DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 921G
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00583
1. MEDICARE/MEDICAID PROVID (L1) 245277	ER NO.	3. NAME AND AL (L3) ST RAPHAL			B CENTER	4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 175197200	NO.	(L4) 601 GRANT (L5) EVELETH ,			(L6) 55734	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	9/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	06/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :		Program Re			2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	76 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	VF) 8. Patient Room Size
13.Total Certified Beds	76 (L13) 76 (L17)	B. Not in Comp	liance with Progr	am	5. Life Safety Code	9. Beds/Room
15. Total Celtified Beds		-	and/or Applied V		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
76	.,					
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM			NCELLATION I	DATE).		
10. STATE SORVET AGENCT KEW	IARKS (IF AFFLIC)	BLE SHOW LIC CA	INCLLLATION	DALE).		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Teresa Ament, HFE NEI	I	0	2/01/2017	(L19)	Mark Meath	, Enforcement Specialist 02/01/2017 (L20)
РА	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBI	LITY	20. COM	PLIANCE WITH	I CIVIL	21. 1. Statement of Finan	ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to	Participate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	bl Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	-				5. Bour of the Above	
2. Tuonity is not 2.1gio.	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 04/01/1985	BEGINNINC	G DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	-
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	()		03-Risk of Involuntary Termination	on OTHER
		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind St	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	30	. DETERMINATION	OF APPROVAL	DATE		
	22	12/20/2016				
	(L32)			(L33)	DETERMINATION APPI	ROVAL



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



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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVI	SIT
	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).

ITEI	м	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix	F0225	Correction	ID Prefix F0226	6 Correction	ID Prefix	F0309 Correction
Reg. #	483.13(c)(1)(ii)-(iii), (- (4)	c)(2) Completed	Reg. #	B(c) Completed	Reg. #	483.25 Completed
LSC		12/05/2016		12/05/2016	LSC	12/05/2016
ID Prefix	F0334	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. #	483.25(n)	Completed	483.65 Reg. #	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	
REVIEWE STATE AC	ED BY RE GENCY (IN	VIEWED BY ITIALS) TA/mm	DATE 02/01/2017	SIGNATURE OF SURVEYOR 29433		DATE 12/19/2016
REVIEWE CMS RO		VIEWED BY ITIALS)	DATE	TITLE		DATE
FOLLOW	UP TO SURVEY CO	MPLETED ON		R ANY UNCORRECTED DEFICIEI CTED DEFICIENCIES (CMS-2567)	NCIES. WAS A SENT TO TH	A SUMMARY OF HE FACILITY?

POST-CERTIFICATION REVISIT REPORT

IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	V2	DATE OF R	-
NAME OF FACILITY ST RAPHAELS HEALTH & REH	HAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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).

ITEN	И	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	101 Completed	Reg. #	Completed
LSC	K0271	11/17/2016	LSC <u>K0321</u>	11/17/2016	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	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
REVIEWE STATE AC		REVIEWED BY (INITIALS) TL/mm	DATE 02/01/2017	SIGNATURE OF SURVEYOR	19251	DATE 12/13/2016
REVIEWE CMS RO	ЕD ВҮ	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOW		Y COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)	NCIES. WAS A SENT TO THE	

					CENTERS FOR MED	
					AND TRANSMITTAL	ID: 921G
		TO BE COMPI	LETED BY I	HE SIAI	TE SURVEY AGENCY	Facility ID: 00583
1. MEDICARE/MEDICAID PROVID	ER NO.	3. NAME AND AL (L3) ST RAPHAI			CENTED	4. TYPE OF ACTION: $\underline{2}(L8)$
(L1) 245277		(L4) 601 GRANT		& KEHAI	DUENIER	1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID N (L2) 175197200	NU.	(L4) OUT GRAINT (L5) EVELETH,			(L6) 55734	3. Termination 4. CHOW
(12) 173177200			IVIIN		. ,	5. Validation6. Complaint7. On-Site Visit9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGO	ORY	<u>02</u> (L7)	8. Full Survey After Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Fun Survey Arter Complaint
6. DATE OF SURVEY 11/04	4/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED A	AS:		
From (a):		A. In Complia			And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re			2. Technical Personnel	6. Scope of Services Limit
		Compliance			3. 24 Hour RN	7. Medical Director
		1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size
12.Total Facility Beds	76 (L18)	X 7			5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	76 (L17)	X B. Not in Con	pliance with Prog and/or Applied W		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDC	WN	Requirements	and/or reprice w	arvers.	* Code: B * 15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
76	19 511	ICI	IID		1801 (e) (1) 01 1801 (j) (1).	
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM				ATE).		
10. STATE SURVET ADENCT REM	IARKS (II AI I LICA	BLE SHOW LIC CA	INCELLATION	AIL).		
17. SURVEYOR SIGNATURE		Deter			10 CTATE CLIDVEN ACENCY	
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Susan Frericks, HPR	R SWS	1	2/01/2016		Mark meath	, Enforcement Specialist 12/19/2016
				(L19)		(L20)
PA	RT II - TO BE (~~~		~ ~ ~ ~		
		JUNIFLEIEDI	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	FATE AGENCY
19. DETERMINATION OF ELIGIBII		20. COM	PLIANCE WITH		21. 1. Statement of Finan	cial Solvency (HCFA-2572)
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	LITY Participate	20. COM	PLIANCE WITH		 Statement of Finar Ownership/Contro 	cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
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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:

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

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

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

<u>Potential Consequences</u> - 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

St Raphaels Health & Rehabilitation Center November 19, 2016 Page 3

> 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

St Raphaels Health & Rehabilitation Center November 19, 2016 Page 4

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.

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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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 St Raphaels Health & Rehabilitation Center November 19, 2016 Page 6 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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	-	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
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F 225 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has beet your verification. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/IND The facility must not been found guilty of mistreating residen had a finding entered registry concerning of residents or misate and report any know court of law against indicate unfitness for other facility staff to or licensing authority The facility must entity involving mistreat including injuries of misappropriation of	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with (c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or the State nurse aide registry ties. usure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported	F 2:	25			12/5/16
	to other officials in a through established	administrator of the facility and accordance with State law d procedures (including to the					
	State survey and ce	ertification agency).					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 12/18/2016

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	violations are thoro	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress.				
	to the administrator representative and with State law (inclu certification agency incident, and if the	vestigations must be reported r or his designated to other officials in accordance uding to the State survey and v) within 5 working days of the alleged violation is verified ive action must be taken.				
	by: Based on interview facility failed to imm potential mistreatm and thoroughly inve- mistreatment for 2 reviewed for potent Findings include: R17's annual Minin 8/13/16, identified of disease, psychosis also identified R17 cognition, and requ with toileting, perso transfers. The care R17 rejected cares abusive toward stat	NT is not met as evidenced y and document review, the nediately report allegations of ent to the State Agency (SA) estigate allegations of potential of 4 residents (R17, R25) ial mistreatment. mum Data Set (MDS) dated diagnoses of Alzheimer's , and depression. The MDS had severely impaired ired extensive staff assistance onal hygiene, bathing, and plan dated 8/13/16, indicated at times, could be verbally ff, and exhibited short (slap, hit, strike out, pinch,		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, were interviewed and it was detern that R17 obtained the bruise from sleeping on her fistimmediate co action for R17 was done; including reminders to staff to utilize non-pharmacological interventions resident behaviors and to offer/end rest in bed when resident appears Chart reviewed, resident care plan updatedR 17 has not received a other bruises to eye areaStaff to encourage use of travel pillow to s her head on 11-23-16 R25 had attempted to elope on 10-15-16on 10-17-16, the elope was reported to the state agency immediate corrective action was d	staff nined prrective , , with courage sleepy. any upport	

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	that R17's right eye	port dated 9/25/16, indicated was black, blue, and puffy, ury of unknown origin.			R25 including; elopement assessment RN, relocation to more secure unit, wandergaurd in place, and care plan v updated on 10-17-16R25 has not ha	was	
	identified a bruise r progress note also	p.m. a progress note near R17's right eye. The indicated R17 denied being			any successful elopement attempts sin this corrective measure was initiated. In order to identify other residents who	ince	
	resistive and comb would had a history	e had a history of being ative with cares, and she of scratching herself. On ss notes identified the			were possibly affected, all events occurring after 11-4-16 have been reviewed by IDT to assure that policies were followed and reporting requirement		
	interdisciplinary tea R17's resting positi	Im (IDT) met and determined on was to sit with her hand by the head on her hand. The			were met Systemic changes to prevent similar occurrence include: *review of the VA		
	periorbital (around	s caused pressure to her the eye) area. The IDT not sit in any other position			reporting policy which was found to be appropriate; * a weekend call list has been generat	ted	
	refused to lay dowr	er wheelchair and often n. The IDT note indicated the to prevent future reoccurrence			and made available for staff to contact management for clarification of reporta events		
	gloves or cloth in h	vas to have resident wear soft and when up in wheelchair to ands from excess pressure and			* the care providers algorithms for reporting and the necessity of immedia investigation and reporting has been	iate	
	reduce potential for On 11/2/16, at 9:47	r bruising. ' a.m. nursing assistant (NA)-I			re-enforced as the tool to determine w to report *additionally, staff received education		
		ey are to report any bruising to cal nurse (LPN) immediately.			the abuse prevention plan and manda reporters *the event reporting policy has been	atory	
	use a facility specif	a.m. LPN-B stated NAs are to ic body observation sheet observation. The NA would			reviewed and remains appropriate *all nursing staff will be trained on the above measures on 12-1-16.		
	complete the form to the LPN, as well	and report all skin conditions as turn in this sheet to the Id then document weekly and			Monitoring to assure compliance has been initiated and entails: a weekend review each week for 4 weeks will be		
	update registered r LPN would open ar	nurse (RN) if indicated. The nd complete a skin event if te the RN if an event is			completed by the CM for any events opened to assure appropriate investigation and reporting has been		
		would monitor the bruises until			completed; and Monday through Frida	ays	

Facility ID: 00583

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F 225	or medication admi LPN-B also stated staff are to measur report, and docume bruise was of unkn area (face, peri are (VA) report was to b they are to report to immediately, fax th facility investigation for the resident dur was unsure of the t stated it is a very sl On 11/4/16, at 9:55 (DON) stated she o blue, and puffy righ immediately to the confirmed it should time it was discove facility was unable bruise, they have to The DON stated st reporting. The facility Abuse F directed staff to not building immediate notify the administr social services. The defined injuries of u of the injury was not the source of the in and the injury is lo vulnerable to traum	t administration record (TAR) inistration record (MAR). when bruises are identified, e the area, complete an event ent in progress notes. If a own origin, in a suspicious ta, breast), a vulnerable adult be filed. LPN-B also stated o the nurse manager e report to the (SA), initiate the n, and interview all staff caring ing the past 24 hours. LPN-B time to report to the SA, but	F 2	this review will be c after morning meet events reviewed wi actions to the DON Mondaythe audits reviewed at quality ongoing auditsthe responsible for the audits and complian 12-5-16. The Social Service will compile monthl present to quality conservice designee is	Il be submitted with or designee every s results are to be council for the need or e DON/designee is completion of these nce will be achieved by designee or designee y VA reports and		

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	9/23/16, identified a The MDS also india intact and had no b wandering. The MI required staff assiss on and off the unit. An Safety Events-E 10/15/16, indicated 10/15/16, between was found wheeling and also towards the incident was not re (SA) until 10/17/16 The Elopement Riss indicate R25 had u attempts in the pass statements about he risk for elopement. The SA Incident Re form indicated the elopement report of On 11/4/16, at 9:40 (DON) verified the until 11/17/16. The DON happened on a Safe	Elopement form dated I R25 eloped three times on 5:45 p.m. and 6:15 p.m. R25 g himself down the front ramp ne outside front steps. The ported to the State Agency sk Assessment dated 10/18/16, nsuccessful elopement et, and had verbalized eaving. R25 was at moderate eport-Submission Completed state agency received the				

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F 226 SS=D	to avoid this from h	appening again. P/IMPLMENT	F 22	6	12/5/16
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	by: Based on interview facility failed to imm potential mistreatm and thoroughly inve- mistreatment for 2 reviewed for potent Findings include: R17's annual Minir 8/13/16, identified of disease, psychosis also identified R17 cognition, and requ	num Data Set (MDS) dated diagnoses of Alzheimer's , and depression. The MDS had severely impaired ired extensive staff assistance		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, were interviewed and it was detern that R17 obtained the bruise from sleeping on her fist&immediate co action for R17 was done; including reminders to staff to utilize non-pharmacological interventions resident behaviors and to offer/end rest in bed when resident appears Chart reviewed, resident care plan updated &R 17 has not received a	staff nined rrective g, s with courage sleepy. ny other
	with toileting, perso transfers. The care R17 rejected cares abusive toward stat tempered behavior and punch).	anal hygiene, bathing, and plan dated 8/13/16, indicated at times, could be verbally ff, and exhibited short (slap, hit, strike out, pinch,		bruises to eye area&Staff to encou use of travel pillow to support her 11-23-16& R25 had attempted to elope on 10-15-16&on 10-17-16, the eloper was reported to the state agency&immediate corrective acti- done for R25 including; elopement	nead on nent on was

Facility ID: 00583

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CIENCY MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE	
 t eye was black, blue, and puffy, n injury of unknown origin. 4:21 p.m. a progress note lise near R17's right eye. The also indicated R17 denied being e, she had a history of being ombative with cares, and she story of scratching herself. On ogress notes identified the y team (IDT) met and determined position was to sit with her hand by e rests her head on her hand. The d this caused pressure to her und the eye) area. The IDT will not sit in any other position s in her wheelchair and often down. The IDT note indicated the not oprevent future reoccurrence ent was to have resident wear soft in hand when up in wheelchair to nd hands from excess pressure and al for bruising. 9:47 a.m. nursing assistant (NA)-I ed they are to report any bruising to ractical nurse (LPN) immediately. 8:58 a.m. LPN-B stated NAs are to pecific body observation sheet skin observation. The NA would orm and report all skin conditions well as turn in this sheet to the 	4	 assessment by RN, relocation secure unit, wandergaurd in preserve unit, wandergaurd in preserve plan was updated on 10-has not had any successful elements since this corrective was initiated. In order to identify other resid were possibly affected, all even occurring after 11-4-16 have be reviewed by IDT to assure that were followed and reporting reviewed by IDT to assure that were followed and reporting reviewed by IDT to assure that were followed and reporting reporting policy which was four appropriate; * a weekend call list has been and made available for staff to management for clarification of events * the care providers algorithm reporting and the necessity of investigation and reporting has re-enforced as the tool to dete to report& * additionally, staff received exit the abuse prevention plan and reporters& * the event reporting policy has reviewed and remains appropriate above measures on 12-1-16. Monitoring to assure compliant 	blace, and 17-16&R25 lopement measure ents who ents been at policies equirements similar f the VA und to be a generated o contact of reportable s for immediate s been ermine when ducation on d mandatory as been oriate d on the nce has		
	& REHAB CENTER & REHAB CENTER BY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) Im page 6 at eye was black, blue, and puffy, in injury of unknown origin. 4:21 p.m. a progress note uise near R17's right eye. The also indicated R17 denied being by she had a history of being combative with cares, and she istory of scratching herself. On rogress notes identified the ry team (IDT) met and determined position was to sit with her hand by a rests her head on her hand. The d this caused pressure to her bund the eye) area. The IDT will not sit in any other position is in her wheelchair and often down. The IDT note indicated the ntion to prevent future reoccurrence lent was to have resident wear soft in hand when up in wheelchair to al for bruising. 9:47 a.m. nursing assistant (NA)-I ed they are to report any bruising to ractical nurse (LPN) immediately.	PLIER & REHAB CENTER AY STATEMENT OF DEFICIENCIES DENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) ID PREFID TAG Im page 6 F 2 Im page 6 F 2 It eye was black, blue, and puffy, in injury of unknown origin. F 2 Im page 6 F 2 It eye was black, blue, and puffy, in injury of unknown origin. F 2 It eye was black blue, and puffy, in injury of unknown origin. F 2 Im page 6 F 2	Puter STREET ADDRESS, CITY, STATE, ZIP COL & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP COL W STATEMENT OF DEFICIENCIES CROSS-REFERENCED BY FULL Y OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) m page 6 F 226 assessment by RN, relocation secure unit, wandergaurd in p care plan was updated on 10- has not had any successful ise near R17's right eye. The also indicated R17 denied being e, she had a history of being g, she had a history of being In order to identify other resid were possibly affected, all eve occurring after 11-4-16 have f reviewed by IDT to assure the were followed and reporting run obtion was to sit with her hand by e rests her head on her hand. The oput the eye) area. The IDT will not sit in any other position sin her wheelchair and often dhands from excess pressure and al for bruising. * a weekend call list has beer and made available for staff to management for clarification e events 9:47 a.m. nursing assistant (NA)-I ad they are to report any bruising to ractical nurse (LPN) immediately. * the exae providers algorithm reporters& * the event reporting pal an reviewed and remains approg- * ald nursing staff will be traine- above measures on 12-1-16. % S8 a.m. LPN-B stated NAs are to pecific body observation. The NA would orm and report all skin conditions well as turn in this sheet to the l would then document weekly and reed nurse (RN) if indicated. The * the ecompleted by the veriew will be completed by the	PULER STREET ADDRESS, CITY, STATE, ZIP CODE & REHAB CENTER 5TREET ADDRESS, CITY, STATE, ZIP CODE 8 REHAB CENTER 5TREET ADDRESS, CITY, STATE, ZIP CODE 97 STATEMENT OF DEFICIENCIES DENCY MUST BE PRECEDED BY FULL OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVINCE SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY) mp age 6 It eye was black, blue, and puffy, in nijury of unknown origin. 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 occurring after 11-4-16 have been reviewed by IDT to assure that policies were followed and reporting requirements in har wheelchair and often down. The IDT mote indicated the tion to prevent future reoccurrence ent was to have resident wear soft in hand when up in wheelchair to dh hands from excess pressure and al for bruising. * a weekend call list has been generated and made available for staff to contact management for clarification of reportable events * 347 a.m. nursing assistant (NA)-I a dthey are to report any bruising to ractical nurse (LPN) immediately. * the care providers algorithms for reporting and the necessity of immediate investigation and reporting has been reviewed and remains appropriate * all nursing staff will be trained on the above measur	

Facility ID: 00583

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			0.00	T 1 T :		<u>MB NO.</u>	APPROVEI 0938-039
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245277	B. WING			11/03/2016	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPI	HAELS HEALTH & RE	HAB CENTER			01 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 226	or medication admi LPN-B also stated y staff are to measure report, and docume bruise was of unknown area (face, peri are (VA) report was to be they are to report to immediately, fax the facility investigation for the resident dur was unsure of the t stated it is a very sh On 11/4/16, at 9:55 (DON) stated she co blue, and puffy righ immediately to the confirmed it should time it was discover facility was unable to bruise, they have to The DON stated star reporting. The facility Abuse F directed staff to not building immediatel notify the administra social services. The defined injuries of u of the injury was not the source of the in and the injury is low vulnerable to traum the director of social	nistration record (MAR). when bruises are identified, e the area, complete an event ent in progress notes. If a own origin, in a suspicious a, breast), a vulnerable adult be filed. LPN-B also stated b the nurse manager e report to the (SA), initiate the a, and interview all staff caring ing the past 24 hours. LPN-B ime to report to the SA, but	F 2	226	with IDT after morning meeting&the weekend events reviewed will be submitted with actions to the DON/designee every Monday&the a results are to be reviewed at quality council for the need on ongoing audits&the DON/designee is respon for the completion of these audits a compliance will be achieved by 12- The Social Service designee/design compile monthly VA reports and pre quality councilthe social service designee is responsible for the report and compliance will be achieved by 12-5-16.	audits / nsible nd 5-16. nee will esent to orts	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/18/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245277	B. WING	i		11/0	03/2016
NAME OF I	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	HAELS HEALTH & RE	HAB CENTER			601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	further directed the administrator, DON services are respon abuse or neglect im 9/23/16, identified a The MDS also indic intact and had no b wandering. The MD required staff assis on and off the unit. An Safety Events-E 10/15/16, indicated 10/15/16, between was found wheeling and also towards th incident was not rep (SA) until 10/17/16. The Elopement Ris indicate R25 had un attempts in the pas statements about le risk for elopement. The SA Incident Ref form indicated the s elopement report o On 11/4/16, at 9:40 (DON) verified the o until 11/17/16. The DON happened on a Sat aware of it until she DON stated license registered (RN) cou agency. The DON f	 charge of building, I, and director of social nsible for reporting suspected nmediately. nimum Data Set (MDS) dated a diagnosis of heart failure. cated R25 was cognitively behaviors, rejection on cares or DS further identified R25 tance for wheelchair mobility Elopement form dated I R25 eloped three times on 5:45 p.m. and 6:15 p.m. R25 g himself down the front ramp he outside front steps. The ported to the State Agency set, and had verbalized eaving. R25 was at moderate eport-Submission Completed state agency received the 	F	226			

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES		0	FORM MB NO.	12/18/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245277	B. WING		11/	03/2016
NAME OF F	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST RAPH	IAELS HEALTH & RE	HAB CENTER		601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	Continued From pa adult reporting and	ge 9 the elopement incident to try	F 22	6		
F 309 SS=D	to avoid this from h 483.25 PROVIDE (HIGHEST WELL B	CARE/SERVICES FOR	F 30	9		12/5/16
	provide the necess or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment				
	by: Based on observat review, the facility f assessed, monitore implemented to pre- of 3 residents (R17 non-pressure relate Findings include: R17's Annual Minin 8/13/16, identified of Alzheimer's disease identified R17 had status and required of daily living (ADLs R17's care plan dat reject cares at time staff, and exhibit sh hit, strike out, pinch also directed staff t	num Data Set (MDS) dated diagnoses that included e, and anemia. The MDS also severely impaired cognitive I staff assistance with activities		F309investigation and report- sa adjustments to R17 as noted above R20 has passed awayR20 was in have bruising to her upper arm and 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, were interviewed and it was detern that R17 obtained the bruise from sleeping on her fistimmediate co action for R17 was done; including reminders to staff to utilize non-pharmacological interventions resident behaviors and to offer/end rest in bed when resident appears Chart reviewed, resident care plan updatedR 17 has not received a other bruises to eye areaStaff to encourage use of travel pillow to su her head on 11-23-16	e. oted to d the staff nined rrective , with sourage sleepy.	

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	-	AND HUMAN SERVICES				FORM	12/18/201 APPROVEI 0938-039
TATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245277	B. WING			11/03/2016	
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPI	HAELS HEALTH & RE	HAB CENTER			01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 10	F3	309			
	have a pale, purplisher right hand. On right upper, inner a reddish purple disc. On 11/4/16, at 8:58 (LPN)-B verified a pback of R17's right not previously awar their was no docum medical record (EMR20's annual MDS diagnoses that inclugeneralized muscle and transischemic The MDS also iden impaired cognition, easily annoyed. In a required staff assis R20's care plan dat observe skin with c to a licensed nurse At 9:09 a.m. LPN-E right upper, inner a light purplish in colowas no documenta On 10/29/16, at 4:0 check was done an were noted. On 11/4/16, at 8:58	 a.m. licensed practical nurse pale, purplish, pink bruise on hand. LPN-B stated she was re of the bruise, and verified nentation in R17's electronic (IR) regarding the bruise. on 8/13/16, identified uded schizophrenia, e weakness, type I diabetes, attacks (TIA's or mini strokes). tified R20 had severely and was short tempered and addition, the MDS stated R20 t with ADLs. ted 11/7/15, directed staff to ares and report any changes or LPN-B also verified there tion in R20's EMR. 7 p.m. R20's weekly skin ad no bruising or other issues a.m. LPN-B stated nursing 			In order to identify other residents w potential to be affected by bruising, residents have had a head to toe sk inspection completed by 11-23-16 a documented on the facility bath skin sheet, and events or VA reports completed per facility policy. Systemic changes to prevent recurr include: *The skin tool has been updated to include LPN observation of all repor skin issues and the policy has been reviewed and remains appropriate *the bruise policy has been reviewed updated to include any bruises rese fingerprints as reportable *stop and watch tool use will be rein during staff education on 12-1-16. *event policy and required investigat have been reviewed and remain appropriate *the care provider algorithm for repor VA incidents as well as mandated reporters policy has been reviewed deemed appropriate to use as a rep guideline *Staff will receive education on all of above on 12-1-16. Monitoring has been put in place to assure that these processes are foll The Clinical Managers/designee wil complete a weekly audit for 4 weeks totaling 10% of the residents on the observation tool use, documentation appropriate action with events and reporting; these audits will be submit the DON/designee.	All ind ind ence rted d and mbling oforced tion orting an porting f the lowed. I s skin n, and itted to	
	diagnoses that inclu generalized muscle and transischemic of The MDS also iden impaired cognition, easily annoyed. In a required staff assis R20's care plan dat observe skin with c to a licensed nurse At 9:09 a.m. LPN-E right upper, inner a light purplish in colo was no documenta On 10/29/16, at 4:0 check was done an were noted. On 11/4/16, at 8:58 assistants (NAs) ar	uded schizophrenia, e weakness, type I diabetes, attacks (TIA's or mini strokes). tified R20 had severely and was short tempered and addition, the MDS stated R20 t with ADLs. ted 11/7/15, directed staff to cares and report any changes 8 verified a bruise on R20's rm which she described as or. LPN-B also verified there tion in R20's EMR. 07 p.m. R20's weekly skin ad no bruising or other issues			fingerprints as reportable *stop and watch tool use will be rein during staff education on 12-1-16. *event policy and required investigat have been reviewed and remain appropriate *the care provider algorithm for reporter VA incidents as well as mandated reporters policy has been reviewed deemed appropriate to use as a rep guideline *Staff will receive education on all of above on 12-1-16. Monitoring has been put in place to assure that these processes are foll The Clinical Managers/designee wil complete a weekly audit for 4 weeks totaling 10% of the residents on the observation tool use, documentation appropriate action with events and reporting; these audits will be submit	aforced tion orting an oorting f the lowed. I s skin n, and itted to	

Facility ID: 00583

If continuation sheet Page 11 of 19

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED	
IND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED	
		245277	B. WING		11/	03/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ST RAPH	IAELS HEALTH & RE	HAB CENTER	601 GRANT AVENUE EVELETH, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 309	Continued From pa	ge 11	F 30	9			
	skin conditions to the sheet to the LPN. T weekly and update indicated. The LPN skin event if indicate event is opened. The bruises until healed record (TAR) or me (MAR). LPN-B also identified, staff are an event report, and	plete the form and report all the LPN, as well as turn in this the LPN would then document the registered nurse (RN) if would open and complete a ed and update the RN if an the LPN would monitor the l in treatment administration redication administration record stated when bruises are to measure the area, complete d document in progress notes.		determination of ongoing need fo Future frequencies of the report w determined by the Quality Counci The DON/designee is responsible auditingcorrection will be achier 12-5-16.	vill be I. e for		
F 334 SS=D	guidelines and prote reporting of bruising bruises of unknown suspicious areas (a breasts, face, peri a policy Skin Integrity dated 2/2011, speci of skin tissue to inc observance of body bruises.	policy dated 1/15/16, directed ocol for monitoring and g, which included monitoring origin and bruises in arms, wrist, finger prints, area). In addition, the facility Assessment/Documentation ifically directed assessments lude inspection and v surfaces for observation of NZA AND PNEUMOCOCCAL	F 33	4		12/5/16	
	The facility must de that ensure that (i) Before offering th each resident, or th representative rece benefits and potent immunization; (ii) Each resident is immunization Octob annually, unless the	evelop policies and procedures ne influenza immunization, e resident's legal ives education regarding the ial side effects of the offered an influenza per 1 through March 31 e immunization is medically he resident has already been					

Facility ID: 00583

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TATEMENT	T OF DEFICIENCIES OF CORRECTION	KANNERSPICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245277	B. WING _		11/03/2016		
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 601 GRANT AVENUE EVELETH, MN 55734	E	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	IOULD BE	(X5) COMPLETIC DATE	
F 334	immunized during t (iii) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po immunization; and (B) That the reside influenza immunization; and (B) That the reside influenza immunization; and (B) That the reside influenza immunization; and (I) Before offering th immunization, each legal representative the benefits and po immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po pneumococcal imm	this time period; the resident's legal the opportunity to refuse medical record includes t indicates, at a minimum, the ent or resident's legal provided education regarding itential side effects of influenza ent either received the ation or did not receive the ation due to medical r refusal. evelop policies and procedures he pneumococcal n resident, or the resident's e receives education regarding itential side effects of the s offered a pneumococcal ss the immunization is licated or the resident has unized; the resident's legal the opportunity to refuse medical record includes t indicated, at a minimum, the ent or resident's legal provided education regarding itential side effects of	F 3(34			

Facility ID: 00583

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		& MEDICAID SERVICES				. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	()	E SURVEY		
		245277	B. WING _		11/	03/2016		
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE			
ST RAPI	HAELS HEALTH & RE	HAB CENTER		601 GRANT AVENUE EVELETH, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
pn the co (v) an pn ye im	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.		F 33	34				
	by: Based on interview facility failed to adm 23-valent polysacch known as the Pneu Polysaccharide Vac the Prevnar 13) for R84), and provide r PPV13 vaccine for reviewed for vaccin Findings include: R70 was a 97 year facility in 4/16. R70 Record revealed no or PCV13 had beer their representative R84 was an 84 yea facility in 9/16. R84 Record revealed no	old resident admitted to the 's Vaccine Administration o risk/benefit for the PPSV23 n offered to the resident or		 F334influenza and pneu immunization. R70 has declined the pneu vaccination and declination filed in the medical record. R84 has passed away. In order to identify others w potential, all residents in the been reviewed for consents for the pneumococcal 23 a 11-15-16as consents are vaccinations are being adm Systemic changes to prevei include: Revision to the consent form to include signature of administering LN, date of v then the uploading of this c declination form upon comp vaccination, unless decline The Admission Pre-administering to the to include 	mococcal s have been with this e facility have s/declinations nd 13 on e obtained the ninistered ent recurrence t / declination f the accination and onsent / oletion of d. mission screen			

Facility ID: 00583

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	-	AND HUMAN SERVICES	r	OME	ORM APPROVED NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IG(X	B) DATE SURVEY COMPLETED	
		245277	B. WING _		11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER		601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 334	Continued From pa	ge 14	F 33	34		
	nursing (ADON) sta or documentation in offered pneumocod evidence R70 and information regardin vaccination. The facility's Pneum dated 6/1/14, direct recommended for a .Documentation in electronic medical in provided and to wh consent that educa	cepting or refusal of		 An admission checklist has been updated to include vaccinations recommended. Staff will receive education on all revision to processes as above on 12 16 Monitoring for compliance has been pplace and the Admissions coordinator/designee will complete a weekly audit of admissions for 4 week assure that new processes are follow and report concerns to the ICN/designee will report monthly Quality Council for determination of ongoing need for audits. Reports will completed monthly for 3 months and at a frequency to be determined by th Quality Council. The infection control RN/designee is responsible for audits and the date certis 12-5-16. 	ut in as to ed nee. to be then e	
F 441 SS=E	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F 44		12/5/16	
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whi (1) Investigates, co in the facility; (2) Decides what pu should be applied to	tablish an Infection Control				

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245277	B. WING			11/0	03/2016
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER			01 GRANT AVENUE		
				E	VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is inco professional practice (c) Linens Personnel must han	fections. ead of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted	F 4	41			
	by: Based on observat review, the facility fa were properly store contamination for 6 R42, R54, R61) wh addition, the facility infection control pra glucometer (portabl glucose levels) che This had the potent received medication	NT is not met as evidenced tion, interview and document ailed to ensure insulin pens d to prevent cross of 6 residents (R8, R28, R40, o utilized insulin pens. In failed to to ensure proper actices were maintained during le monitor that measure blood cks for 3 of 3 observations. ial to affect 38 residents who n from 2 of 3 medication carts of medication administration.			F441insulin and glucometers. Immediate correction has been implemented for R8, R28, R40, R42 R61 by placing their disinfected insu pens in a zip lock baggie on Novem 2016 Immediate correction has been implemented for R8, R28, R40, R42 R61 by issuing a plastic container to their personal glucometer on 11-2-2 inglucometers were disinfected p being placed in the issued containe Other residents with this potential h been identified and pens and gluco	ulin aber 2, 2, R54, o store 2016 rior to r ave	

Facility ID: 00583

If continuation sheet Page 16 of 19

PRINTED: 12/18/2016

		E & MEDICAID SERVICES					0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · /	E SURVEY PLETED
		245277	B. WING				03/2016
NAME OF	PROVIDER OR SUPPLIER	-		STR	EET ADDRESS, CITY, STATE, ZIP CODE	-	
ST RAPI	HAELS HEALTH & RE	HAB CENTER	601 GRANT AVENUE EVELETH, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 441	Continued From pa	age 16	F 4	41			
	On 11/3/16, at 1:24 insulin pens were of together in one con the medication car (LPN)-C verified th the same comparts R8's physician orde had orders for Hun N insulin pen in me R28's physician ord R28 had orders for Lantus insulin pen R40's physician ord R40 had orders for R40 had orders for R40 had Humulog medication cart. R42's physician ord R42 had orders for R42 had orders for R41's physicians of R61's physician ord R61 had orders for R61 had orders for R61 had orders for R61 had orders for R61 had	4 p.m. unboxed, unbagged observed to be stored all mpartment of the first drawer of t. Licensed practical nurse at all insulin pens are stored in ment. ers dated 10/3/16, indicated R8 nulin N insulin. R8 had Humulin edication cart. ders dated 10/3/16, indicated r Lantus insulin. R28 had in medication cart. ders dated 10/3/16, indicated r Humalog and Lantus insulin. and Lantus insulin pens in ders dated 10/3/16, indicated r Lantus and Novolog insulin. ad Novolog insulin pens in rders dated 10/3/16, indicated r Lantus and Novolog insulin.			blaced in individual containers as above. Systematic changes to prevent re- nclude revising the Blood Glucose Monitor policy to include storage containers and use. The hand washing policy was also updated for increase in specifics w regard to medication administratic All above stated changes will be presented in the 12-1-16 staff edu Medication cart audits will comple- times a week by an LN for 2 week assure compliance with storage or bens and glucometers. Audits of glucometer or pen use, fincluding handwashing and infect control) will be done daily by CM/c for a week at alternating times/shi hen to be done weekly on day an afternoon shift for an additional 3 with results to quality council for determination of ongoing audits Audits will also be completed by t CM/designee on handwashing wit medication administration, glucom use and during meal timesthese done daily at alternating times/shift one week, then weekly for an add weeks in order to determine comp with infection control regulations for medication pass and mealtimes results to quality council for determ of ongoing audits. Audits will be submitted to the DON/designee will report to the Q assure compliance and then at a	currence e vith on. cation ted 3 s to f insulin lesignee fts and d weeks he h heter e will be fts for itional 3 bliance or audit nination	

Facility ID: 00583

If continuation sheet Page 17 of 19

ATEMEN	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED	
		245277	B. WING		11	11/03/2016	
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		00,2010	
	HAELS HEALTH & RE	HAB CENTER	601 GRANT AVENUE EVELETH, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 441	observed to be stor medication cart in p names on them. Up the sample in R19's gloves, left R19's ro glucometer on top opening the drawer glucometer in R19' potential to contam LPN-B then disinfe medication cart. On 11/2/16, at 11:0 to perform a blood R19's dedicated glu obtaining the samp removed gloves with hands, left R19's ro glucometer on top opening drawer. LF glucometer in R19' potential to contam On 11/2/16, at 11:1 perform a blood glu dedicated glucome obtaining a sample placed glucometer opened the drawer glucometer in resid the potential to contain In addition, LPN-D did not wash or dis task. On 11/3/16, at 1:37 nursing (ADON) co medication cart sho	red in the first drawer of the blastic baggies with residents pon completion of obtaining s room, LPN-B removed bom, and placed the of the medication cart prior to r and placing the uncleaned s plastic baggie, which had the inate the medication cart. cted hands with sani-wipes on 5 a.m. LPN-D was observed glucose check on R19 with ucometer. Upon completion of ble in R19's room, LPN-D thout washing or disinfecting bom and placed the uncleaned of the medication cart prior to PN-D then placed the s plastic baggie, which had the inate the medication cart. 6 a.m. LPN-D was observed to ucose check on R13 with R13's ter. Upon completion of in residents room, LPN-D on top of medication cart, , and placed the unclean lent's plastic baggie, which had taminate the medcation cart. then removed gloves. LPN-D infect hands after completing	F 44	1 Council. The DON/designee is respo audits. Compliance will be achieved			

If continuation sheet Page 18 of 19

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/18/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245277	B. WING		11/	03/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB 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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	covered individual of verified there was a with insulin pens be should have been in On 11/4/2016, at 9: glucometers and pe and placed in cover containers. In addit removed and hands immediately after re The undated facility standard precaution gloves before touch or environmental su immediately after re the policy directed t contamination and	 ill be placed in plastic, containers. The ADON also a risk of cross contamination eing stored together. They in individually labeled bags. 42 a.m. ADON stated ens were disinfected yesterday red, plastic individual ion, gloves should have been is washed or disinfected emoval. Policy and procedure for the directed staff to remove thing non-contaminated items urfaces and wash hands emoving gloves. In addition, he staff to avoid 	F 441			

Facility ID: 00583

If continuation sheet Page 19 of 19

		AND HUMAN SERVICES		15377025		APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245277	B. WING		11/0	08/2016
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ſS	КO	00		
-	ALLEGATION OF (DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Marshal Division or time of this survey, Center was found r with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National	Survey was conducted by the nent of Public Safety, Fire n November 8, 2016. At the St. Raphael's Healthcare not in substantial compliance nts for participation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.				
	DEFICIENCIES (M HEALTHCARE FIF STATE FIRE MAR	R THE FIRE SAFETY (-TAGS) TO: RE INSPECTIONS SHAL DIVISION STREET, SUITE 145		EPO	C	
	Or by email to:					
	y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 11/23/2016

Electronically Signed

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.

Facility ID: 00583

PRINTED: 11/30/2016

the second second second second second	The Construction of South Construction of South Construction States	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
		245277	B. WING	-		11/0	8/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	AELS HEALTH & RE	HAB CENTER		-	01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa Marian.Whitney@s Angela.Kappenmar	tate.mn.us and	ĸ	000		¢	
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.			Δ.		
	2. The actual, or pr	oposed, completion date.	l I				
		r title of the person rection and monitoring to ence of the deficiency.					
	2-story building with building was constru- constructed in 1974 II(111) construction II(111) construction was inspected as of The building is fully has a fire alarm sys- corridors and space	h & Rehabilitation Center is a h a full basement. The original ructed in 1954 with an addition 4. The 1954 building is of type and the 1974 building is type building. 7 fire sprinklered. The facility stem with smoke detection in the sopen to the corridors that is matic fire department					
		apacity of 76 beds and had a time of the survey.					
К 271	The requirement a NOT MET as evide NFPA 101 Dischar		K	271			11/17/16

		& MEDICAID SERVICES	_			0938-039	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			• •			TE SURVEY MPLETED	
		B. WING 1			/08/2016		
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
T RAPH	IAELS HEALTH & RE	HAB CENTER		601 GRANT AVENUE EVELETH, MN 55734			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETIC	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE	
K 271 SS=E	Continued From pa	ige 2	K 27	1			
00-E	Discharge from Exi	its					
		ranged in accordance with 7.7,					
		lking surface meeting the					
		with respect to changes in be maintained free of					
		onally, the exit discharge shall					
		all-weather travel surface in					
		MS Survey and Certification					
	Letter 05-38. 18.2.7, 19.2.7, S&C	NOE 29					
		s not met as evidenced by:					
		tion and staff interview, the		All items identified will be removed	d from		
		tain the exit discharge in		stairwell and stored appropriately			
	practice could affect	7, 19.2.7. This deficient ct 20 residents.		elsewhere on the campus. The Plant Operations Manager an designee will monitor for complian	d/or his ce in		
	Findings include:			the issue. This was completed November 17			
		veen the hours of 11:30 AM					
		/08/2016, it was observed that irvell had several boxes,					
		nt and 10 metal chairs stored					
		t in accordance with LSC (12)					
		tice was verified by the rvisor at the time of inspection.					
K 321 SS=D		ous Areas - Enclosure	K 32	21		11/17/16	
00-0	Hazardous Areas -	Enclosure					
	2012 EXISTING						
		are protected by a fire barrier resistance rating (with 3/4-hour					
		an automatic fire extinguishing					
	system in accorda	nce with 8.7.1. When the					
		c fire extinguishing system					
		areas shall be separated from noke resisting partitions and					
		ce with 8.4. Doors shall be					

Event ID: 921G21

Facility ID: 00583

If continuation sheet Page 3 of 4

PRINTED: 11/30/2016

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
245277			B, WING			11	11/08/2016	
	PROVIDER OR SUPPLIER	HAB CENTER		601	REET ADDRESS, CITY, STATE, ZIP CODE I GRANT AVENUE 'ELETH, MN 55734			
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETIO DATE	
K 321	have nonrated or fi that do not exceed the door. Describe the floor a hazardous areas th 19.3.2.1 Area Seperation N/ a. Boiler and Fuel-I b. Laundries (large c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fea g. Laboratories (if of Hazard - see K322 This STANDARD Based on observa facility did not main rooms not in accor section 19.3.2.1. T 3 to 5 residents. Findings include: On facility tour betw and 3:30 PM on 11 the laundry soiled I self-closed and po 19.3.2.1. This deficient prace	Automatic Sprinkler A Automatic Sprinkler A Binches from the bottom of and zone locations of hat are deficient in REMARKS. Automatic Sprinkler A Fired Heater Rooms ir than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe	K	321	A door closer will be installed to deficient practice on 11/17/2016. This will be monitored by the Pla Operations Manager and or Desi	nt		

Facility ID: 00583

If continuation sheet Page 4 of 4



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

St Raphaels Health & Rehabilitation Center November 19, 2016 Page 2

"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

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00583	B. WING _		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CIT	Y, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAR CENTER	RANT AVENU ETH, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been	d s on f f			
	that may result from orders provided tha the Department with	hearing on any assessmer n non-compliance with thes at a written request is made hin 15 days of receipt of a ent for non-compliance.	е			
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electroni nsure orders consistent wit artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo e licensing orders are	h			
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE	S SIGNATURE	TITLE		(X6) DATE 11/28/16

Electronically Signed

STATE FORM

If continuation sheet 1 of 18

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00583	B. WING		11/	11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ST RAPH	IAELS HEALTH & RE	HAR CENTER	NT AVENUE H, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 000	Continued From pa	age 1	2 000				
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departn On 10/31/16-11/3/1 Department's staff, the following correct Please indicate in y correction that you and identify the dat	6, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, the when they will be completed nent of Health is documenting	i				
	federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n	Correction Orders using ag numbers have been sota state statutes/rules for number appears in the far left Prefix Tag." The state					
	statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are after the statement evidence by." Follo	compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00583	B. WING	B. WING		
	PROVIDER OR SUPPLIER	HAB CENTER 601 GRA	DRESS, CITY, S NT AVENUE 1, MN 55734	STATE, ZIP CODE	·	03/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			12/5/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident in bed.				
	by: Based on observati review, the facility f assessed, monitore implemented to pre	ent is not met as evidenced ion, interview, and document ailed to ensure bruises were ed, and interventions were event further bruising for for 2 , R20) who were reviewed for ed skin conditions.		Tag 2830 Corrected		
	Findings include:					
	8/13/16, identified of Alzheimer's disease identified R17 had s	num Data Set (MDS) dated diagnoses that included e, and anemia. The MDS also severely impaired cognitive I staff assistance with activities				

	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00583	B. WING		11/	03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST RAPI	HAELS HEALTH & RE	HAR CENTER	NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 3	2 830			
	of daily living (ADL	5).				
	reject cares at time staff, and exhibit sh hit, strike out, pinch also directed staff t report any changes On 10/31/16, at 8:5 have a pale, purplis her right hand. On right upper, inner a reddish purple disc					
	(LPN)-B verified a p back of R17's right not previously awar their was no docum	a.m. licensed practical nurse bale, purplish, pink bruise on hand. LPN-B stated she was re of the bruise, and verified nentation in R17's electronic IR) regarding the bruise.				
	diagnoses that inclu generalized muscle and transischemic The MDS also iden impaired cognition,	on 8/13/16, identified uded schizophrenia, weakness, type I diabetes, attacks (TIA's or mini strokes). tified R20 had severely and was short tempered and addition, the MDS stated R20 t with ADLs.				
		ted 11/7/15, directed staff to ares and report any changes .				
	right upper, inner a	8 verified a bruise on R20's rm which she described as or. LPN-B also verified there tion in R20's EMR.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00583	B. WING		11/03/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE. ZIP CODE		
		601 GB4	ANT AVENUE	,		
	IAELS HEALTH & RE	EVELET	H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 4	2 830			
		07 p.m. R20's weekly skin nd no bruising or other issues				
	assistants (NAs) ar observation sheet of The NA would com skin conditions to the sheet to the LPN. The weekly and update indicated. The LPN skin event if indicate event is opened. The bruises until healed record (TAR) or me (MAR). LPN-B also identified, staff are an event report, an	a.m. LPN-B stated nursing re to use a facility specific body during weekly skin observation plete the form and report all he LPN, as well as turn in this The LPN would then document the registered nurse (RN) if would open and complete a ted and update the RN if an he LPN would monitor the d in treatment administration edication administration record o stated when bruises are to measure the area, complete d document in progress notes	e			
	guidelines and prot reporting of bruising bruises of unknown suspicious areas (a breasts, face, peri a policy Skin Integrity dated 2/2011, spec of skin tissue to inco	g, which included in the roy directed occil for monitoring and g, which included monitoring n origin and bruises in arms, wrist, finger prints, area). In addition, the facility Assessment/Documentation ifically directed assessments clude inspection and y surfaces for observation of				
	The Director of Nur develop, review, an procedures to ident related skin issues, implemented, asse for all residents. Th	THOD OF CORRECTION: rsing or designee could nd/or revise policies and tify and assess not-pressure , such as bruises, are ssed and revised as needed the Director of Nursing or ucate all appropriate staff on				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED	
		00583	B. WING		11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ST RAPH	HAELS HEALTH & RE	HAR CENTER	NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
2 830	Continued From pa	ge 5	2 830			
		cedures. sing or designee could systems to ensure ongoing				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one	,			
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375		12/5/16	
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.				
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to ensure insulin pens		Tag 21375		
	were properly store contamination for 6 R42, R54, R61) wh addition, the facility infection control pra glucometer (portabl glucose levels) che This had the potent received medication		1	Corrected		
	Findings include:					
	insulin pens were o together in one con the medication cart	p.m. unboxed, unbagged bserved to be stored all partment of the first drawer of . Licensed practical nurse at all insulin pens are stored in				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00583	B. WING		11/0	11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
ST RAPH	IAELS HEALTH & RE	HAR CENTER	NT AVENUE H, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 6	21375				
	the same compartr	nent.					
		ers dated 10/3/16, indicated R8 nulin N insulin. R8 had Humulir dication cart.					
		ders dated 10/3/16, indicated Lantus insulin. R28 had in medication cart.					
	R40 had orders for	ders dated 10/3/16, indicated Humalog and Lantus insulin. and Lantus insulin pens in					
	R42 had orders for	ders dated 10/3/16, indicated Lantus and Novolog insulin. d Novolog insulin pens in					
		rders dated 10/3/16, indicated Lantus insulin. R54 had cation cart.					
	R61 had orders for	ders dated 10/3/16, indicated Novolog and Lantus insulin. and Lantus pens in the					
	perform a blood glu dedicated glucome observed to be stor medication cart in p names on them. Up	p.m. LPN-B was observed to ucose check on R19 with R19's ter. Glucometers were red in the first drawer of the plastic baggies with residents pon completion of obtaining s room, LPN-B removed	5				
	gloves, left R19's ro glucometer on top	oom, and placed the of the medication cart prior to r and placing the uncleaned					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00583	B. WING		11/	11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST RAPH	HAELS HEALTH & RE	HAB CENTER	NT AVENUE H, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 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.						
	to perform a blood R19's dedicated glu obtaining the samp removed gloves wi hands, left R19's ro glucometer on top opening drawer. LF glucometer in R19'	5 a.m. LPN-D was observed glucose check on R19 with ucometer. Upon completion of ole in R19's room, LPN-D thout washing or disinfecting oom and placed the uncleaned of the medication cart prior to PN-D then placed the s plastic baggie, which had the ninate the medication cart.					
	perform a blood glu dedicated glucome obtaining a sample placed glucometer opened the drawer glucometer in resid the potential to con In addition, LPN-D	6 a.m. LPN-D was observed to ucose check on R13 with R13's eter. Upon completion of in residents room, LPN-D on top of medication cart, and placed the unclean dent's plastic baggie, which had taminate the medcation cart. then removed gloves. LPN-D infect hands after completing	3				
	nursing (ADON) co medication cart sho decontaminated af and glucometers v covered individual verified there was a with insulin pens be	7 p.m. the assistant director of onfirmed that the top of ould have been ter placement of glucometer, vill be placed in plastic, containers. The ADON also a risk of cross contamination eing stored together. They in individually labeled bags.					
		:42 a.m. ADON stated ens were disinfected yesterday	,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00583	B. WING		11/	11/03/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ST RAPH	IAELS HEALTH & RE	HAR CENTER	NT AVENUE H, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21375	Continued From pa	ige 8	21375				
	containers. In addit	red, plastic individual ion, gloves should have been s washed or disinfected emoval.					
	standard precaution gloves before touch or environmental su immediately after re the policy directed to contamination and						
	Director of Nursing review, and/or revis ensure an infection medication adminis appropriately imple Director of Nursing appropriate staff or The Director of Nur	THOD OF CORRECTION: The or designee could develop, se policies and procedures to control program that includes stration and hand hygiene is mented for all residents. The or designee could educate all the policies and procedures. sing or designee could systems to ensure ongoing					
	TIME PERIOD FOR Twenty-One (21) D						
21426	MN St. Statute 144 Prevention And Con	A.04 Subd. 3 Tuberculosis ntrol	21426			12/5/16	
(r ii c	maintain a compret infection control pro current tuberculosis issued by the Unite	e provider must establish and nensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00583	B. WING		11/	11/03/2016	
	PROVIDER OR SUPPLIER	HAB CENTER 601 GRA	DRESS, CITY, NT AVENUE 1, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21426	Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must	21426				
	by: Based on interview facility failed to ens E-2) received a sec the second step Ma recorded. In addition of 5 residents (R54	ent is not met as evidenced and document review, the ure 2 of 5 employees (E-1 and cond step Mantoux and/or had antoux read, interpreted and on, the facility failed to ensure 2 and R84) had second step idministered and recorded the facility.		Tag 21426 Corrected			
	Transmission of My Health-Care Setting residents must rece (TB) screening with within 3 months pri must include an as	es for Preventing the ycobacterium Tuberculosis in gs, 2005, (MMWR) directed all eive a baseline tuberculosis nin 72 hours of admission or or to admission. The screening sessment of the resident's risk any current TB symptoms.					
nnesota De ATE FORM	epartment of Health	toux (a screening test for	6899	921G11	lf continuet	on sheet 10 c	

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00583	B. WING	B. WING		11/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ST RAPH	IAELS HEALTH & RE	HAR CENTER	NT AVENUE H, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	age 10	21426				
	read on 7/29/16, as employee file lacke administration or re E-2's first step Mar 8/16/16, and read of E-2's second step v	administered on 7/27/16, and s 0 mm, negative. E-1's ed documentation of esults of second step TST. ntoux was administered on on 8/18/16, as 0 mm, negative. was administered on 11/2/16, e file lacked documentation of					
	second step Manto 10/21/16, and R84' documentation of a R54 was admitted medical record lack	to the facility on 9/23/16. R84's oux was administered on 's medical record lacked a second step TST result. to the facility on 8/15/16. R54's ked documentation of second					
	nursing (ADON) wa that E-1 had the se at his orientation, b The ADON further and should have se during her monthly explained that E-2 administered on 10 The ADON stated s follow-ups. The AD longer employed at) p.m. the assistant director of as interviewed and explained cond step Mantoux scheduled out he never showed up for it. stated that she missed this, een it was not administered employee checks. ADON had a second step Mantoux 0/21/16, but it was not read. she missed both of these ON further stated E-1 is no t the facility, and E-2 had the bux administered on 11/2/16,					
	verified R84 lacked results of the seco further stated the fa	11/3/16, at 1:55 p.m. the ADON d documentation regarding the ond step Mantoux. The ADON acility missed the second step nt R54. The ADON explained					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00583	B. WING		11/	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	FATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER	NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From pa	ge 11	21426			
		i control checklist had been Mantoux screening had been				
	Mantoux Administra directed newly adm screening under "M mantoux within 72 of two-step Mantou personnel, prior to resident contact. A	culosis Screening (TB) and ation policy dated 8/15, litted residents will received TE latrix Observations" and first hours of admission. Step one x is performed on newly hired orientation on the floor or Second Step is completed 14 same form is used for	5			
	The director of nurs develop, review, an procedures to ensu- testing is done on a Education could be staff. Monitoring sy developed to ensur	THOD OF CORRECTION: sing (DON) or designee could id/or revise policies and ire tuberculosis screening and all staff and residents. provided for all appropriate stems such as audits could be e ongoing compliance, and to the quality committee for				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			12/5/16
	reporter who has revulnerable adult is or who has knowled has sustained a phreasonably explained	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an				

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00583	B. WING		11/0	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	AELS HEALTH & RE	HAB CENTER 601 GRA	NT AVENUE			
STRAFT		EVELETH	I, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 12	21980			
21980	the individual is adr reporter is not requir maltreatment of the to admission, unles (1) the individual wa another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in this known or suspected knows or has reaso been made to the c (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must subdivision. If the r time believes that a agency will determin the reported error w the criteria under se 17, paragraph (c), o	arable adult solely because nitted to a facility, a mandated ired to report suspected a individual that occurred prior s: as admitted to the facility from the reporter has reason to ole adult was maltreated in the nows or has reason to believe a vulnerable adult as defined by subdivision 21, clause (4). required to report under the ection may voluntarily report as section requires a report of d maltreatment, if the reporter on to know that a report has	21980			
	(5). The lead ager	on 17, paragraph (c), clause ncy shall consider this naking an initial disposition of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00583		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		11/03/2016		
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAR CENTER	NT AVENUE H, MN 55734			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
21980	Continued From pa	ige 13	21980			
	the report under su	bdivision 9c.				
	This MN Requirem	ent is not met as evidenced				
	by:	and document review, the		Tag 21980		
		nediately report allegations of				
	and thoroughly inve	ent to the State Agency (SA) estigate allegations of potential of 4 residents (R17, R25) ial mistreatment.		Corected		
	Findings include:					
	8/13/16, identified of disease, psychosis also identified R17 cognition, and requ with toileting, perso transfers. The care R17 rejected cares abusive toward stat	mum Data Set (MDS) dated diagnoses of Alzheimer's , and depression. The MDS had severely impaired ired extensive staff assistance onal hygiene, bathing, and plan dated 8/13/16, indicated at times, could be verbally ff, and exhibited short (slap, hit, strike out, pinch,				
	that R17's right eye	oort dated 9/25/16, indicated was black, blue, and puffy, ury of unknown origin.				
	identified a bruise r progress note also hurt by anyone, she resistive and comba would had a history 9/28/16, the progre interdisciplinary tea	p.m. a progress note hear R17's right eye. The indicated R17 denied being a had a history of being ative with cares, and she of scratching herself. On ss notes identified the m (IDT) met and determined on was to sit with her hand by				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		11/03/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	•	
	HAELS HEALTH & RE	601 GBA	NT AVENUE			
		EVELETI	H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ge 14	21980			
	IDT determined this periorbital (around ti indicated R17 will n while she rests in h refused to lay down facility intervention of similar incident w gloves or cloth in ha protect face and ha reduce potential for On 11/2/16, at 9:47 and NA-J stated that the licensed practic On 11/4/16, at 8:58 use a facility specifi during weekly skin complete the form a to the LPN, as well LPN. The LPN wou update registered n LPN would open ar indicated and update opened. The LPN w healed in treatment or medication admi LPN-B also stated w staff are to measure pruise was of unkne area (face, peri are (VA) report was to k they are to report to immediately, fax the facility investigation for the resident duri	s caused pressure to her the eye) area. The IDT ot sit in any other position er wheelchair and often b. The IDT note indicated the to prevent future reoccurrence vas to have resident wear soft and when up in wheelchair to nds from excess pressure and bruising. a.m. nursing assistant (NA)-I ey are to report any bruising to al nurse (LPN) immediately. a.m. LPN-B stated NAs are to c body observation sheet observation. The NA would and report all skin conditions as turn in this sheet to the ld then document weekly and urse (RN) if indicated. The nd complete a skin event if te the RN if an event is would monitor the bruises until administration record (TAR) nistration record (MAR). when bruises are identified, e the area, complete an event ent in progress notes. If a town origin, in a suspicious a, breast), a vulnerable adult be filed. LPN-B also stated o the nurse manager e report to the (SA), initiate the , and interview all staff caring ing the past 24 hours. LPN-B ime to report to the SA, but				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00583		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		B. WING		11/	11/03/2016					
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE						
ST RAPHAELS HEALTH & REHAB CENTER 601 GRANT AVENUE EVELETH, MN 55734										
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE				
21980	On 11/4/16, at 9:55 (DON) stated she of blue, and puffy righ immediately to the confirmed it should time it was discover facility was unable bruise, they have to The DON stated st reporting. The facility Abuse I directed staff to nor building immediate notify the administr social services. Th defined injuries of to of the injury was not the source of the ir and the injury was not the source of the ir and the injury was extent of the injury (e.g. the injury is lo vulnerable to traum the director of social investigate all accid further directed the administrator, DON services are respon abuse or neglect in R25's quarterly Mir 9/23/16, identified a The MDS also india intact and had no b wandering. The MI required staff assis on and off the unit. An Safety Events-E 10/15/16, indicated	a.m. the director of nursing did not know why R17's black, at eye wasn't reported state agency. The DON have been reported at the red. The DON stated if the to determine the origin of o report within 1 to 2 hours. aff has been trained on VA Prevention Plan dated 7/1/15, tify the facility charge of ly of all incidents who would rator, DON, and director of e Abuse Prevention Plan unknown source as the source of observed by any person or njury could not be explained, suspicious because of the or the location of the injury cated in an area not generally ha). The policy further directed al services and DON to dents and incidents. The policy e charge of building, I, and director of social nsible for reporting suspected	,							

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
	00583		B. WING		11/0	03/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
	IAELS HEALTH & RE	HAR CENTER	NT AVENUE			
		EVELET	H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ge 16	21980			
	was found wheeling	g himself down the front ramp				
		ne outside front steps. The				
		ported 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					
		ed practical nurses (LPN) and uld also report to the state				
		further stated she had a LPN				
		6, and reviewed vulnerable				
	adult reporting and	the elopement incident to try				
	to avoid this from h	appening again.				
	SUGGESTED METHOD OF CORRECTION:					
	The director of nurs	sing (DON) or designee, could				
	review and/or revise	e facility policies and				
		to abuse prohibition. The				
		ould re-educated all staff on				
		procedures. Reports of ies of unknown origin could be				
		iance with these policies, with				
		intation maintained. An				
	auditing system cou	uld be developed and				
		results shared with the facility's	S			
		t & Assurance committee, to				
	ensure on-going co	mpliance.				1

921G11

If continuation sheet 17 of 18

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00583		00583	B. WING		11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE		NT AVENUE H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 17	21980			
21980	-	age 17 R CORRECTION: Fourteen	21980			
	epartment of Health					