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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: APSU

Facility ID: 00672

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/01/2016** (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 **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NE II 03/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245345

March 2, 2016

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

Dear Ms. Lewis:

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 January 15, 2016 the above facility is certified for:

53 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 53 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 17, 2016

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

RE: Project Number S5345025

Dear Ms. Lewis:

On December 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 10, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On February 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 11, 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 December 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 10, 2015, effective January 15, 2016 and therefore remedies outlined in our letter to you dated December 23, 2015, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245345		2/1/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 01/15/2016	ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 01/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 2/17/2016	SIGNATURE OF SURVEYOR 34985	DATE 2/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/10/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245345	A. Building 01 - MAIN BUILDING 01 B. Wing	2/11/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 01/15/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 01/15/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 01/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	02/17/2016	25822	02/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/8/2015	☐ 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
245345 Y1	A. Building 02 - CHAPEL B. Wing Y2	2/11/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 01/15/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 01/15/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 01/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 02/17/2016	SIGNATURE OF SURVEYOR 25822	DATE 02/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/8/2015	☐ 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

February 17, 2016

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

Re: Reinspection Results - Project Number S5345024

Dear Ms. Lewis:

On February 1, 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 February 1, 2016. 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00672 Y1	A. Building B. Wing Y2	2/1/2016 Y3

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

This report is completed by a 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 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 01/15/2016	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 01/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 02/17/2016	SIGNATURE OF SURVEYOR 34985	DATE 2/1/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/10/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: APSU12

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: APSU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00672

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/10/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **53** (L18)
13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
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
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 01/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Certified Mail # 7011 0470 0000 5262 2496
December 23, 2015

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

RE: Project Number S5345025

Dear Ms. Lewis:

On December 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this

visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Licensing and Certification Section
1400 E. Lyon St.
Marshall, MN 56258
Telephone: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 19, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If

the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 10, 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 June 10, 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 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, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	12/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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		1/15/16

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

Electronically Signed | 01/06/2016

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 plan of care related to the initiation of a foley catheter for 1 of 1 resident (R68) reviewed for hospice services. Findings include: During observation of morning cares on 12/10/15, at 7:59 a.m. R68 was observed to have an indwelling Foley catheter. Review of the progress note dated 11/01/15 12:36 p.m. indicated R68 had complained of (c/o) being unable to void. A bladder scan was performed and the hospice nurse was subsequently notified. The note further included: " She placed a 16 F (french) foley catheter with very minimal return. She left catheter in place for resident comfort and stated the bladder scanning could be picking up his abdominal ascites while scanning his bladder. Nursing to continue to monitor his output and comfort level and NP (nurse practitioner) will see resident tomorrow." R68's facility face sheet indicated an admission date of 10/7/15 with hospice services. R68's diagnoses included liver cell carcinoma. The care plan dated 10/20/15 indicated R68 was continent of bowel and bladder and required assistance with toileting related to end stage disease process. The care plan did not identify the use of an indwelling Foley catheter. When interviewed on 12/10/15, at 12:10 p.m. the assistant director of nursing (ADON) confirmed R68's care plan did not include the placement of	F 280	St. Isidore Health Center of Greenwood Prairie staff routinely develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents functional abilities and quality of life. The residents and their family/legal representative are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. During the mandatory meeting January 14, 2015, the licensed nursing staff will be 1) reinstructed on the facility s policies for care plan reviews and updates 2) informed of the regulatory requirement that the residents care plans be current at all times and 3) reminded of the importance of addressing Foley catheter use in the plan of care. The care plan for resident number 68 was reviewed by a registered nurse and updated to reflect the insertion of an indwelling Foley catheter.	

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F 280	Continued From page 2 an indwelling catheter and should have.	F 280	To monitor compliance, the care plans of all residents with an indwelling Foley catheter have been reviewed for accuracy and completeness. The care plans of an additional 6 residents (10 percent) will be audited for completeness. If noncompliance is noted, additional care plan auditing and staff training will be done. During the interdisciplinary care conferences (conducted at least quarterly and with significant change in the resident□s condition), the care plans will continue to be reviewed to assure the plans accurately reflect the resident□s condition and the care and services needed/provided. Compliance will be reviewed during the January Quality Assessment and Assurance Committee quarterly meeting.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334		1/15/16

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F 334	Continued From page 3 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment	F 334		

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F 334	Continued From page 4 and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer an influenza vaccine for 1 of 5 residents (R68) and failed to administer a pneumococcal vaccine for 1 of 5 (R56) residents reviewed for immunizations. Findings include: R68 was admitted to the facility on 10/7/15 per the electronic record face sheet. The Flu and Pneumonia Vaccination Consent September 2015/2016 form was completed and signed by R68 on 10/7/15. The form indicated R68 consented to have the flu vaccine. Review of R68's signed physician orders dated 12/7/15 did not include an order for the influenza vaccine. Further review of R68's record did not include evidence that the influenza vaccine had been administered. When interviewed on 12/10/15, at 10:07 a.m. registered nurse (RN)-A confirmed R68 had not received the influenza vaccine until 12/9/15 after brought to the facility's attention by the surveyor. The policy titled, Influenza Vaccine dated 10/06	F 334	St. Isidore Health Center of Greenwood Prairie has developed policies and procedures to ensure that 1) each resident is offered an annual influenza immunization October 1 through March 31 and a pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized 2) before offering the influenza and pneumococcal immunizations, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunizations 3) the resident or the resident's legal representative has the opportunity to refuse immunization and 4) the resident's medical record includes documentation that indicates the following: "that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza and pneumococcal immunizations; and "that the resident either received the	

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F 334	Continued From page 5 included: "To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza by assuring that each resident is informed about the benefits and risks of immunizations and has the opportunity to be immunized." R56 was admitted to the facility on 8/21/15 per the electronic record face sheet. The Flu and Pneumonia Vaccination Consent September 2015/2016 for was completed and signed by R56 on 9/28/15. The form indicated R68 had consented to have the pneumonia vaccine. Review of R56's signed physician orders dated 10/21/15 did not include an order for the pneumonia vaccine. Further review of R56's record did not include evidence that the pneumonia vaccine had been administered. When interviewed on 12/10/15, at 10:07 a.m. RN-A confirmed R56 had not received the pneumococcal vaccine until 12/9/15 after brought to facility's attention by the surveyor. The undated policy titled, Pneumococcal Vaccine included: "It is the policy of this facility that all residents are given the opportunity to receive the pneumococcal vaccine after resident and/or resident's responsible party is educated on the possible risks and potential benefits of the vaccine."	F 334	influenza and pneumococcal immunizations or did not receive the immunizations due to medical contraindications or refusal. The immunization related policies and procedures were reviewed and found appropriate. All resident records have been audited to assure that the resident has received the pneumococcal immunization and the annual influenza immunization or that there is documentation explaining why the immunizations were not administered. During the mandatory meeting January 14, 2015, the nursing staff will be re-educated on the regulatory requirements and the facility□s policy/procedures addressing 1) the administration of influenza and pneumococcal immunizations 2) the related resident/family notification and education and 3) the resident/family right to refuse the immunizations. On December 9, 2015, resident number 68 received the influenza vaccine and resident number 56 received the pneumococcal vaccine. Their medical records have been updated to reflect administration of the vaccinations. To monitor compliance, the infection control nurse will audit the records of residents admitted to the facility during the next 90 days to assure that the residents have received the influenza and pneumococcal immunizations and if not,	

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F 334	Continued From page 6	F 334	whether there is documentation verifying why the vaccines were not administered. If noncompliance is noted, additional monitoring and staff education will be completed. Compliance will be reviewed during the January Quality Assessment and Assurance Committee quarterly meeting.	

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	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2015**

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

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

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

Electronically Signed | 01/06/2016

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 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: 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. This facility will be surveyed as two separate buildings. St. Isidore Health Center of Greenwood Prairie is a 2-story building that was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1993, addition was constructed to the South that was determined to be of Type II(222) construction. Because these two buildings are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 53 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 162 residents. Findings include: On facility tour between 9:00 AM and 12:00 PM on 12/08/2015, the review of the fire drills reports for December 2014 to November 2015. The following was found:	K 050	Fire drills will be conducted and recorded on various shifts monthly per regulations. Environmental Services Director to implement and maintain. Administrator responsible to monitor.	1/15/16

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K 050	Continued From page 3 1. The following fire drills were missed: a. 2015 - 1st quarter - evening and night shift b. 2015 - 4th quarter - day shift c. 2014- 4th quarter- night shift These deficient practices were confirmed by the Director of Environmental Services (CR) at the time of discovery.	K 050		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 12:00 PM on 12/08/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system.	K 154	The fire watch policy will be revised to meet current regulations, using the policy found on the State Fire Marshal website. Environmental Services Director to complete. Administrator to monitor.	1/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/08/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 4 This deficient practice was confirmed by the Facility Maintenance Director (CR) at the time of discovery.	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 12:00 PM on 12/08/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (CR) at the time of discovery.	K 155	The fire watch policy will be revised to meet current regulations, using the policy found on the State Fire Marshal website. Environmental Services Director to complete. Administrator to monitor.	1/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**12/08/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Isidore Health Center of Greenwood Prairie - Chapel Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/06/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**12/08/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us 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. This facility will be surveyed as two separate buildings. St. Isidore Health Center of Greenwood Prairie, 2005 addition is a 2-story building. The 2005 addition was determined to be of Type II (222) construction. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		1/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**12/08/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 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 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 162 residents. Findings include: On facility tour between 9:00 AM and 12:00 PM on 12/08/2015, the review of the fire drills reports for December 2014 to November 2015. The following was found: 1. The following fire drills were missed: a. 2015 - 1st quarter - evening and night shift b. 2015 - 4th quarter - day shift c. 2014- 4th quarter- night shift These deficient practices were confirmed by the Director of Environmental Services (CR) at the time of discovery.	K 050	Fire drills will be conducted and recorded on various shifts monthly per regulations. Environmental Services Director to implement and maintain. Administrator responsible to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**12/08/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 3	K 154		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 12:00 PM on 12/08/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (CR) at the time of discovery.	K 154	The fire watch policy will be revised to meet current regulations using the policy found on the State Fire Marshal website. Environmental Services Director to complete. Administrator to monitor.	1/15/16
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is	K 155		1/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**12/08/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 4 provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 12:00 PM on 12/08/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (CR) at the time of discovery.	K 155	The fire watch policy will be revised to meet current regulations using the policy found on the State Fire Marshal website. Environmental Services Director to complete. Administrator to monitor.	

MDH
Minnesota
Department
of Health

Certified Mail # 7011 0470 0000 5262 2496
December 23, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5345025

Dear Ms. Lewis:

The above facility was surveyed on December 7, 2015 through December 10, 2015 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 Kathy Serie, Unit Supervisor at 507-537-7158.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00672	A. BUILDING: _____ B. WING _____	12/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00672	A. BUILDING: _____ B. WING _____	12/10/2015

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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 December 7, 8, 9 and 10th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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		
2 570	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 plan of care related to the initiation of a foley catheter for 1 of 1 resident (R68) reviewed for hospice services. Findings include: During observation of morning cares on 12/10/15, at 7:59 a.m. R68 was observed to have an indwelling Foley catheter. Review of the progress note dated 11/01/15 12:36 p.m. indicated R68 had complained of (c/o) being unable to void. A bladder scan was performed and the hospice nurse was subsequently notified.	2 570	Corrected	1/15/16

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2 570	Continued From page 3 The note further included: " She placed a 16 F (french) foley catheter with very minimal return. She left catheter in place for resident comfort and stated the bladder scanning could be picking up his abdominal ascites while scanning his bladder. Nursing to continue to monitor his output and comfort level and NP (nurse practitioner) will see resident tomorrow." R68's facility face sheet indicated an admission date of 10/7/15 with hospice services. R68's diagnoses included liver cell carcinoma. The care plan dated 10/20/15 indicated R68 was continent of bowel and bladder and required assistance with toileting related to end stage disease process. The care plan did not identify the use of an indwelling Foley catheter. When interviewed on 12/10/15, at 12:10 p.m. the assistant director of nursing (ADON) confirmed R68's care plan did not include the placement of an indwelling catheter and should have. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		1/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21426	Continued From page 4 (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). 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 perform a two-step tuberculin skin test (TST) for 1 of 5 employees (E1). In addition, the facility failed to ensure TST's were accurately documented for 3 of 5 employees (E2 and E4) and 5 of 5 residents (R27, R56, R64, R68, and R69) per current Center for Disease Control and Prevention (CDC) recommendations and per facility policy. Findings include: Employee (E)-1 had a hire date of 8/7/15, and had a documented first step TST on 5/18/15 from a previous employer. There was no	21426	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST ISIDORE HEALTH CENTER OF GREENWOC	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 5 evidence the facility had completed a second TST application. When interviewed on 12/10/15, at 9:09 a.m. registered nurse (RN)-A stated E1 had received yearly TST's from her previous employer and felt that would be sufficient. The dates of the last 2 TST's for E1 were 5/18/15 and 5/12/14 with negative results. RN-A confirmed E1 had not received a 2nd step TST upon hire. The facility policy titled, Tuberculosis, Employee Screening for, revised August 2011 included: All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment. 2. The Employee Health Coordinator (or designee) will accept documented verification of two-step TST or BAMT results within the preceding 12 months. R64 was admitted to the facility on 7/15/15. A first step TST was placed on 7/15/15 at 2:10 p.m. and read on 7/17/15. The electronic medication administration record (EMAR) indicated the TST was read between the hours of 7:00 a.m. - 3:00 p.m. with a negative result. The result did not include millimeters (mm) of induration (palpable hardness) around the injection site. A second step TST was placed on 7/29/15 between the hours of 7:00 a.m. - 3:00 p.m. and read on 7/31/15 between the hours of 7:00 a.m. - 3:00 p.m. with a negative result. The result did not include mm of induration around the injection site. Surveyor was unable to determine if either test was read between a 48 - 72 hour time period. R69 was admitted to the facility 11/23/15. A first	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00672	A. BUILDING: _____ B. WING _____	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21426	Continued From page 6	21426		

step TST was placed on 11/23/15 between the hours of 7:00 a.m. - 3:00 a.m. and read on 11/25/15 between the hours of 7:00 a.m. - 3:00 p.m. with a negative result. The result did not include mm of induration around the injection site. A second step TST was placed on 12/7/15 between the hours of 7:00 a.m. - 3:00 p.m. and read on 12/9/15 between the hours of 7:00 a.m. - 3:00 p.m. with a negative result. The result did not include mm of induration around the injection site. Surveyor was unable to determine if either test was read between a 48 - 72 hour time period.

R27 was admitted to the facility on 10/27/15. A first step TST was placed on 10/27/15 between the hours of 7:30 a.m. - 2:00 p.m. read on 10/29/15 between the hours of 7:30 a.m. - 2:00 p.m. with a negative result. The result did not include mm of induration around the injection site. A second step TST was placed on 11/10/15 between the hours of 7:30 a.m.- 2:00 p.m. and read on 11/12/15 between the hours of 7:30 a.m. - 2:00 p.m. with a negative result. The result did not include mm of induration around the injection site. Surveyor was unable to determine if either test was read between a 48 - 72 hour time period.

R68 was admitted to the facility on 10/7/15. A first step TST was placed on 10/7/15 between the hours of 7:00 a.m. - 3:00 p.m. and read on 10/9/15 between the hours of 7:00 a.m. - 3:00 p.m. with a negative result. The result did not include mm of induration around the injection site. A second step TST was placed on 10/21/15 between the hours of 7:00 a.m.- 3:00 p.m. and read on 10/23/15 between the hours of 7:00 a.m. - 3:00 p.m. with a negative result. The result did not include mm of induration around the injection site. Surveyor was unable to determine if either test was read between a 48 - 72 hour time period.

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21426	Continued From page 7 R56 had an initial admission date of 7/27/15. A first step TST was placed on 7/27/15 between the hours of 5:30 p.m. - 1:00 a.m. and read on 7/30/15 between the hours of 5:30 p.m. - 1:00 a.m. with a negative result. The result did not include mm of induration around the injection site. A second step TST was placed on 8/10/15 between the hours of 10:30 a.m.- 1:00 p.m. and read on 8/13/15 between the hours of 5:30 p.m. - 1:00 a.m. with a negative result and "0" mm induration. Surveyor was unable to determine if either test was read between a 48 - 72 hour time period. E2 had a hire date of 10/1/15. A 2nd step TST was placed on 10/19/15 at 9:35 a.m. Documentation indicated the 2nd step TST was negative with "0" mm induration; the documentation did not include the date the TST was read. Surveyor was unable to determine if the test was read between a 48-72 hour time period. E4 had a hire date of 10/15/15. A 2nd step TST was placed on 10/27/15 at 10:00 a.m. and read on 10/29/15 with a negative result and "0" mm of induration. The result did not include time the result was read. Surveyor was unable to determine if the test was read between a 48-72 hour time period. When interviewed on 12/10/15, at 9:13 a.m. RN-A confirmed the documentation of resident TST's was incomplete and did not include exact time TST's were placed or read nor mm of induration around the injection site. RN-A further confirmed the documentation for E2 and E4's 2nd step TST's was incomplete.	21426		

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21426	Continued From page 8 The facility policy titled, Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Tests revised August 2013 included: 4. A qualified nurse or healthcare practitioner will interpret the TST forty-eight (48) to seventy-two (72) hours after administration. All test results must be read in mm. SUGGESTED METHOD OF CORRECTION: The administrator or designee could monitor for compliance of the tuberculosis screening process for all employees and residents to ensure the TST and baseline TB screenings are being completed according to CDC recommendations. The administrator or designee could update their current policies related to tuberculin testing and TB screening for staff and residents and educate responsible staff related to the changes. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		