux read, interpreted and recorded. In addition, the facility failed to ensure 2 of 5 residents (R54 and R84) had second step Mantoux properly administered and recorded upon admission to the facility. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline tuberculosis (TB) screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. E-1's first step Mantoux (a screening test for	21426	Tag 21426 Corrected	

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21426	Continued From page 10	21426		

tuberculosis) was administered on 7/27/16, and read on 7/29/16, as 0 mm, negative. E-1's employee file lacked documentation of administration or results of second step TST.

E-2's first step Mantoux was administered on 8/16/16, and read on 8/18/16, as 0 mm, negative. E-2's second step was administered on 11/2/16, and E-1's employee file lacked documentation of the results.

R84 was admitted to the facility on 9/23/16. R84's second step Mantoux was administered on 10/21/16, and R84's medical record lacked documentation of a second step TST result.

R54 was admitted to the facility on 8/15/16. R54's medical record lacked documentation of second step Mantoux being administered.

On 11/3/16, at 1:50 p.m. the assistant director of nursing (ADON) was interviewed and explained that E-1 had the second step Mantoux scheduled at his orientation, but he never showed up for it. The ADON further stated that she missed this, and should have seen it was not administered during her monthly employee checks. ADON explained that E-2 had a second step Mantoux administered on 10/21/16, but it was not read. The ADON stated she missed both of these follow-ups. The ADON further stated E-1 is no longer employed at the facility, and E-2 had the second step Mantoux administered on 11/2/16, and will be read on 11/4/16.

In an interview on 11/3/16, at 1:55 p.m. the ADON verified R84 lacked documentation regarding the results of the second step Mantoux. The ADON further stated the facility missed the second step Mantoux for resident R54. The ADON explained

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ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(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
21426	Continued From page 11 that a new infection control checklist had been implemented, and Mantoux screening had been left off of it. The facility's Tuberculosis Screening (TB) and Mantoux Administration policy dated 8/15, directed newly admitted residents will received TB screening under "Matrix Observations" and first mantoux within 72 hours of admission. Step one of two-step Mantoux is performed on newly hired personnel, prior to orientation on the floor or resident contact. A Second Step is completed 14 days later, and the same form is used for documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure tuberculosis screening and testing is done on all staff and residents. Education could be provided for all appropriate staff. Monitoring systems such as audits could be developed to ensure ongoing compliance, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	21980		12/5/16

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21980	Continued From page 12	21980		

individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of

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21980	Continued From page 13 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential mistreatment to the State Agency (SA) and thoroughly investigate allegations of potential mistreatment for 2 of 4 residents (R17, R25) reviewed for potential mistreatment. Findings include: R17's annual Minimum Data Set (MDS) dated 8/13/16, identified diagnoses of Alzheimer's disease, psychosis, and depression. The MDS also identified R17 had severely impaired cognition, and required extensive staff assistance with toileting, personal hygiene, bathing, and transfers. The care plan dated 8/13/16, indicated R17 rejected cares at times, could be verbally abusive toward staff, and exhibited short tempered behavior (slap, hit, strike out, pinch, and punch). A facility Event Report dated 9/25/16, indicated that R17's right eye was black, blue, and puffy, and this was an injury of unknown origin. On 9/28/16, at 4:21 p.m. a progress note identified a bruise near R17's right eye. The progress note also indicated R17 denied being hurt by anyone, she had a history of being resistive and combative with cares, and she would had a history of scratching herself. On 9/28/16, the progress notes identified the interdisciplinary team (IDT) met and determined R17's resting position was to sit with her hand by her eye as she rests her head on her hand. The	21980	Tag 21980 Corected	

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21980	Continued From page 14 IDT determined this caused pressure to her periorbital (around the eye) area. The IDT indicated R17 will not sit in any other position while she rests in her wheelchair and often refused to lay down. The IDT note indicated the facility intervention to prevent future reoccurrence of similar incident was to have resident wear soft gloves or cloth in hand when up in wheelchair to protect face and hands from excess pressure and reduce potential for bruising. On 11/2/16, at 9:47 a.m. nursing assistant (NA)-I and NA-J stated they are to report any bruising to the licensed practical nurse (LPN) immediately. On 11/4/16, at 8:58 a.m. LPN-B stated NAs are to use a facility specific body observation sheet during weekly skin observation. The NA would complete the form and report all skin conditions to the LPN, as well as turn in this sheet to the LPN. The LPN would then document weekly and update registered nurse (RN) if indicated. The LPN would open and complete a skin event if indicated and update the RN if an event is opened. The LPN would monitor the bruises until healed in treatment administration record (TAR) or medication administration record (MAR). LPN-B also stated when bruises are identified, staff are to measure the area, complete an event report, and document in progress notes. If a bruise was of unknown origin, in a suspicious area (face, peri area, breast), a vulnerable adult (VA) report was to be filed. LPN-B also stated they are to report to the nurse manager immediately, fax the report to the (SA), initiate the facility investigation, and interview all staff caring for the resident during the past 24 hours. LPN-B was unsure of the time to report to the SA, but stated it is a very short time window.	21980		

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21980	Continued From page 15 On 11/4/16, at 9:55 a.m. the director of nursing (DON) stated she did not know why R17's black, blue, and puffy right eye wasn't reported immediately to the state agency. The DON confirmed it should have been reported at the time it was discovered. The DON stated if the facility was unable to determine the origin of bruise, they have to report within 1 to 2 hours. The DON stated staff has been trained on VA reporting. The facility Abuse Prevention Plan dated 7/1/15, directed staff to notify the facility charge of building immediately of all incidents who would notify the administrator, DON, and director of social services. The Abuse Prevention Plan defined injuries of unknown source as the source of the injury was not observed by any person or the source of the injury could not be explained, and the injury was suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma). The policy further directed the director of social services and DON to investigate all accidents and incidents. The policy further directed the charge of building, administrator, DON, and director of social services are responsible for reporting suspected abuse or neglect immediately. R25's quarterly Minimum Data Set (MDS) dated 9/23/16, identified a diagnosis of heart failure. The MDS also indicated R25 was cognitively intact and had no behaviors, rejection on cares or wandering. The MDS further identified R25 required staff assistance for wheelchair mobility on and off the unit. An Safety Events-Elopement form dated 10/15/16, indicated R25 eloped three times on 10/15/16, between 5:45 p.m. and 6:15 p.m. R25	21980		

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21980	Continued From page 16 was found wheeling himself down the front ramp and also towards the outside front steps. The incident was not reported to the State Agency (SA) until 10/17/16. The Elopement Risk Assessment dated 10/18/16, indicate R25 had unsuccessful elopement attempts in the past, and had verbalized statements about leaving. R25 was at moderate risk for elopement. The SA Incident Report-Submission Completed form indicated the state agency received the elopement report on 10/17/16. On 11/4/16, at 9:40 a.m. the director of nursing (DON) verified the elopement was not reported until 11/17/16, and should have been reported on 11/15/16. The DON stated the elopement happened on a Saturday and she was not made aware of it until she came in on Monday. The DON stated licensed practical nurses (LPN) and registered (RN) could also report to the state agency. The DON further stated she had a LPN meeting on 10/27/16, and reviewed vulnerable adult reporting and the elopement incident to try to avoid this from happening again. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and/or revise facility policies and procedures related to abuse prohibition. The DON or designee could re-educated all staff on these policies and procedures. Reports of abuse/neglect/injuries of unknown origin could be reviewed for compliance with these policies, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.	21980		

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21980	Continued From page 17 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		