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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 924J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00593

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245483**
2.STATE VENDOR OR MEDICAID NO.
(L2) **940220900**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE NORTH SHORE ESTATES LLC**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 07/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/19/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245483

September 9, 2016

Ms. Brittney Hunt, Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, Minnesota 55807

Dear Ms. Hunt:

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 June 30, 2016 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 29, 2016

Ms.. Brittney Hunt, Administrator
The North Shore Estates LLC
7700 Grand Avenue
Duluth, Minnesota 55807

RE: Project Number S5483025

Dear Ms.. Hunt:

On June 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 26, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 20, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 12, 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 May 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 26, 2016, effective June 30, 2016 and therefore remedies outlined in our letter to you dated June 10, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245483 Y1	A. Building B. Wing Y2	7/20/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0280	Correction	ID Prefix	F0282	Correction	ID Prefix	F0309	Correction
Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	Completed
LSC		06/30/2016	LSC		06/30/2016	LSC		06/30/2016
ID Prefix	F0314	Correction	ID Prefix	F0318	Correction	ID Prefix	F0441	Correction
Reg. #	483.25(c)	Completed	Reg. #	483.25(e)(2)	Completed	Reg. #	483.65	Completed
LSC		06/30/2016	LSC		06/30/2016	LSC		06/30/2016
ID Prefix	F0465	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.70(h)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		06/30/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	07/29/2016	29625	07/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/26/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245483 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	06/30/2016	LSC K0025	06/30/2016	LSC K0029	06/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	06/30/2016	LSC K0052	06/15/2016	LSC K0056	06/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	06/15/2016	LSC K0076	06/30/2016	LSC K0104	06/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	07/29/2016	27200	07/12/16
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/25/2016

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 29, 2016

Ms.. Brittney Hunt, Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

Re: Reinspection Results - Project Number S5483025

Dear Ms.. Hunt:

On July 20, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 26, 2016, with orders received by you on . At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00593 Y1	A. Building B. Wing Y2	7/20/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20570	Correction	ID Prefix 20830	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0405 Subp. 4	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed
LSC	06/30/2016	LSC	06/30/2016	LSC	06/30/2016
ID Prefix 20895	Correction	ID Prefix 20900	Correction	ID Prefix 21390	Correction
Reg. # MN Rule 4658.0525 Subp. 2.B	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed
LSC	06/30/2016	LSC	06/30/2016	LSC	06/30/2016
ID Prefix 21426	Correction	ID Prefix 21685	Correction	ID Prefix 21942	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1415 Subp. 2	Completed	Reg. # MN St. Statute 144A.10 Subd. 8b	Completed
LSC	06/30/2016	LSC	06/30/2016	LSC	06/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TA/mm	07/29/2016	29625	07/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 5/26/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 924J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00593

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245483**
2.STATE VENDOR OR MEDICAID NO.
(L2) **940220900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ELIGIUS HEALTH CENTER**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR SWS 07/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 10, 2016

Ms.. Brittney Hunt, Administrator
St Eligius Health Center
7700 Grand Avenue
Duluth, Minnesota 55807

RE: Project Number S5483025

Dear Ms.. Hunt:

On May 26, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 5, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 26, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 26, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIGIUS HEALTH CENTER	7700 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		6/30/16

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

Electronically Signed | 06/17/2016

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

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to reflect palm protector application for 1 of 1 resident (R59) as directed by occupational therapy (OT). Findings include: R59's Face Sheet printed 5/26/16, identified R59's diagnoses as vascular dementia, chronic pain syndrome, anxiety, depression, and bilateral hand contractures. R59's quarterly Minimum Data Set (MDS) dated 5/3/16, indicated R59 had limited upper and lower extremity range of motion (ROM) bilaterally. R59's care plan dated 5/8/16, identified a problem area for skin integrity related to R59's bilateral hand contractures. The approaches directed staff to apply palm protectors daily - on in the morning and off at bedtime. R59's nursing assistant (NA) care sheet dated 5/24/16, directed the NA staff to encourage the right palm protector. On 5/24/16, at 1:55 p.m. R59 was seated in her wheelchair watching television. R59's hands lacked palm protectors and/or any type of hand splints. R59 stated she was supposed to have the palm protectors on her hands, however the staff didn't put them on after R59 had lunch. The white lamb's wool palm protectors were observed to be lying on the dressers beside R59's bed (one on the dresser on the right side of R59's bed and one on the dresser on the left side of R59's bed). R59's hands were clinched with the finger tips	F 280	R59's care plan was immediately corrected to reflect splint application. R59's TAR was corrected for accuracy to reflect splint application. DON or their designee will review all residents' with adaptive equipment, including splints, braces, etc.'s care plans, worksheets, and TARs to ensure that they are accurate and the treatment is in place properly. To be completed by 6/17/16. A meeting was held on 6/2/16 with DON, Clinical Managers, Health Information Manager, and Therapy Department Manager to discuss process of informing nursing of any changes regarding adaptive equipment. Therapy Department will email all licensed nurses, Clinical Managers, DON and Health Information Manager whenever there is a change in adaptive equipment so that this can be changed in their care plan, worksheet, and/or TAR as applicable by the Clinical Manager and the Health Information Manager. All nursing staff will be educated on this by 6/30/16. DON or their designee will conduct an audit of all residents with adaptive equipment weekly X 4 weeks, then biweekly X 8 weeks to ensure care plans, worksheets, and TARs are updated. Following the completion of this, DON or their designee will conduct random audits of residents with splints or braces to	

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F 280	Continued From page 2 tightly clenched against the palms of R59's hands. On 5/25/16, at 7:00 a.m. R59 was lying in her bed, both hands were clenched and lacked palm protectors or any type of splint. White lamb's wool palm protectors were observed to be lying on the dressers beside R59's bed, in the same location they had been observed on the day prior. On 5/25/16, at 11:50 a.m. R59 was seated in her wheelchair in her room. R59 had a splint on her left hand. R59 confirmed she did not have the palm protectors or splint on her hand the day prior (5/24/16), as R59 stated she couldn't get anyone to put them on for her. R59's occupational therapy (OT) progress note dated 5/20/16, indicated R59 had hand contractures and nursing staff had been provided with a schedule for wear and care of R59's palm protectors. In addition, the palm protector for R59's right hand was scheduled to be applied in the evening for full night time wear, thus enabling R59 to be free during the day to feed. R59's left palm protector was scheduled to be worn during the day. OT had provided the nursing staff a direction sheet dated 5/20/16, for application of R59's palm protectors. OT directed the licensed practical nurse (LPN) to apply the left palm protector in the morning. The left palm protector was to remain placed during the day and be removed at night. The afternoon LPN was responsible for applying the right palm protector to the right hand after supper. The right palm protector was to remain on overnight and be removed with morning cares. On 5/25/16, at 11:55 a.m. LPN-A confirmed it was nursing staff's responsibility to place the palm protectors on R59. LPN-A stated the day nurse was supposed to place the left palm protector on	F 280	ensure accuracy. Policy and procedure for splint and brace application was reviewed and updated as needed on 6/8/16 and nursing staff was educated on this on 6/8/16.	

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F 280	Continued From page 3 in the morning between 6:30 a.m. and 10:30 a.m.; the left palm protector was supposed to stay on until after dinner time and the right palm protector was supposed to be placed and remain on through the night and taken off before breakfast. LPN-A verified R59's palm protectors were both off this morning. On 5/25/16, at 12:16 p.m. registered nurse (RN)-B verified R59's care plan had not been revised with the new OT directions which instructed the nursing staff to place the left palm protector on in the morning and removed at night; and the right palm protector to be placed on after supper and to remain on through the night. RN-B stated the revision of the care plan must have been missed. RN-B proceeded to revise R59's care plan to reflect the current OT orders for contracture care. On 5/26/16, at 10:35 a.m. director of nursing (DON) stated it was her expectation that care plans be revised when appropriate. DON confirmed R59's care plan should have been revised to reflect current contracture care. Care Plans-Comprehensive policy dated 10/10, directed an individualized care plan would be developed to meet the resident's medical, nursing, mental and psychological needs. The care plan was designed to enhance the optimal functioning of the resident by focusing on a rehabilitation program. In addition, assessments of resident's was ongoing and care plans would be revised as information about the resident's condition changed.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		6/30/16

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F 282	Continued From page 4 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure the care plan was followed for pressure ulcer interventions for 1 of 3 residents (R7) reviewed for pressure ulcers. Findings include: R7's Face Sheet printed 5/25/16, indicated R7's diagnoses included heart failure, low back pain, acute respiratory failure, pressure ulcer of the left buttock, deep tissue injury, shortness of breath weakness, osteoarthritis and depression. The care plan Skin Integrity with a problem start date of 4/19/16, and edited last on 5/20/16, indicated R7 was at risk for skin breakdown related to the diagnoses of major depressive disorder, anxiety, impaired mobility, obesity, history of falls, incontinence, bilateral lower extremity edema, anemia, venous stasis dermatitis, seborrhea, history of cellulitis, and stasis pigmentation to the right lower extremity. R7's skin was currently impaired with the following skin issues: Left buttocks had two red/purple lines that ran parallel to each other and measure 15.0 centimeters (cm) by 3.5 cm, possibly caused from a lift sheet as R7 stated he was transferred with a mechanical lift in the hospital. Buttocks crease had an open slit that measured 3.5 cm by 0.1 cm that appears to be moisture associated skin damage (MASD). Right inner buttocks had a Stage I pressure ulcer	F 282	F282- It is the policy of St.Eligius Health Center to ensure resident care plans are followed. R7 interventions for skin impairments include: * bariatric bed with air mattress set at 6 * bariatric wheelchair with an increased depth and higher back for support * ROHO wheelchair cushion in place for advanced pressure relief with green gripper mat underneath for traction to seat. ROHO cushion is also pushed through the back of the wheelchair for added stability of placement. R7's air mattress will be checked every shift for proper inflation and ROHO cushion checked daily for proper inflation by a licensed nurse. Additional interventions include: * Juven BID per RD recommendation for skin health * MVI with minerals * Offering and encouraging hourly repositioning, note that resident has been refusing this at times. All residents requiring every 1-2 hour repositioning will continue to have quarterly and PRN assessments to review interventions. Interventions to allow for pressure reduction will remain in effect.	

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F 282	Continued From page 5 that was red, nonblanchable, and measured 2.0 cm by 0.7 cm. R7 was at risk for skin breakdown and would be on an every one hour repositioning schedule. The care plan approaches included to provide every one hour repositioning. On 5/25/16, R7 was continuously observed from 7:40 a.m. until 9:12 a.m. and repositioning was not offered or provided until R7 requested to lay down. At 7:40 a.m. R7 was sitting up in the wheelchair in his room. R7 was sitting on the yellow canvas lift sling and the ROHO (a pressure reducing cushion) cushion. At 8:25 a.m. R7 received breakfast. No change was made in R7's position. At 8:32 a.m. the director of nursing (DON) removed R7's breakfast tray. R7 requested coffee from the DON. No change was made in R7's position. At 8:34 a.m. R7 received coffee from the DON. No change was made in R7's position. At 8:51 a.m. a nursing assistant (NA) asked R7 if he needed anything and if he was comfortable. R7 denied having to go to the bathroom. The NA did not offer repositioning. The NA was in R7's room for approximately 15 seconds. At 9:12 a.m. R7 put on the call light. Registered nurse (RN)-C answered the call light. R7 requested to the RN to lay down. The RN then asked NA-A to assist with transferring R7 to bed. After retrieving the mechanical lift and bed linens RN-C and NA-A transferred R7 onto the bed. R7's buttocks were observed with RN-C. R7's buttocks were red, blanchable and without open areas. NA-A stated R7 was to be repositioned every hour. RN-C stated the facility had a policy not to disrupt residents during meals to be repositioned. NA-A further stated she got R7 up at around	F 282	DON and designee did review on 6-6-16 repositioning procedure for residents with skin impairments for staff on duty 5-25-16 to review. All Nursing staff will review above by 7-1-16. DON or designee will conduct audits for all residents requiring 1-2 hour interventions weekly x 4, then biweekly x 4, then random audits monthly. Results will be provided to QA committee to determine further audit necessity.	

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F 282	Continued From page 6 "7:30-ish." NA-A verified R7 was not repositioned until he requested to lay down. On 5/25/16, at 9:50 a.m. R7 stated staff did not ask or offer to reposition him until he asked RN-C to lay down. On 5/26/16, at 7:15 a.m. the DON stated a tissue tolerance test (a test to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) was not done because R7 was admitted with pressure ulcers. The DON would expect staff to reposition R7 every one hour as directed by the care plan. The facility's Repositioning policy dated 4/4/16, indicated the purpose of the procedure was to provide guidelines for the assessment of resident needs to aid in the development of an individualized care plan for repositioning. To promote comfort for all bed or chair bound residents to prevent skin breakdown, promote circulation and provide pressure relief for the residents. An addendum to repositioning residents dated 4/4/16, indicated residents on every one hour repositioning or individual repositioning programs would be repositioned as soon as possible before and after meals to avoid being interrupted.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		6/30/16

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F 309	Continued From page 7 and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide coordination of care between the facility and the hospice agency for 1 of 1 resident (R23) reviewed for hospice. Findings include: R23's physician order dated 5/16, indicated R23 had been admitted to hospice care on 9/12/15, with diagnosis of Alzheimer's disease. R23's care plan dated 4/21/16, indicated R23 received hospice services related to Alzheimer's disease and directed staff to collaborate with the hospice agency regarding resident/family needs and concerns and to request any special need visits form hospice, as needed, for R23 related to Chaplin services, social services, nursing services or companion visits. On 5/24/16, at 3:20 p.m. registered nurse (RN)-F was interviewed and stated R23 receives hospice services, an aide and a nurse come. RN-F did not know what the Hospice staff's schedule was. On 5/25/16, at 12:35 p.m. RN-E stated that the facility used the hospice provider's care plan to direct care, however was unable to find it in R23's medical record and confirmed R23's facility's care plan referred staff to the hospice provider's care plan for care directives. In addition, RN-E verfied R23's facility's care plan directed staff to coordinate care with the hospice provider. At the	F 309	F309- Provide care/services for highest well being. It is the Policy of St. Eligius Health Center to ensure residents receiving hospice services receive coordination of care between their hospice provider and our facility. R23's plan of care was not updated for coordination of care between their hospice provider and our facility. This has been corrected as follows- Facility requested schedule from the hospice provider for all services provided to resident by hospice. Monthly schedule has been received and added to plan of care. In addition, R23's hospice plan of care was placed in their medical record. The following has been put in place for all hospice residents- Hospice services will provide a schedule for any services the resident will receive from hospice while in our facility. This calendar is given to the Clinical Manager or designee who will then update the plan of care for the resident. All staff from Hospice that provide services for the resident will alert the Clinical Manager or their designee that they are in the facility to provide a service.	

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F 309	Continued From page 8 same time, RN-E stated R23's medical record lacked a calendar which indicated what disciplines were to see R23 and lacked an aide plan of care indicating what services the aide would be providing to R23. On 5/25/16, at 12:30 p.m. licensed practical nurse (LPN)-D stated she was not aware of a hospice schedule, the hospice aides just show up. On 5/26/16, at 9:00 a.m. nursing assistant (NA)-F stated she knew R23 had a hospice aide, but did not know when they were to show up. NA-F stated she did not know for sure what cares the hospice aide provided for R23, but if facility staff had not done daily cares for R23, the hospice aide may do cares. If the facility had provided cares for R23, the hospice aide would do R23's nails, play the guitar for her, or rub R23's back. On 5/26/16, at 10:00 a.m. the director of nursing (DON) verified a coordination of care was lacking. Verifying the plan of care, aide care plan and calendar of when staff were to be coming to the facility should have been available for facility staff from the hospice agency. The facility policy Hospice Program revised 1/14, indicated Hospice providers who contract with the facility are held responsible for meeting the professional standards and timeliness of service as any contracted individual or agency associated with the facility. The policy also indicated when a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family would be developed.	F 309	Clinical Manager or their designee will then document in the resident's medical record the service that was provided. NAR worksheet will be updated with Hospice NAR visits so they can coordinate ADLs with Hospice. All staff will be updated on the above by 6-30-16.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		6/30/16

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F 314	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning according to the resident's assessed needs to prevent the development of pressure ulcers for 1 of 3 residents (R7) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.	F 314	It is the policy of St. Eligius Health Center to provide interventions to reduce the risk of pressure ulcers. Resident R7 was noted to have the following areas of impairment upon return from the hospital: *Two linear red/purple skin on left buttocks that appear to be DTI possibly from Hoyer lift sheet used in the hospital per resident *One left inner buttocks stage 1 pressure ulcer and open slit to buttocks crease consistent with MASD. These areas were noted on the resident□s readmission skin assessment. Surveyor notes on Significant Change MDS of 4-25-16 coded as having two stage 2 areas that were not present upon admission. Note this was not communicated at the exit conference or would have been disputed; these areas are actually the DTI in evolution as noted by wound Nurse Note 4-20-16. The open	

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F 314	Continued From page 10 Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined. R7's Face Sheet printed 5/25/16, indicated R7's diagnoses included heart failure, low back pain, acute respiratory failure, pressure ulcer of the left buttock, deep tissue injury, shortness of breath weakness, osteoarthritis and depression. The Readmission Skin Risk Assessment with Braden (a tool used to predict pressure ulcer risk) dated 4/13/16, indicated R7 was at risk for pressure ulcers. Skin concerns included the left buttock had two parallel purple/red lines that measured 15 centimeters (cm) by 3.5 cm. The buttock crease had an open slit that measured 3.5 cm by 1 cm. The right inner buttock had a Stage I pressure ulcer that was red, nonblanchable and measured 2 cm by 0.7 cm. R7 had limited mobility due to weakness and needed the assistance of three staff to turn in bed. A Significant Change Skin Assessment dated 4/25/16, indicated R7 had a ROHO cushion (a pressure reduction cushion) on the wheelchair and an air mattress on the bed to assist with pressure relief. The Braden Scale indicated R7 was at risk for skin breakdown. Skin concerns included the left outer buttock had a double bruise like area where the lift sling would rest. The area measured 14 cm by 2 cm with areas of	F 314	areas were at the site of the DTI. Per NPUAP DTI definition, Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration. DON and MDS Nurse reviewed the notes and modified the MDS to reflect that this was DTI area versus two stage 2 areas. Resident also noted to have chronic Lymphedema to lower extremities with a white area noted to Left lower extremity upon readmission. Ultrasound of extremity completed 4-21-16 with no evidence of DVT, treatment in place. On 5/25/16 resident R7 was observed from 7:40 AM until 9:12 AM resident was not repositioned until 9:12 am, per NA-A resident was out of bed around 7:30 AM. Resident was on every 1 hour repositioning d/t skin impairments. Resident then assisted into bed by RN-C and NAR, buttocks were red, blanchable and without open areas at that time. R7 interventions for skin impairments include: * bariatric bed with air mattress set at 6 * bariatric wheelchair with an increased depth and higher back for support * ROHO wheelchair cushion in place for advanced pressure relief with green gripper mat underneath for traction to seat. ROHO cushion is also pushed	

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F 314	Continued From page 11 peeled skin at the bottom that measured 1.5 cm by 1.0 cm and the upper end of the bruised area measured 0.75 cm by 0.5 cm. The rest of the buttocks were clear with no pressure areas noted. R7's coccyx area was pink. R7 was on an every one hour repositioning schedule which remained appropriate. The significant change Minimum Data Set (MDS) dated 5/5/16, indicated R7 was cognitively intact. R7 had no behaviors or rejection of cares. R7 needed the extensive assistance of two staff with bed mobility, transfer, dressing and using the toilet. R7 was not ambulatory. R7 had one Stage I pressure ulcer, two Stage II pressure ulcers that were not present on admission or was at a lesser stage on the prior assessment. The date of the oldest pressure ulcer was 4/20/16. In addition R7 had two unstageable pressure areas with suspected deep tissue injury in evolution, present on admission. R7 did not have any healed pressure ulcers. R7 had a pressure reducing device on the chair and on the bed. R7 was on a turning and repositioning program and received pressure ulcer care. The Skin Integrity care plan with a problem start date of 4/19/16, and edited last on 5/20/16, indicated R7 was at risk for skin breakdown related to the diagnoses of major depressive disorder, anxiety, impaired mobility, obesity, history of falls, incontinence, bilateral lower extremity edema, anemia, venous stasis dermatitis, seborrhea, history of cellulitis, and stasis pigmentation to the right lower extremity. R7's skin was currently impaired with the following skin issues: Right abdominal fold has an open slit which measured 0.7 cm with redness along the fold.	F 314	through the back of the wheelchair for added stability of placement. Air mattress checked every shift for proper inflation, ROHO cushion checked daily for proper inflation by a licensed nurse. Additional interventions include * Juven BID per RD recommendation skin health * MVI with minerals * Offer and encourage hourly repositioning-note resident has been refusing this at time. All residents requiring every 1-2 hour repositioning will continue to have quarterly and PRN assessments to review interventions. Interventions to allow for pressure reduction will remain in effect. DON did review on 6-6-16 repositioning procedure for residents with skin impairments for NAR staff on duty 5-25-16 to review policies. All Nursing staff will be review policy and procedure regarding repositioning by 7-1-16. DON or designee will conduct audits for all residents requiring 1-2 hour interventions weekly x 4, then biweekly x 4, then random audits monthly for quality assurance and consistent compliance. Results will be provided to QA committee to determine further audit necessity.	

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Left buttocks had two red/purple lines that ran parallel to each other and measure 15.0 cm by 3.5 cm possibly caused from a lift sheet as R7 stated he was transferred with a mechanical lift in the hospital.
Buttocks crease had an open slit that measured 3.5 cm by 0.1 cm that appears to be MASD (moisture associated skin damage).
Right inner buttocks had a Stage I pressure ulcer that was red, nonblanchable, and measured 2.0 cm by 0.7 cm.
Redness to right side of the scrotum.
Tops of both feet were edematous, dry and dark red.
Left lower leg was red, slightly warm to the touch and had a white open area on the anterior aspect that measured 2.0 cm by 2.0 cm.
R7 was at risk for skin breakdown and would be on an every one hour repositioning schedule. The care plan directed staff to assist R7 with keeping the skin clean and dry. R7 had a pressure reduction mattress on the bed and a pressure reduction cushion in the wheelchair. Provide every one hour repositioning. Apply barrier cream with zinc to R7's buttocks three times a day and as needed for protection to the slit and stage one pressure area on the left inner buttocks. Wound care to bilateral lower extremities included cleanse the lower extremities with water and mild soap, rinse, and pat dry.

On 5/25/16, R7 was continuously observed from 7:40 a.m. until 9:12 a.m. and repositioning was not offered or provided until R7 requested to lay down. At 7:22 a.m. two staff entered R7's room and provided morning cares. At 7:40 a.m. R7 was sitting up in the wheelchair in his room. R7 was sitting on the yellow canvas type lift sling and the ROHO cushion. At 8:25 a.m. R7 received

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breakfast. No change was made in R7's position. At 8:32 a.m. the director of nursing (DON) removed R7's breakfast tray. R7 requested coffee from the DON. No change was made in R7's position. At 8:34 a.m. R7 received coffee from the DON. No change was made in R7's position. At 8:51 a.m. a nursing assistant (NA) asked R7 if he needed anything and if he was comfortable. R7 denied having to go to the bathroom. The NA did not offer repositioning. The NA was in R7's room for approximately 15 seconds. At 9:12 a.m. R7 put on the call light. Registered nurse (RN)-C answered the call light. R7 requested to the RN to lay down. The RN then asked NA-A to assist with transferring R7 to bed. After retrieving the mechanical lift and bed linens RN-C and NA-A transferred R7 onto the bed. R7's buttocks were observed with RN-C. R7's buttocks were red, blanchable and without open areas. NA-A stated R7 was to be repositioned every hour.
RN-C stated the facility had a policy not to disrupt residents during meals to be repositioned.
NA-A further stated she got R7 up at around "7:30 ish." NA-A verified R7 was not repositioned until when he requested to lay down.

The medical record lacked documentation of when the pressure areas healed.

On 5/25/16, at 9:50 a.m. R7 stated staff did not ask or offer to reposition him until he asked RN-C to lay down.

On 5/26/16, at 7:15 a.m. the DON stated a tissue tolerance test (a test to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) was not done because R7 was admitted with pressure ulcers. The DON would expect staff to

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F 314	Continued From page 14 reposition R7 every one hour as directed by the care plan. The facility's Repositioning policy dated 4/4/16, indicated the purpose of the procedure was to provide guidelines for the assessment of resident needs to aid in the development of an individualized care plan for repositioning. To promote comfort for all bed or chair bound residents to prevent skin breakdown, promote circulation and provide pressure relief for the residents. An addendum to repositioning residents dated 4/4/16, indicated residents on every one hour repositioning or individual repositioning programs would be repositioned as soon as possible before and after meals to avoid being interrupted.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate treatment for 1 of 1 resident (R59) reviewed with a contracture. Findings include:	F 318	R59's care plan was immediately corrected to reflect splint application. R59's TAR was corrected for accuracy to reflect splint application. DON or their designee will review all residents' with adaptive equipment,	6/30/16

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F 318	Continued From page 15 R59's Face Sheet printed 5/26/16, identified R59's diagnoses as vascular dementia, chronic pain syndrome, anxiety, depression, and bilateral hand contractures. R59's quarterly Minimum Data Set (MDS) dated 5/3/16, indicated R59's cognition was intact, required extensive assist with bed mobility, transferring, personal hygiene, toileting, and eating. In addition, R59 had limited upper and lower extremity range of motion (ROM) bilaterally. R59's pressure ulcer Care Area Assessment (CAA) dated 5/10/16, indicated R59 wore bilateral hand splints daily related to hand contractures. On 5/24/16, at 1:55 p.m. R59 was seated in her wheelchair watching television. R59's hands lacked palm protectors and/or any type of hand splints. R59 stated she was supposed to have the palm protectors on her hands, however the staff didn't put them on after R59 had lunch. The white lamb's wool palm protectors were observed to be lying on the dressers beside R59's bed (one on the dresser on the right side of R59's bed and one on the dresser on the left side or R59's bed). R59's hands were clinched with the finger tips tightly clenched against the palms of R59's hands. On 5/25/16, at 7:00 a.m. R59 was lying in her bed, both hands were clenched and lacked palm protectors or any type of splint. White lamb's wool palm protectors were observed to be lying on the dressers beside R59's bed, in the same location they had been observed on the day prior. On 5/25/16, at 11:50 a.m. R59 was seated in her wheelchair in her room. R59 had a splint on her left hand. R59 confirmed she did not have the	F 318	including splints, braces, etc.'s care plans, worksheets, and TARs to ensure that they are accurate and the treatment is in place properly. To be completed by 6/17/16. A meeting was held on 6/2/16 with DON, Clinical Managers, Health Information Manager, and Therapy Department Manager to discuss process of informing nursing of any changes regarding adaptive equipment. Therapy Department will email all licensed nurses, Clinical Managers, DON and Health Information Manager whenever there is a change in adaptive equipment so that this can be changed in their care plan, worksheet, and/or TAR as applicable by the Clinical Manager and the Health Information Manager. All nursing staff will be educated on this by 6/30/16. DON or their designee will conduct an audit of all residents with adaptive equipment weekly X 4 weeks, then biweekly X 8 weeks to ensure care plans, worksheets, and TARs are updated. Following the completion of this, DON or their designee will conduct random audits of residents with splints or braces to ensure accuracy. Policy and procedure for splint and brace application was reviewed and updated as needed on 6/8/16 and nursing staff reviewed this on 6/8/16.	

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palm protectors or splint on her hand the day prior (5/24/16) as R59 stated she couldn't get anyone to put them on for her. R59 stated she thought some of the staff didn't know how to put them on correctly.
R59's occupational therapy (OT) progress note dated 5/20/16, indicated R59 had hand contractures and nursing staff had been provided with a schedule for wear and care of R59's palm protectors. In addition, the palm protector for R59's right hand was scheduled to be applied in the evening for full night time wear, thus enabling R59 to be free during the day to feed. R59's left palm protector was scheduled to be worn during the day.
OT had provided the nursing staff a direction sheet dated 5/20/16, for application of R59's palm protectors. OT directed the licensed practical nurse (LPN) to apply the left palm protector in the morning. The left palm protector was to remain placed during the day and be removed at night. The afternoon LPN was responsible for applying the right palm protector to the right hand after supper. The right palm protector was to remain on overnight and be removed with morning cares.
R59's care plan dated 5/8/16, identified a problem area for skin integrity related to R59's bilateral hand contractures. The approaches directed staff to apply palm protectors daily - on in the morning and off at bedtime.
R59's nursing assistant (NA) care sheet dated 5/24/16, directed the NA staff to encourage the right palm protector.
On 5/25/16, at 11:55 a.m. LPN-A confirmed it was nursing staff's responsibility to place the palm protectors on R59. LPN-A stated the day nurse was supposed to place the left palm protector on in the morning between 6:30 a.m. and 10:30 a.m.; the left palm protector was supposed to stay on

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F 318	Continued From page 17 until after dinner time and the right palm protector was supposed to be placed and remain on through the night and taken off before breakfast. LPN-A verified R59's palm protectors were both off this morning. On 5/25/16, at 12:02 p.m. NA-C confirmed R59's palm protectors were not on her hands this morning prior to NA-C assisting R59 with morning cares. On 5/25/16, at 12:16 p.m. registered nurse (RN)-B stated R59's hand protectors should be placed on in the morning. RN-B stated the OT instructions should be followed by the staff with regards to R59's hand protectors. RN-B verified R59's care plan had not been revised with the new OT directions which instructed the nursing staff to place the left palm protector on in the morning and removed at night; and the right palm protector to be placed on after supper and to remain on through the night. A policy related to contracture care was not provided.	F 318		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		6/30/16

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F 441	Continued From page 18 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control practices were followed for 1 of 2 residents (R66) who were in contact isolation. Findings include: R66's Face Sheet indicated R66 had diarrhea. R66's received a physician's order on 5/24/16, to be placed on contact precautions prophylactically for suspected clostridium difficile (a bacteria).	F 441	Correct precaution techniques were reviewed with LPN- B on 5/24/16. All staff will review the policy and procedure for infection control precautions including hand washing, PPE and that equipment such as stethoscopes, thermometers and B/P cuffs should be dedicated to one person who is on precautions and they are not to be shared. This review will be completed by 6-30-16 for staff.	

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F 441	Continued From page 19 R66's temporary care plan for clostridium difficile (c. diff) dated 5/24/16, indicated contact precautions were implemented per infection control policy. R66's nursing assistant (NA) care sheet indicated R66 was on precautions for c. diff. On 5/24/16, at 3:28 p.m. licensed practical nurse (LPN)-B entered R66's room with a thermometer and a blood pressure cuff and a stethoscope was hung around LPN-B's neck. LPN-B entered R66's room without donning any personal protective equipment (PPE) such as gloves or a gown. LPN-B proceeded to take R66's vital signs (blood pressure, temperature, pulse and respirations). LPN-B exited R66's room without washing her hands. LPN-B brought the thermometer and blood pressure cuff and placed them on the medication cart which was stationed two doors down and across the hall from R66's room. LPN-B then went back towards R66's room and opened the drawer of the isolation cart which was placed directly outside of R66's room. LPN-B opened the drawer and retrieved a pair of gloves, put them on and took a couple of bleach disposable wipes out of the container. LPN-B returned to the medication cart, briskly wiped off the blood pressure cuff and thermometer case and the top of the medication cart with the bleach wipes. LPN-B lacked disinfecting the stethoscope which remained around LPN-B's neck. LPN-B immediately placed the blood pressure cuff and thermometer into the medication cart and LPN-B removed her gloves. On 5/24/16, at 3:35 p.m. LPN-B stated she was aware R66 was being tested for c.diff. LPN-B confirmed once the isolations carts were placed	F 441	Boxes containing blood pressure cuffs, stethoscopes and thermometers are now available in the first floor treatment room that are to be dedicated to one resident on precautions and not shared. This was implemented 6-10-16. All rooms with precautions have a bin outside the room with details on the infection. Also in the bin will be our hand washing policy. Audits of staff appropriately donning PPE, and use of dedicated equipment for residents on precautions will be completed weekly times 4, then biweekly times 4. From there, QA committee will review and determine further audit necessity.	

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outside of the resident rooms the resident was considered to be in isolation. LPN-B verified there was not a designated blood pressure cuff, thermometer or stethoscope located in R66's room and there should have been. LPN-B confirmed she had taken R66's vital signs, thus LPN-B had had direct contact with R66. LPN-B confirmed she had not washed her hands upon exiting R66's room and she should have washed them with soap and water.

On 5/25/16, at 12:33 p.m. registered nurse (RN)-B verified R66 was in contact isolation prophylactically as R66 was suspicious for c.diff. RN-B confirmed R66 had been having loose stools and was on long term antibiotics. RN-B stated even though R66's culture hadn't been confirmed yet for c.diff, contact precautions for c.diff should be followed by all staff. RN-B confirmed LPN-B should have worn a gown and gloved with any potential for contact with R66 or R66's furniture or equipment. RN-B confirmed prior to exiting R66's room LPN-B should have washed her hands with soap and water.

On 5/26/16, at 8:58 a.m. RN-D (Infection Preventionist) verified R66 was in contact isolation for suspected c.diff. RN-D stated it was expected that staff follow isolation precautions for c.diff even if R66 was placed on contact precautions prophylactically. RN-D stated contact precautions included gowning and gloving when appropriate and utilizing soap and water for hand hygiene. RN-D stated R66 should have had a designated thermometer, blood pressure cuff and stethoscope located in R66's room. RN-D stated if such equipment needed to be removed from R66's room after it had been used, the equipment should have been disinfected with the bleach

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disposable wipes with a contact time (the amount of time necessary for a disinfectant to obtain maximum effective disinfection of the contacted area) of five minutes. RN-D confirmed wiping equipment with the bleach wipes and placing them directly into a medication cart without allowing the five minute contact time was not an appropriate disinfecting technique.

On 5/26/16, at 10:32 a.m. director of nursing (DON) confirmed it was her expectation that staff followed appropriate isolation precautions.

Clostridium Difficile information sheet [undated] which was located in the isolation cart outside of R66's room indicated:
- Gloves should be worn at all times - gloves should be donned before entering the resident's room
- Gowns should be worn when entering the resident's room if the staff anticipated contact with the resident, environment surfaces or items in the resident's room
- Hands should be washed with soap and water before leaving the resident' s room

Infection Control Resident Care - Guidelines for Clostridium Difficile Associated Disease dated 2010, indicated:
- Contact precautions should be implemented
- Hands should be washed frequently with soap and water
- Gloves should be worn when entering the room
- Gowns should be worn when physical contact with the resident or the resident's environment was anticipated
- Common use equipment such as stethoscopes and blood pressure cuffs should be

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F 441	Continued From page 22 dedicated to the infected resident and not shared with other residents	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain 5 of 30 resident rooms (rooms 104, 110, 213, 221, 227) which required maintenance. Findings include: On 5/26/16, at 9:10 a.m. the environmental service director (ESD) stated a maintenance log was kept on each unit at the nursing station. The staff entered any needed repairs to resident rooms in these logs. The maintenance staff checked the logs at least once a day and completed the requested repairs. There were no outstanding requests for repairs noted in the logs. On 5/26/16, from 9:10 a.m. until 9:43 a.m. a tour of the facility was completed with ESD and the administrator. ESD and administrator verified the following resident room concerns which required maintenance: - In room 104, there were two brown stained ceiling tiles in the bathroom, one above the sink and one above the toilet.	F 465	A room maintenance log was implemented on 6/13/16. Environmental services staff are completing an audit of each room on a monthly basis to ensure necessary room maintenance is being completed and rooms are in good repair. New ceiling tiles have been ordered to replace the stained ones and will be installed on or by 6/30/16. Scuff marks, patching, and painting of damaged areas in rooms will be completed on or by 6/30/16.	6/30/16

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F 465	Continued From page 23 - In room 110, there were four brown stained ceiling tiles; two in the bathroom one above the toilet and one above the sink. In addition, two stained ceiling tiles above the entrance of the door. - In room 213, there were black scuff marks on the wall by the closets with areas of exposed white sheet rock. - In room 221, the ceiling tile directly over where the television was stationed had a large brown stain. - In room 227, there were black scuff marks on the wall where the wheelchair was located which had areas of exposed white sheet rock. The Resident Room Monitoring policy dated 9/2008, indicated resident living areas would be maintained to assure they were clean, attractive, comfortable, odorless and free from contamination.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Eligius Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/17/2016

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

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K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St. Eligius Health Center is a 2-story building with a fulll basement. The building was constructed at 2 different times. The original building was constructed in 1971 with an addition in 2005. Both buildings are type II (111) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building, the 2005 building is support services only. The building is fully sprinkler protected, by a complete automatic fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 70 beds and had a census of 60 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 30 of 60 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, observations revealed that there is a penetration located around a pipes that is passing through the 2 hour fire barrier above the ceiling tile over the double doors located by Resident rooms 219 and 118. This deficient condition was verified by a Maintenance Supervisor.	K 011	We are patching the penetrations in our fire barrier wall with a UL-listed fire rated caulk so that there are no open penetrations through the wall. We will have this completed and compliant by no later than 06/30/2016.	6/30/16

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K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA Life Safety Code 101 2000 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 60 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, observation revealed that there is a penetration found around conduit and piping that is passing through the 1 hour smoke barrier above the ceiling tiles in the smoke barrier wall located by resident room 200.. This deficient condition was verified by a Maintenance Supervisor.	K 025	We are patching holes through our smoke barrier wall with a UL-listed fire rated caulk so that there are no open penetrations through the wall. We will have this completed and compliant by no later than 06/30/2016.	6/30/16
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029		6/30/16

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K 029	Continued From page 4 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities of 20 of 60 residents, as well as an undetermined number of staff, and visitors . Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, observation revealed that the door to the elevator control/mechanical room did not completely close and positively latch into the frame. This deficient condition was verified by a Maintenance Supervisor.	K 029	We are changing out the door and will have this completed and compliant by no later than 06/30/2016.	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050		6/30/16

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K 050	Continued From page 5 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2, during the last 12-month period. This deficient practice could affect 60 of 60 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had not conducted a fire drill for the evening shift in the 3rd calendar quarter during the last 12 month time frame. This deficient condition was verified by a Maintenance Supervisor.	K 050	Fire drills are now being conducted once a shift per quarter to ensure compliance.	
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	K 052		6/15/16

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K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 60 of 60 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, observations revealed that during the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by a Maintenance Supervisor.	K 052	We had identified this prior to survey inspection. Once we discovered this deficient practice, we started verification with our DACT that they were receiving the signal during our monthly tests of our fire alarm system. The 4 deficient months were at the beginning of our annual window and since then we have been in compliance.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler	K 056		6/30/16

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K 056	Continued From page 7 protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 60 of 60 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, observations reveled the following deficient conditions affecting the facility's fire sprinkler system: 1. There are standard and quick response fire sprinkler heads located in the living room on the 1st and 2nd floors at the nurses station. 2. It was found that the fire sprinkler system gauges located at the main sprinkler riser have not been replaced or recalibrating. 3. The fire sprinkler spare head that is located in the kitchen refrigerator had a frangible glass bulb that had no color and it could not be accurately ascertained that there is any fluid within the bulb. This deficient practice was confirmed by the Maintenance Supervisor.	K 056	An organization has been approved and work is set to begin to replace the differing sprinkler heads in the living room areas. A new system gauge has been ordered and will be replaced. The sprinkler head in the kitchen refrigerator has been ordered and will be replaced. All work is scheduled to be completed on or by 6-30-16.	

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K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 60 of 60 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 1:30 PM to 4:30 PM on 05/25/2016, a review of documentation and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any documentation for the annual fire sprinkler testing and for 2 of 4 quarterly fire sprinkler flow test verifying that they have been completed. This deficient practice was confirmed by the Maintenance Supervisor.	K 062	We had identified this deficient practice prior to our annual inspection. The maintenance department learned that we had to start testing the system annually and testing the flow quarterly. Viking Sprinkler came in and educated the staff on how to test our system in January of 2016. We have since started testing the system's flow quarterly and will continue to test it on a quarterly basis. We will continue our annual inspections as well. This deficient practice has been corrected.	6/15/16
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas	K 076		6/30/16

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	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIGIUS HEALTH CENTER	**7700 GRAND AVENUE** **DULUTH, MN 55807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 9 shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Observations revealed that the facility failed to maintain the required clearances between oxygen administration requirement from heat/ignition sources in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition) sections 8-2.1.2.3 and 8-2.1.2.4(d). This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively 20 of 60 residents, as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, observations revealed the following condition found affecting oxygen use within the beauty shop: 1. In the facility's beauty shop there were two residents who were on oxygen therapy via nasal cannula that was being supplied by a portable oxygen cylinder. One of the residents was wheeled in and placed under a potable bonnet style hair dryer and the other resident was being tended to by the beautician. The oxygen cylinder was affixed to the rear of the residents wheelchair and the wheelchair was placed such that the	K 076	St. Eligius Health Center ensures residents who use oxygen therapy do so safely while grooming. Administrator and DON spoke with the beautician on 6/1/16 to develop a policy and procedure for oxygen use in the beauty shop. Policy and procedure was implemented on 6/3/16 educating all staff and residents. Residents on oxygen therapy will not be allowed to use electric or battery operated clippers, razors, hair dryers, curling irons, or other powered tools while wearing their oxygen. If a resident is safe to have their oxygen removed and a doctor's order has been obtained, the resident will wait twenty minutes without their oxygen on and then be allowed to use electric or battery operated tools to shave or style their hair. If a resident is not safe to have their oxygen removed, they must not use electric or battery operated tools for any	

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K 076	Continued From page 10 oxygen cylinder valve and connections were within 12 inches of the heating element/fan motor. 2. The beautician had stated that they have always tended to the resident on oxygen that way. The beautician had also discussed the use of electric clippers and other electric or battery operated devices within the 12 inch area around the point of intentional expulsion. 3. The facility does not have any policy currently in place for addressing the oxygen use of resident within the beauty shop. This deficient practice was confirmed by the Maintenance Supervisor.	K 076	purpose. If a resident is in the beauty shop and their oxygen is removed, their oxygen will be placed in a stroller and set outside of the beauty shop for safety.	
K 104 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 60 of 60 residents as well as an undetermined number of staff, and visitors to the facility.	K 104	Smoke and fire damper testing was scheduled prior to our annual survey but had not occurred yet. The deficient practice was identified prior to annual survey. All of our smoke and fire dampers in the building will be identified, tested and documented by no later than 06/30/2016. After that we will be testing them every 4 years.	6/30/16

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K 104	Continued From page 11 Findings include: On facility tour between 1:00 AM to 4:30 PM on 05/25/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years. This deficient practice was confirmed by the Maintenance Supervisor.	K 104		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 10, 2016

Ms.. Brittney Hunt, Administrator
St Eligius Health Center
7700 Grand Avenue
Duluth, Minnesota 55807

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5483025

Dear Ms.. Hunt:

The above facility was surveyed on May 23, 2016 through May 26, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIGIUS HEALTH CENTER	7700 GRAND AVENUE DULUTH, MN 55807

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 05/23/16 through 05/26/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure the care plan was followed for pressure ulcer interventions for 1 of 3 residents (R7) reviewed for pressure ulcers. Findings include: R7's Face Sheet printed 5/25/16, indicated R7's diagnoses included heart failure, low back pain, acute respiratory failure, pressure ulcer of the left buttock, deep tissue injury, shortness of breath weakness, osteoarthritis and depression. The care plan Skin Integrity with a problem start date of 4/19/16, and edited last on 5/20/16, indicated R7 was at risk for skin breakdown related to the diagnoses of major depressive disorder, anxiety, impaired mobility, obesity, history of falls, incontinence, bilateral lower extremity edema, anemia, venous stasis dermatitis, seborrhea, history of cellulitis, and stasis pigmentation to the right lower extremity.	2 565	Corrected.	6/30/16

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2 565	Continued From page 3 R7's skin was currently impaired with the following skin issues: Left buttocks had two red/purple lines that ran parallel to each other and measure 15.0 centimeters (cm) by 3.5 cm, possibly caused from a lift sheet as R7 stated he was transferred with a mechanical lift in the hospital. Buttocks crease had an open slit that measured 3.5 cm by 0.1 cm that appears to be moisture associated skin damage (MASD). Right inner buttocks had a Stage I pressure ulcer that was red, nonblanchable, and measured 2.0 cm by 0.7 cm. R7 was at risk for skin breakdown and would be on an every one hour repositioning schedule. The care plan approaches included to provide every one hour repositioning. On 5/25/16, R7 was continuously observed from 7:40 a.m. until 9:12 a.m. and repositioning was not offered or provided until R7 requested to lay down. At 7:40 a.m. R7 was sitting up in the wheelchair in his room. R7 was sitting on the yellow canvas lift sling and the ROHO (a pressure reducing cushion) cushion. At 8:25 a.m. R7 received breakfast. No change was made in R7's position. At 8:32 a.m. the director of nursing (DON) removed R7's breakfast tray. R7 requested coffee from the DON. No change was made in R7's position. At 8:34 a.m. R7 received coffee from the DON. No change was made in R7's position. At 8:51 a.m. a nursing assistant (NA) asked R7 if he needed anything and if he was comfortable. R7 denied having to go to the bathroom. The NA did not offer repositioning. The NA was in R7's room for approximately 15 seconds. At 9:12 a.m. R7 put on the call light. Registered nurse (RN)-C answered the call light. R7 requested to the RN to lay down. The RN then	2 565		

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2 565	Continued From page 4 asked NA-A to assist with transferring R7 to bed. After retrieving the mechanical lift and bed linens RN-C and NA-A transferred R7 onto the bed. R7's buttocks were observed with RN-C. R7's buttocks were red, blanchable and without open areas. NA-A stated R7 was to be repositioned every hour. RN-C stated the facility had a policy not to disrupt residents during meals to be repositioned. NA-A further stated she got R7 up at around "7:30-ish." NA-A verified R7 was not repositioned until he requested to lay down. On 5/25/16, at 9:50 a.m. R7 stated staff did not ask or offer to reposition him until he asked RN-C to lay down. The medical record lacked documentation of when the pressure areas healed. On 5/26/16, at 7:15 a.m. the DON stated a tissue tolerance test (a test to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) was not done because R7 was admitted with pressure ulcers. The DON would expect staff to reposition R7 every one hour as directed by the care plan. The facility's Repositioning policy dated 4/4/16, indicated the purpose of the procedure was to provide guidelines for the assessment of resident needs to aid in the development of an individualized care plan for repositioning. To promote comfort for all bed or chair bound residents to prevent skin breakdown, promote circulation and provide pressure relief for the residents. An addendum to repositioning residents dated 4/4/16, indicated residents on every one hour repositioning or individual	2 565		

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2 565	Continued From page 5 repositioning programs would be repositioned as soon as possible before and after meals to avoid being interrupted. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to	2 570	Corrected.	6/30/16

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2 570	Continued From page 6 reflect palm protector application for 1 of 1 resident (R59) as directed by occupational therapy (OT). Findings include: R59's Face Sheet printed 5/26/16, identified R59's diagnoses as vascular dementia, chronic pain syndrome, anxiety, depression, and bilateral hand contractures. R59's quarterly Minimum Data Set (MDS) dated 5/3/16, indicated R59 had limited upper and lower extremity range of motion (ROM) bilaterally. R59's care plan dated 5/8/16, identified a problem area for skin integrity related to R59's bilateral hand contractures. The approaches directed staff to apply palm protectors daily - on in the morning and off at bedtime. R59's nursing assistant (NA) care sheet dated 5/24/16, directed the NA staff to encourage the right palm protector. On 5/24/16, at 1:55 p.m. R59 was seated in her wheelchair watching television. R59's hands lacked palm protectors and/or any type of hand splints. R59 stated she was supposed to have the palm protectors on her hands, however the staff didn't put them on after R59 had lunch. The white lamb's wool palm protectors were observed to be lying on the dressers beside R59's bed (one on the dresser on the right side of R59's bed and one on the dresser on the left side of R59's bed). R59's hands were clinched with the finger tips tightly clenched against the palms of R59's hands. On 5/25/16, at 7:00 a.m. R59 was lying in her bed, both hands were clenched and lacked palm protectors or any type of splint. White lamb's wool	2 570		

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2 570	Continued From page 7 palm protectors were observed to be lying on the dressers beside R59's bed, in the same location they had been observed on the day prior. On 5/25/16, at 11:50 a.m. R59 was seated in her wheelchair in her room. R59 had a splint on her left hand. R59 confirmed she did not have the palm protectors or splint on her hand the day prior (5/24/16), as R59 stated she couldn't get anyone to put them on for her. R59's occupational therapy (OT) progress note dated 5/20/16, indicated R59 had hand contractures and nursing staff had been provided with a schedule for wear and care of R59's palm protectors. In addition, the palm protector for R59's right hand was scheduled to be applied in the evening for full night time wear, thus enabling R59 to be free during the day to feed. R59's left palm protector was scheduled to be worn during the day. OT had provided the nursing staff a direction sheet dated 5/20/16, for application of R59's palm protectors. OT directed the licensed practical nurse (LPN) to apply the left palm protector in the morning. The left palm protector was to remain placed during the day and be removed at night. The afternoon LPN was responsible for applying the right palm protector to the right hand after supper. The right palm protector was to remain on overnight and be removed with morning cares. On 5/25/16, at 11:55 a.m. LPN-A confirmed it was nursing staff's responsibility to place the palm protectors on R59. LPN-A stated the day nurse was supposed to place the left palm protector on in the morning between 6:30 a.m. and 10:30 a.m.; the left palm protector was supposed to stay on until after dinner time and the right palm protector was supposed to be placed and remain on through the night and taken off before breakfast. LPN-A verified R59's palm protectors were both off this morning.	2 570		

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2 570	Continued From page 8 On 5/25/16, at 12:16 p.m. registered nurse (RN)-B verified R59's care plan had not been revised with the new OT directions which instructed the nursing staff to place the left palm protector on in the morning and removed at night; and the right palm protector to be placed on after supper and to remain on through the night. RN-B stated the revision of the care plan must have been missed. RN-B proceeded to revise R59's care plan to reflect the current OT orders for contracture care. On 5/26/16, at 10:35 a.m. director of nursing (DON) stated it was her expectation that care plans be revised when appropriate. DON confirmed R59's care plan should have been revised to reflect current contracture care. Care Plans-Comprehensive policy dated 10/10, directed an individualized care plan would be developed to meet the resident's medical, nursing, mental and psychological needs. The care plan was designed to enhance the optimal functioning of the resident by focusing on a rehabilitation program. In addition, assessments of resident's was ongoing and care plans would be revised as information about the resident's condition changed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are revised. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		

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	00593	A. BUILDING: _____ B. WING _____	05/26/2016

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide coordination of care between the facility and the hospice agency for 1 of 1 resident (R23) reviewed for hospice. Findings include: R23's physician order dated 5/16, indicated R23 had been admitted to hospice care on 9/12/15, with diagnosis of Alzheimer's disease. R23's care plan dated 4/21/16, indicated R23 received hospice services related to Alzheimer's disease and directed staff to collaborate with the hospice agency regarding resident/family needs and concerns and to request any special need visits form hospice, as needed, for R23 related to Chaplin services, social services, nursing services or companion visits.	2 830	Corrected.	6/30/16

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2 830	Continued From page 10 On 5/24/16, at 3:20 p.m. registered nurse (RN)-F was interviewed and stated R23 receives hospice services, an aide and a nurse come. RN-F did not know what the Hospice staff's schedule was. On 5/25/16, at 12:35 p.m. RN-E stated that the facility used the hospice provider's care plan to direct care, however was unable to find it in R23's medical record and confirmed R23's facility's care plan referred staff to the hospice provider's care plan for care directives. In addition, RN-E verfied R23's facility's care plan directed staff to coordinate care with the hospice provider. At the same time, RN-E stated R23's medical record lacked a calendar which indicated what disciplines were to see R23 and lacked an aide plan of care indicating what services the aide would be providing to R23. On 5/25/16, at 12:30 p.m. licensed practical nurse (LPN)-D stated she was not aware of a hospice schedule, the hospice aides just show up. On 5/26/16, at 9:00 a.m. nursing assistant (NA)-F stated she knew R23 had a hospice aide, but did not know when they were to show up. NA-F stated she did not know for sure what cares the hospice aide provided for R23, but if facility staff had not done daily cares for R23, the hospice aide may do cares. If the facility had provided cares for R23, the hospice aide would do R23's nails, play the guitar for her, or rub R23's back. On 5/26/16, at 10:00 a.m. the director of nursing (DON) verified a coordination of care was lacking. Verifying the plan of care, aide care plan and calendar of when staff were to be coming to the facility should have been available for facility staff from the hospice agency. The facility policy Hospice Program revised 1/14, indicated Hospice providers who contract with the facility are held responsible for meeting the	2 830		

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2 830	Continued From page 11 professional standards and timeliness of service as any contracted individual or agency associated with the facility. The policy also indicated when a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family would be developed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure coordinated care for hospice residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further	2 895		6/30/16

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2 895	Continued From page 12 decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate treatment for 1 of 1 resident (R59) reviewed with a contracture. Findings include: R59's Face Sheet printed 5/26/16, identified R59's diagnoses as vascular dementia, chronic pain syndrome, anxiety, depression, and bilateral hand contractures. R59's quarterly Minimum Data Set (MDS) dated 5/3/16, indicated R59's cognition was intact, required extensive assist with bed mobility, transferring, personal hygiene, toileting, and eating. In addition, R59 had limited upper and lower extremity range of motion (ROM) bilaterally. R59's pressure ulcer Care Area Assessment (CAA) dated 5/10/16, indicated R59 wore bilateral hand splints daily related to hand contractures. On 5/24/16, at 1:55 p.m. R59 was seated in her wheelchair watching television. R59's hands lacked palm protectors and/or any type of hand splints. R59 stated she was supposed to have the palm protectors on her hands, however the staff didn't put them on after R59 had lunch. The white lamb's wool palm protectors were observed to be lying on the dressers beside R59's bed (one on the dresser on the right side of R59's bed and one on the dresser on the left side or R59's bed). R59's hands were clinched with the finger tips tightly clenched against the palms of R59's	2 895	Corrected.	

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2 895	Continued From page 13 hands. On 5/25/16, at 7:00 a.m. R59 was lying in her bed, both hands were clenched and lacked palm protectors or any type of splint. White lamb's wool palm protectors were observed to be lying on the dressers beside R59's bed, in the same location they had been observed on the day prior. On 5/25/16, at 11:50 a.m. R59 was seated in her wheelchair in her room. R59 had a splint on her left hand. R59 confirmed she did not have the palm protectors or splint on her hand the day prior (5/24/16) as R59 stated she couldn't get anyone to put them on for her. R59 stated she thought some of the staff didn't know how to put them on correctly. R59's occupational therapy (OT) progress note dated 5/20/16, indicated R59 had hand contractures and nursing staff had been provided with a schedule for wear and care of R59's palm protectors. In addition, the palm protector for R59's right hand was scheduled to be applied in the evening for full night time wear, thus enabling R59 to be free during the day to feed. R59's left palm protector was scheduled to be worn during the day. OT had provided the nursing staff a direction sheet dated 5/20/16, for application of R59's palm protectors. OT directed the licensed practical nurse (LPN) to apply the left palm protector in the morning. The left palm protector was to remain placed during the day and be removed at night. The afternoon LPN was responsible for applying the right palm protector to the right hand after supper. The right palm protector was to remain on overnight and be removed with morning cares. R59's care plan dated 5/8/16, identified a problem area for skin integrity related to R59's bilateral hand contractures. The approaches directed staff to apply palm protectors daily - on in the	2 895		

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2 895	Continued From page 14 morning and off at bedtime. R59's nursing assistant (NA) care sheet dated 5/24/16, directed the NA staff to encourage the right palm protector. On 5/25/16, at 11:55 a.m. LPN-A confirmed it was nursing staff's responsibility to place the palm protectors on R59. LPN-A stated the day nurse was supposed to place the left palm protector on in the morning between 6:30 a.m. and 10:30 a.m.; the left palm protector was supposed to stay on until after dinner time and the right palm protector was supposed to be placed and remain on through the night and taken off before breakfast. LPN-A verified R59's palm protectors were both off this morning. On 5/25/16, at 12:02 p.m. NA-C confirmed R59's palm protectors were not on her hands this morning prior to NA-C assisting R59 with morning cares. On 5/25/16, at 12:16 p.m. registered nurse (RN)-B stated R59's hand protectors should be placed on in the morning. RN-B stated the OT instructions should be followed by the staff with regards to R59's hand protectors. RN-B verified R59's care plan had not been revised with the new OT directions which instructed the nursing staff to place the left palm protector on in the morning and removed at night; and the right palm protector to be placed on after supper and to remain on through the night. A policy related to contracture care was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and provide staff education related to the provision of contracture care and application of splints. The DON or designee could develop and auditing system in order to ensure compliance.	2 895		

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2 895	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning according to the resident's assessed needs to prevent the development of pressure ulcers for 1 of 3 residents (R7) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel)	2 900	Corrected.	6/30/16

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2 900	Continued From page 16 Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined. R7's Face Sheet printed 5/25/16, indicated R7's diagnoses included heart failure, low back pain, acute respiratory failure, pressure ulcer of the left buttock, deep tissue injury, shortness of breath weakness, osteoarthritis and depression. The Readmission Skin Risk Assessment with Braden (a tool used to predict pressure ulcer risk) dated 4/13/16, indicated R7 was at risk for pressure ulcers. Skin concerns included the left buttock had two parallel purple/red lines that measured 15 centimeters (cm) by 3.5 cm. The buttock crease had an open slit that measured 3.5 cm by 1 cm. The right inner buttock had a Stage I pressure ulcer that was red, nonblanchable and measured 2 cm by 0.7 cm.	2 900		

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2 900	Continued From page 17 R7 had limited mobility due to weakness and needed the assistance of three staff to turn in bed. A Significant Change Skin Assessment dated 4/25/16, indicated R7 had a ROHO cushion (a pressure reduction cushion) on the wheelchair and an air mattress on the bed to assist with pressure relief. The Braden Scale indicated R7 was at risk for skin breakdown. Skin concerns included the left outer buttock had a double bruise like area where the lift sling would rest. The area measured 14 cm by 2 cm with areas of peeled skin at the bottom that measured 1.5 cm by 1.0 cm and the upper end of the bruised area measured 0.75 cm by 0.5 cm. The rest of the buttocks were clear with no pressure areas noted. R7's coccyx area was pink. R7 was on an every one hour repositioning schedule which remained appropriate. The significant change Minimum Data Set (MDS) dated 5/5/16, indicated R7 was cognitively intact. R7 had no behaviors or rejection of cares. R7 needed the extensive assistance of two staff with bed mobility, transfer, dressing and using the toilet. R7 was not ambulatory. R7 had one Stage I pressure ulcer, two Stage II pressure ulcers that were not present on admission or was at a lesser stage on the prior assessment. The date of the oldest pressure ulcer was 4/20/16. In addition R7 had two unstageable pressure areas with suspected deep tissue injury in evolution, present on admission. R7 did not have any healed pressure ulcers. R7 had a pressure reducing device on the chair and on the bed. R7 was on a turning and repositioning program and received pressure ulcer care. The Skin Integrity care plan with a problem start	2 900		

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2 900	Continued From page 18 date of 4/19/16, and edited last on 5/20/16, indicated R7 was at risk for skin breakdown related to the diagnoses of major depressive disorder, anxiety, impaired mobility, obesity, history of falls, incontinence, bilateral lower extremity edema, anemia, venous stasis dermatitis, seborrhea, history of cellulitis, and stasis pigmentation to the right lower extremity. R7's skin was currently impaired with the following skin issues: Right abdominal fold has an open slit which measured 0.7 cm with redness along the fold. Left buttocks had two red/purple lines that ran parallel to each other and measure 15.0 cm by 3.5 cm possibly caused from a lift sheet as R7 stated he was transferred with a mechanical lift in the hospital. Buttocks crease had an open slit that measured 3.5 cm by 0.1 cm that appears to be MASD (moisture associated skin damage). Right inner buttocks had a Stage I pressure ulcer that was red, nonblanchable, and measured 2.0 cm by 0.7 cm. Redness to right side of the scrotum. Tops of both feet were edematous, dry and dark red. Left lower leg was red, slightly warm to the touch and had a white open area on the anterior aspect that measured 2.0 cm by 2.0 cm. R7 was at risk for skin breakdown and would be on an every one hour repositioning schedule. The care plan directed staff to assist R7 with keeping the skin clean and dry. R7 had a pressure reduction mattress on the bed and a pressure reduction cushion in the wheelchair. Provide every one hour repositioning. Apply barrier cream with zinc to R7's buttocks three times a day and as needed for protection to the slit and stage one pressure area on the left inner buttocks. Wound care to bilateral lower	2 900		

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2 900	Continued From page 19 extremities included cleanse the lower extremities with water and mild soap, rinse, and pat dry. On 5/25/16, R7 was continuously observed from 7:40 a.m. until 9:12 a.m. and repositioning was not offered or provided until R7 requested to lay down. At 7:22 a.m. two staff entered R7's room and provided morning cares. At 7:40 a.m. R7 was sitting up in the wheelchair in his room. R7 was sitting on the yellow canvas type lift sling and the ROHO cushion. At 8:25 a.m. R7 received breakfast. No change was made in R7's position. At 8:32 a.m. the director of nursing (DON) removed R7's breakfast tray. R7 requested coffee from the DON. No change was made in R7's position. At 8:34 a.m. R7 received coffee from the DON. No change was made in R7's position. At 8:51 a.m. a nursing assistant (NA) asked R7 if he needed anything and if he was comfortable. R7 denied having to go to the bathroom. The NA did not offer repositioning. The NA was in R7's room for approximately 15 seconds. At 9:12 a.m. R7 put on the call light. Registered nurse (RN)-C answered the call light. R7 requested to the RN to lay down. The RN then asked NA-A to assist with transferring R7 to bed. After retrieving the mechanical lift and bed linens RN-C and NA-A transferred R7 onto the bed. R7's buttocks were observed with RN-C. R7's buttocks were red, blanchable and without open areas. NA-A stated R7 was to be repositioned every hour. RN-C stated the facility had a policy not to disrupt residents during meals to be repositioned. NA-A further stated she got R7 up at around "7:30 ish." NA-A verified R7 was not repositioned until when he requested to lay down. The medical record lacked documentation of when the pressure areas healed.	2 900		

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2 900	Continued From page 20 On 5/25/16, at 9:50 a.m. R7 stated staff did not ask or offer to reposition him until he asked RN-C to lay down. On 5/26/16, at 7:15 a.m. the DON stated a tissue tolerance test (a test to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) was not done because R7 was admitted with pressure ulcers. The DON would expect staff to reposition R7 every one hour as directed by the care plan. The facility's Repositioning policy dated 4/4/16, indicated the purpose of the procedure was to provide guidelines for the assessment of resident needs to aid in the development of an individualized care plan for repositioning. To promote comfort for all bed or chair bound residents to prevent skin breakdown, promote circulation and provide pressure relief for the residents. An addendum to repositioning residents dated 4/4/16, indicated residents on every one hour repositioning or individual repositioning programs would be repositioned as soon as possible before and after meals to avoid being interrupted. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and promote new pressure ulcers from developing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.	2 900		

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2 900	Continued From page 21 The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		6/30/16

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	00593	A. BUILDING: _____ B. WING _____	05/26/2016

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21390	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control practices were followed for 1 of 2 residents (R66) who were in contact isolation. Findings include: R66's Face Sheet indicated R66 had diarrhea. R66's received a physician's order on 5/24/16, to be placed on contact precautions prophylactically for suspected clostridium difficile (a bacteria). R66's temporary care plan for clostridium difficile (c. diff) dated 5/24/16, indicated contact precautions were implemented per infection control policy. R66's nursing assistant (NA) care sheet indicated R66 was on precautions for c. diff. On 5/24/16, at 3:28 p.m. licensed practical nurse (LPN)-B entered R66's room with a thermometer and a blood pressure cuff and a stethoscope was hung around LPN-B's neck. LPN-B entered R66's room without donning any personal protective equipment (PPE) such as gloves or a gown. LPN-B proceeded to take R66's vital signs (blood pressure, temperature, pulse and respirations). LPN-B exited R66's room without washing her hands. LPN-B brought the thermometer and blood pressure cuff and placed them on the medication cart which was stationed two doors down and across the hall from R66's room. LPN-B then went back towards R66's room and opened the drawer of the isolation cart which was placed directly outside of R66's room. LPN-B opened the drawer and retrieved a pair of	21390	Corrected.	

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21390	Continued From page 23	21390		

gloves, put them on and took a couple of bleach disposable wipes out of the container. LPN-B returned to the medication cart, briskly wiped off the blood pressure cuff and thermometer case and the top of the medication cart with the bleach wipes. LPN-B lacked disinfecting the stethoscope which remained around LPN-B's neck. LPN-B immediately placed the blood pressure cuff and thermometer into the medication cart and LPN-B removed her gloves.

On 5/24/16, at 3:35 p.m. LPN-B stated she was aware R66 was being tested for c.diff. LPN-B confirmed once the isolations carts were placed outside of the resident rooms the resident was considered to be in isolation. LPN-B verified there was not a designated blood pressure cuff, thermometer or stethoscope located in R66's room and there should have been. LPN-B confirmed she had taken R66's vital signs, thus LPN-B had had direct contact with R66. LPN-B confirmed she had not washed her hands upon exiting R66's room and she should have washed them with soap and water.

On 5/25/16, at 12:33 p.m. registered nurse (RN)-B verified R66 was in contact isolation prophylactically as R66 was suspicious for c.diff. RN-B confirmed R66 had been having loose stools and was on long term antibiotics. RN-B stated even though R66's culture hadn't been confirmed yet for c.diff, contact precautions for c.diff should be followed by all staff. RN-B confirmed LPN-B should have worn a gown and gloved with any potential for contact with R66 or R66's furniture or equipment. RN-B confirmed prior to exiting R66's room LPN-B should have washed her hands with soap and water.

On 5/26/16, at 8:58 a.m. RN-D (Infection

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21390	Continued From page 24	21390		

Preventionist) verified R66 was in contact isolation for suspected c.diff. RN-D stated it was expected that staff follow isolation precautions for c.diff even if R66 was placed on contact precautions prophylactically. RN-D stated contact precautions included gowning and gloving when appropriate and utilizing soap and water for hand hygiene. RN-D stated R66 should have had a designated thermometer, blood pressure cuff and stethoscope located in R66's room. RN-D stated if such equipment needed to be removed from R66's room after it had been used, the equipment should have been disinfected with the bleach disposable wipes with a contact time (the amount of time necessary for a disinfectant to obtain maximum effective disinfection of the contacted area) of five minutes. RN-D confirmed wiping equipment with the bleach wipes and placing them directly into a medication cart without allowing the five minute contact time was not an appropriate disinfecting technique.

On 5/26/16, at 10:32 a.m. director of nursing (DON) confirmed it was her expectation that staff followed appropriate isolation precautions.

Clostridium Difficile information sheet [undated] which was located in the isolation cart outside of R66's room indicated:
- Gloves should be worn at all times - gloves should be donned before entering the resident's room
- Gowns should be worn when entering the resident's room if the staff anticipated contact with the resident, environment surfaces or items in the resident's room
- Hands should be washed with soap and water before leaving the resident' s room

Infection Control Resident Care - Guidelines for

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21390	Continued From page 25 Clostridium Difficile Associated Disease dated 2010, indicated: - Contact precautions should be implemented - Hands should be washed frequently with soap and water - Gloves should be worn when entering the room - Gowns should be worn when physical contact with the resident or the resident's environment was anticipated - Common use equipment such as stethoscopes and blood pressure cuffs should be dedicated to the infected resident and not shared with other residents SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures are maintained. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		6/30/16

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21426	Continued From page 26 This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R17, R103, R114) received the baseline tuberculosis (TB) screening. In addition, the facility failed to ensure 4 of 5 new employees (licensed practical nurse - LPN-C, nursing assistant NA-D, NA-E, and maintenance M-B) received the second step of the tuberculin skin test (TST). Findings include: RESIDENT TB SCREENING: R17 was readmitted to the facility on 1/28/16. R17's medical record lacked completion of the Baseline TB Screening Tool for Residents. R103 was readmitted to the facility on 3/19/16. R103's medical record lacked completion of the Baseline TB Screening Tool for Residents. R114 was admitted to the facility on 1/30/16. R114's medical record lacked completion of the Baseline TB Screening Tool for Residents. EMPLOYEE TST: LPN-C's hire date was 4/12/16. LPN-C's TST administration form indicated LPN-C received the first step TST on 4/12/16. This test was read on	21426	Corrected.	

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21426	Continued From page 27 4/14/16, with a negative - 0 millimeter (mm) induration result. LPN-C's second step TST was due to be administered by 5/5/16, and had not been administered. NA-D's hire date was 4/1/16. NA-D's TST administration form indicated NA-D received the first step TST on 4/7/16. This test was read on 4/10/16, with a negative - 0 mm induration result. NA-D's second step TST was due to be administered by 5/1/16, and had not been administered. NA-E's hire date was 3/17/16. NA-E's TST administration form indicated NA-E received the first step TST on 3/17/16. This test was read on 3/19/16, with a negative - 0 mm induration result. NA-E's second step TST was due to be administered by 4/9/16, and had not been administered. M-B's hire date was 2/12/16. M-B's TST administration form indicated M-B received the first step TST on 2/12/16. This test was read on 2/15/16, with a negative - 0 mm induration result. M-B's second step TST was due to be administered by 3/7/16, and had not been administered. On 5/26/16, at 8:50 a.m. registered nurse (RN)-D who was also the infection preventionist, confirmed all employees upon hire and all residents upon admission were to be screened for TB and provided the TST. RN-D confirmed R17, R103, and R114's medical records lacked a TB screening. In addition, RN-D confirmed LPN-C, NA-D, NA-E and M-B's second step TST's had not been administered within one to three weeks following the first step TST and all of these employees were current employees except for NA-E who had just resigned. However, NA-E had worked at the facility during the time she should have received the second step TST.	21426		

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21426	Continued From page 28 On 5/26/16, at 10:34 a.m. director of nursing (DON) confirmed the facility should have followed the Center for Disease Control and Prevention (CDC) guidelines with regards to TB screening and TST. The Baseline TB Screening Tool for Health Care Workers indicated if the results of the first step TST was negative, the second step TST should be performed in one to three weeks. Tuberculosis Infection Control Program policy dated 1/2012, indicated screening and surveillance of residents and employees for TB would be completed according to the facility's TB risk classification. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents are screened for physical signs and symptoms of active TB disease on admission. The DON or designee could educate the appropriate staff on the policies/procedures, and could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant,	21685		6/30/16

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21685	Continued From page 29 including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain 5 of 30 resident rooms (rooms 104, 110, 213, 221, 227) which required maintenance. Findings include: On 5/26/16, at 9:10 a.m. the environmental service director (ESD) stated a maintenance log was kept on each unit at the nursing station. The staff entered any needed repairs to resident rooms in these logs. The maintenance staff checked the logs at least once a day and completed the requested repairs. There were no outstanding requests for repairs noted in the logs. On 5/26/16, from 9:10 a.m. until 9:43 a.m. a tour of the facility was completed with ESD and the administrator. ESD and administrator verified the following resident room concerns which required maintenance: - In room 104, there were two brown stained ceiling tiles in the bathroom, one above the sink and one above the toilet. - In room 110, there were four brown stained ceiling tiles; two in the bathroom one above the toilet and one above the sink. In addition, two stained ceiling tiles above the entrance of the door.	21685	Corrected.	

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21685	Continued From page 30 - In room 213, there were black scuff marks on the wall by the closets with areas of exposed white sheet rock. - In room 221, the ceiling tile directly over where the television was stationed had a large brown stain. - In room 227, there were black scuff marks on the wall where the wheelchair was located which had areas of exposed white sheet rock. The Resident Room Monitoring policy dated 9/08, indicated resident living areas would be maintained to assure they were clean, attractive, comfortable, odorless and free from contamination. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could develop, review, and/or revise policies and procedures to ensure resident's environment is maintained in a safe, clean and sanitary manner. The Administrator or designee could educate all appropriate staff on the policies and procedures. The Administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care	21942		6/30/16

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21942	Continued From page 31 home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council. Findings include: On 5/25/16, at 10:04 a.m. the director of social services (SW)-A was interviewed and stated the facility hosts an annual "family council" meeting for families. This year the meeting was held on 5/3/216, and the topic was the recent sale of the building to Monarch Health Care. SW-A stated she did not inquire if the group wanted to meet more often, have a leader, or discuss the purpose of a family council. 5 people attended, and the facility set the agenda and ran the meeting. SW-A stated she did not ask if anyone wanted to be a leader for a family council. The previous "family council" meeting was on 3/26/15, and the topic of discussion was Effective Communication Strategies; three family members attended. There were 14 months between one meeting and the next. On 5/26/16, at 9:50 a.m. family member (FM)-F was interviewed and stated she attended the meeting on 5/3/16. FM-F stated she would be interested in a family council that met more often than annually. FM-F stated as far as she knew, they had never offered for families to meet more	21942	Corrected.	

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21942	Continued From page 32 often, stating, "not at all." On 5/26/16, at 10:07 a.m. FM-E was interviewed and stated he had attended the meeting on 5/3/16, and he has heard nothing of a family council. FM-E stated that meeting was about the facility being bought out and there was nothing about families discussing overall concerns about the facility or providing input into the life of the home. On 5/26/16, at 10:13 a.m. SW-A stated they only had the meeting for families once a year, they have not offered for a family council to meet more than annual, or offered to set up a family council, whether with staff support or private. On 5/26/16, at approximately 11:30 a.m. the administrator was interviewed and stated she was now aware of how the facility hosted an annual meeting called a "family council" and that it did not fill the role of providing families an opportunity to meet to discuss grievances or concerns or issues related to a loved one living in the facility. A Family Council policy dated 11/11, indicated a purpose to provide resources and personnel to support the meetings of families, responsible parties and legal guardians. The policy stated a resident's family has the right to meeting in the facility with families of other residents in the facility. The policy defines a family group or council as a group that meets regularly to -Discuss and offer suggestions about facility policies and procedures affecting resident's care, treatment and quality of life. -support each other -plan resident and family activities	21942		

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21942	Continued From page 33 -participate in educational activities. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a Family Council. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		