### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D1D3 Facility ID: 00339

1. MEDICARE/MEDICAID PROVIDE (L1) 245327 2.STATE VENDOR OR MEDICAID N (L2) 448415000  5. EFFECTIVE DATE CHANGE OF C (L9)	TO.	3. NAME AND ADDRESS OF FACILITY (L3) <b>DIVINE PROVIDENCE HEALTH C</b> (L4) <b>312 EAST GEORGE ST PO BOX 13</b> (L5) <b>IVANHOE, MN</b> 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD				4. TYPE OF ACTION:  1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Co	2. Recertification 4. CHOW 6. Complaint 9. Other
6. DATE OF SURVEY 09/3 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	0/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	25 (L18) 25 (L17)	Complianc1. A		gram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code  * Code: A	6. Scope of Servic7. Medical Direct	ces Limit for
14. LTC CERTIFIED BED BREAKDO  18 SNF 18/19 SNF  25 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM.  17. SURVEYOR SIGNATURE  Kathryn Serie, Unit Sup  PAI	ervisor	Date:	0/01/2015	(L19)	18. STATE SURVEY AGENCY  Camala Fiske-Downing,  L OFFICE OR SINGLE S	Enforcement Speciali	Date: ist 10/02/2015 (L20)
DETERMINATION OF ELIGIBIL			IPLIANCE WITH	ł CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (He e:	CFA-1513)
22. ORIGINAL DATE  OF PARTICIPATION  07/01/1986  (L24)	23. LTC AGREED BEGINNING		4. LTC AGREEN ENDING DA'		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimburs	INVOLUNTA 05-Fail to Me	ARY et Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspension	VE SANCTIONS a of Admissions:	(L44) (L45)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	<u>OTHER</u>	Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/		(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION	OF APPROVAL	(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245327

October 1, 2015

Mr. Timothy Byrne, Administrator Divine Providence Health Center 312 East George St PO Box 136 Ivanhoe, Minnesota 56142

Dear Mr. Byrne:

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 September 16, 2015 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 25 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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

October 1, 2015

Mr. Timothy Byrne, Administrator Divine Providence Health Center 312 East George St PO Box 136 Ivanhoe, Minnesota 56142

RE: Project Number S5327025

Dear Mr. Byrne:

On August 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 12, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2015 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 August 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 12, 2015, effective September 16, 2015 and therefore remedies outlined in our letter to you dated August 24, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Riske. 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

Enclosure

cc: Licensing and Certification File

## Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245327	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/30/2015		
Name	e of Facility		Street Address, City, State, Zip Code			
DIVINE PROVIDENCE HEALTH CENTER		312 EAST GEORGE ST PO BOX 136				

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

(Y4) Item	()	(5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5) I	Date
		Correction				Correction					Correction
ID Prefix	F0225	Completed 09/11/2015	ID Prefix	F0226		Completed <b>09/11/2015</b>		ID Prefix	F0278		Completed <b>09/11/2015</b>
	483.13(c)(1)(ii)-(iii), (c			483.13(c)					483.20(g) - (j)		_
LSC		_	LSC					LSC			=
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0279	09/11/2015	ID Prefix	F0282		09/11/2015		ID Prefix	F0309		09/11/2015
•	483.20(d), 483.20(k)(1	)		483.20(k)(3)(ii)					483.25		=
LSC		_	LSC					LSC			=
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0315	09/16/2015	ID Prefix	-		09/16/2015					_
Reg. # LSC	483.25(d)	_	Reg. #	483.25(I)				Reg. #			_
		<u> </u>	LSC				<u> </u>				=
		Correction				Correction					Correction
ID D "		Completed	15.5 (			Completed					Completed
ID Prefix				-							
Reg. #			Reg. #					Reg. #			_
		<u> </u>	200								_
		Correction				Correction					Correction
ID D ('		Completed	1D D "			Completed		ID D "			Completed
		_									_
Reg. #		_	Reg. #					Reg. #			=
		<u> </u>									=
Reviewed I	By Review	ed By	Date:	Signature	of Sur	veyor:				Date:	
State Agen	cy KS/kfd		10/01/201	5		(	304	8		09/30	/2015
Reviewed E	By Review	ed By	Date:	Signature	of Sur	veyor:				Date:	
CMS RO											
Followup t	o Survey Completed	on:		Check for any	Uncor	rected Defic	cienci	es. Was a	Summary of		
	8/12/2015			Uncorrected	a Deilo	Hericies (CIV	13-236	or) Sent to	the Facility?	YES	NO

## Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

 Provider / Supplier / CLIA / Identification Number 245327	(Y2) Multiple Con A. Building B. Wing	struction 01 - MAIN BUILDING 01	(Y3) Date of Revisit 9/18/2015

Name of Facility
DIVINE PROVIDENCE HEALTH CENTER

Street Address, City, State, Zip Code 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5	5) l	Date
		Correction			Correction					Correction
ID Prefix		Completed <b>08/11/2015</b>	ID Prefix		Completed		ID Prefix			Completed
	NFPA 101				-					
-	K0076		LSC				LSC			<del>-</del> -
		Correction			Correction					Correction
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		<u> </u>			=					_
Reg. # LSC			Reg. #				Reg. # LSC			<u> </u>
		Correction			Correction					Correction
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		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #										_
-			LSC				LSC			<del>-</del> -
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #					•					<del>_</del>
		<del>-</del>	LSC							<del>-</del>
Reviewed I	By Reviewe	ed By	Date:	Signature of Sur	veyor:			D	ate:	
State Agen	cy GS/kfd		10/01/2015			3548	2	(	09/18	3/2015
	By Reviewe	ed By	Date:	Signature of Sur	veyor:			D	ate:	
CMS RO										
Followup to Survey Completed on:				Check for any Uncor Uncorrected Defice	rrected Defic	ciencie	es. Was a	the Feetline	/FC	
	8/11/2015			Chicon rected Delic	ACTIONS (ON	.J-230	, Jent to	ine racinty:	/ES	NO

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: D1D322

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D1D3 Facility ID: 00339

MEDICARE/MEDICAID PROVIDER NO.     (L1) 245327  2.STATE VENDOR OR MEDICAID NO.     (L2) 448415000	3. NAME AND ADDRESS OF FA (L3) <b>DIVINE PROVIDENCE</b> (L4) <b>312 EAST GEORGE ST</b> (L5) <b>IVANHOE, MN</b>	HEALTH CE		4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TIC 2 AOA 3 Other	7. PROVIDER/SUPPLIER CATE 01 Hospital 05 HHA 02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	GORY  09 ESRD  10 NF  11 ICF/IID  12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)  09/30
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  25 (L18)  13.Total Certified Beds  25 (L17)	A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC  X B. Not in Compliance with Program Requirements and/or App	ogram	And/Or Approved Waivers Of 7  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNI  5. Life Safety Code  * Code: B	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  25 (L37) (L38) (L39)	ICF IID (L42) (L43)		5. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICA  17. SURVEYOR SIGNATURE  Lois Boerboom, HFE NE II  PART II - TO BE (  19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Participate  2. Facility is not Eligible  (L21)	Date:  09/16/2015  COMPLETED BY HCFA R  20. COMPLIANCE WIT RIGHTS ACT:	(L19) Ka	OFFICE OR SINGLE ST	Enforcement Specialist 09/21/2015 (L20)  FATE AGENCY  cial Solvency (HCFA-2572)  I Interest Disclosure Stmt (HCFA-1513)
(L27) B. Rescind St	(L25)  WE SANCTIONS of Admissions: (L44) aspension Date: (L45)	ATE	26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimburse  03-Risk of Involuntary Termination  04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ment 06-Fail to Meet Agreement
(L28)	. INTERMEDIARY/CARRIER NO.  03001  . DETERMINATION OF APPROVA	(L31)	30. REMARKS  DETERMINATION APPR	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 0022

August 26, 2015

Mr. Timothy Byrne, Administrator Divine Providence Health Center 312 East George St PO Box 136 Ivanhoe, Minnesota 56142

RE: Project Number S5327025

Dear Mr. Byrne:

On August 12, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Divine Providence Health Center August 26, 2015 Page 2

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

<u>Informal Dispute Resolution</u> - 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 Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 <u>Kathryn.serie@state.mn.us</u> Office: (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 September 21, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

Divine Providence Health Center August 26, 2015 Page 4 in your plan of correction.

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 12, 2015 (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 February 12, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

Divine Providence Health Center August 26, 2015 Page 5

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Divine Providence Health Center August 26, 2015 Page 6 Feel free to contact me if you have questions.

Sincerely,

Kumalu 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

Enclosure

cc: Licensing and Certification File

PRINTED: 08/24/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/	12/2015
	PROVIDER OR SUPPLIER PROVIDENCE HEALTI	H CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE .	(X5) COMPLETION DATE
	INITIAL COMMENT  The facility's plan of as your allegation of Department's acceptottom of the first pube used as verification.  Upon receipt of an revisit of your facility validate that substate regulations has been your verification.  483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INITIALEGATIONS/INITIALEGATIONS or mistreating resident had a finding entered registry concerning of residents or mistagent and report any known court of law against indicate unfitness for other facility staff to or licensing authority.  The facility must entire involving mistreatment including injuries of misappropriation of immediately to the stoother officials in a second court of the second c	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.  acceptable POC an on-site y may be conducted to antial compliance with the en attained in accordance with (c)(2) - (4) PORT DIVIDUALS  of employ individuals who have f abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; whedge it has of actions by a tan employee, which would or service as a nurse aide or the State nurse aide registry	F (	0000	CROSS-REFERENCED TO THE APPROP	hers: was eporting within 2 within 2 suspecediately rt from olicy on with eview po Septemi	g; 4 24 tted / the all blicy ber.
	State survey and co	ertification agency).  Ive evidence that all alleged			September 11 <sup>th</sup> , 2015.		
ADODATOD	A DIDECTORIO CATADOMIO	AED/CUIDDUIED DEDDECENITATIVEIS SICA	LATURE		TITLE		(Ve) DATE

ABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Aprinistiato

(X6) DATE

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 appropriate to continued program participation.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2015

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	APPROVE 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE	
		245327	B. WING		08/1	2/2015
NAME OF	PROVIDER OR SUPPLIER		1 .	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	2/2013
DIVINE I	PROVIDENCE HEALTI	1 CENTER		812 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	violations are thoroup revent further pote investigation is in proceed in the results of all into the administrator representative and with State law (inclucertification agency incident, and if the agency incident, and if the agency incident in the results in t	ughly investigated, and must ential abuse while the rogress.	F 225	All alleged occurrences of suspect neglect will be thoroughly investing Director of Nursing and/or design accordance to policy. Prior to the the investigation, the Administratives Director/designee will resinvestigation to ensure completion investigation which will include: and times, summary of all investigation of alleged staff meridentification of the resident(s) in	igated by the nee in ecompletion tor and Socieview the on of relevant daragative in incident, mber(s),	e n of ial tes
	by: Based on interview facility failed to thord immediately report to allegations of susperesident (R9) review allegation of potential Findings include:  During initial interview a.m. R9 was question occurred, R9 stated that was pushing on doing cares. After obottom then put the table. I told him I eathere." R9 stated aft the staff member ab placement of the tow staff member stated.	cted abuse/neglect for 1 of 1 yed and who reported an	:	implemented to prevent a recurred incident. Administrator/designee Nursing/Designee will be respons reporting all incidents with the stainvestigative summaries of incide abuse/neglect will be reviewed by Assurance committee monthly for interdisciplinary team input and recommendations with ongoing procedure and policy at an education; if any procedure and pare made; update all staff at the tiprior to implication.  Correction will be monitored:	ence of the or Director ible for ate. All nts of allege the Quality ractice.  on hire date itinue to inual olicy change	of ed y

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reported the incident to the nurse but didn't recall her name. R9 further stated he had reported to

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Administrator and/or designee.

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F 225  Continued From page 2 nursing once that he'd been left in the mechanical lift for long periods (2 hours on one occasion).  R9's quarterly Minimum Data Set (MDS) assessment dated 5/16/15, identified R9 with a Brief Interview for Mental Status ((BIMS)) score of 14/15, indicating good cognition skills. The MDS further identified R9 had no indicators of delirium and had no behavior indicators. The MDS also identified R9 was free of hallucinations or delusions.  During review of R9's medical record there was an entry dated 4/20/15, at 3:32 p.m. which identified R9 had approached the social service designee (SSD) and shared a concern he'd had over the weekend on the evening of 4/19/15. The SSD stated she communicated R9's concern to the charge nurse, registered nurse (RN)-A and the administrator. The SSD note indicated follow up to R9's concern was in progress.  During review of the facility incident reports and vulnerable adult reports no reports for the described incident/concern could be located.  During interview with the director of nursing (DON) and the administrator on sh 71/15 at 2:00 p.m., they verified after review of the facility's documents, that there had not been an investigation conducted. The administrator stated they were aware there had previously been some		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		SURVEY PLETED
DIVINE PROVIDER OR SUPPLIER  DIVINE PROVIDENCE HEALTH CENTER  SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREET ADDRESS, CITY, STATE, ZP CODE 312 EAST GEORGE ST PO BOX 136 (VANIOE, MN 56142)  FACE CONTINUED FROM MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F225  Continued From page 2 nursing once that he'd been left in the mechanical lift for long periods (2 hours on one occasion).  R9's quarterly Minimum Data Set (MDS) assessment dated 5/16/15, identified R9 with a Brief Interview for Mental Status ((BIMS) score of 14/15, indicating good cognition skills. The MDS further identified R9 had no indicators of delirium and had no behavior indicators. The MDS also identified R9 was free of hallucinations or delusions.  During review of R9's medical record there was an entry dated 4/20/15, at 3:32 p.m. which identified R9 had an oindicators of delirium and the administrator. The SSD note indicated follow up to R9's concern was in progress.  During review of the facility incident reports and vulnerable adult reports no reports for the described incident/concern could be located.  During interview with the director of nursing (DON) and the administrator or 8/11/15 at 2:00 p.m., they verified they both had started at the facility following these allegations. The DON and administrator verified after review of the facility's documents, that there had not been an investigation conducted. The administrator stated they were aware there had previously been some			245327	B. WING	i		08/-	12/2015
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 225  Continued From page 2 nursing once that he'd been left in the mechanical lift for long periods (2 hours on one occasion).  R8's quarterly Minimum Data Set (MDS) assessment dated 5/16/15, identified R9 with a Brief Interview for Mental Status ((BIMS) score of 14/15, indicating good cognition skills. The MDS further identified R9 had no indicators of delirium and had no behavior indicators. The MDS also identified R9 was free of hallucinations or delusions.  During review of R9's medical record there was an entry dated 4/20/15, at 3:32 p.m. which identified R9 had no second to the evening of 4/19/15. The SSD stated she communicated R9's concern to the charge nurse, registered nurse (RN)-A and the administrator. The SSD note indicated follow up to R9's concern was in progress.  During review of the facility incident reports and vulnerable adult reports no reports for the described incident/concern could be located.  During interview with the director of nursing (DON) and the administrator on 8/11/15 at 2:00 p.m., they verified ther review of the facility's documents, that there had not been an investigation conducted. The administrator stated they were aware there had previously been some			H CENTER		3	112 EAST GEORGE ST PO BOX 136		
nursing once that he'd been left in the mechanical lift for long periods (2 hours on one occasion).  R9's quarterly Minimum Data Set (MDS) assessment dated 5/16/15, identified R9 with a Brief Interview for Mental Status ((BIMS) score of 14/15, indicating good cognition skills. The MDS further identified R9 had no indicators of delirium and had no behavior indicators. The MDS also identified R9 was free of hallucinations or delusions.  During review of R9's medical record there was an entry dated 4/20/15, at 3:32 p.m. which identified R9 had approached the social service designee (SSD) and shared a concern he'd had over the weekend on the evening of 4/19/15. The SSD stated she communicated R9's concern to the charge nurse, registered nurse (RN)-A and the administrator. The SSD note indicated follow up to R9's concern was in progress.  During review of the facility incident reports and vulnerable adult reports no reports for the described incident/concern could be located.  During interview with the director of nursing (DON) and the administrator or 8/11/15 at 2:00 p.m., they verified after review of the facility's documents, that there had not been an investigation conducted. The administrator stated they were aware there had previously been some	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE
confusion related to vulnerable adult reporting, but that these allegations would have been appropriate to report immediately to the administrator and State agency. Both the DON and the administrator had been newly employed	F 225	nursing once that h lift for long periods  R9's quarterly Minir assessment dated Brief Interview for M 14/15, indicating go further identified R9 and had no behavior identified R9 was fr delusions.  During review of R9 an entry dated 4/20 identified R9 had all designee (SSD) an over the weekend of SSD stated she con the charge nurse, r the administrator. T up to R9's concern  During review of the vulnerable adult rep described incident/of  During interview wit (DON) and the adm p.m., they verified t facility following the administrator verified documents, that the investigation condu they were aware the confusion related to but that these alleg appropriate to repo administrator and S	e'd been left in the mechanical (2 hours on one occasion).  mum Data Set (MDS) 5/16/15, identified R9 with a Mental Status ((BIMS) score of ood cognition skills. The MDS and had no indicators of delirium or indicators. The MDS also see of hallucinations or  B's medical record there was 1/15, at 3:32 p.m. which opproached the social service of shared a concern he'd had on the evening of 4/19/15. The municated R9's concern to registered nurse (RN)-A and the SSD note indicated follow was in progress.  Be facility incident reports and corts no reports for the concern could be located.  The director of nursing ninistrator on 8/11/15 at 2:00 hey both had started at the see allegations. The DON and red after review of the facility's ere had not been an octed. The administrator stated ere had previously been some of vulnerable adult reporting, ations would have been and timmediately to the state agency. Both the DON	F	225			

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Facility ID: 00339

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		LE CONSTRUCTION		E SURVEY PLETED
		245327	B. WING			08/	12/2015
	PROVIDER OR SUPPLIER PROVIDENCE HEALT	H CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 112 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	stated she recalled staff being rough. complaint to both to nurse as required. documentation of to could not verify who courred and/or who reported to outside.  During phone inter 4:37 p.m. RN-A state complaining that state him in a lift for 2 hours that R9 was credibincident to the nurse incident had allege the nurse that the coreported. RN-A state duty to document the administrator since facility at the time. concern was a vulnt to be investigated.  During interview or administrator verificate complaint and reporting had occument the complaint and reporting had occument the male staff telling. When interviewed incidents on 8/11/1 whether he recalled being rough. R9 states.	onths.  In 8/11/15, at 3:41 p.m. the SSD In R9 complaining of a night SSD stated she reported the she administrator and charge. The SSD verified she had no he details of the complaint and either an investigation had nether the incident was State agencies as required.  In State agencies and no state agencies as required.  In State agencies and no state agencies as required.  In State agencies and no state agencies agencies as required.  In State agencies as required.  In Sta	F2	225			

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Event ID: D1D311

Facility ID: 00339

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245327	B. WING	ì		08/-	12/2015
	PROVIDER OR SUPPLIER	d CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 112 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142	1 00/	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	) BE	(X5) COMPLETION DATE
F 225	bed side table and stated staff had sta can't do nothing abdidn't recall exactly he had reported it to he had reported to in the mechanical listated, "I don't wan."  The facility Vulnera identified abuse in some an accident or to in this section, which reasonably be experimented to the follow 1. Hitting, slapping punishment of the value or the treatments of the value of the treatments of the value of the treatments. Use of repeated gestured or technol communication or ladult or the treatments should be considered be disparaging, use written, or derogated threatening.  3. Use of any aversunreasonable confiscelusion.  Neglect was identifia. Failure or omiss the vulnerable adultincluding, but not line health care, or super 1. Reasonable and maintain the vulner mental health or sa	stated, "Where I eat". R9 also ted, "Shut up you old fart, you out it." R9 further stated he when it happened but stated to the nurse. R9 also verified the nurse that he had been left fit for a long period of time. R9 to cause problems".  ble Adult policy revised 8/1/09, section B. as conduct which is herapeutic conduct as defined the produces or could exted to produce physical pain al distress including, but not ing:  pinching, biting, or corporal vulnerable adult.  or malicious oral, written, ogically produced anguage toward a vulnerable and the eart of a vulnerable adult which eart of	F	225			

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Mannestoa Department of Health Marshall

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245327	B. WING	i		08/	12/2015
	PROVIDER OR SUPPLIER PROVIDENCE HEALT	H CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 112 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		-,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	identified the follow  1. All alleged or sumistreatment, or more than the cause for a thore conducted by the notes of a staff and volunt or suspicions of ab from facility staff or a suse must be reputiled examine the redocument his/her formade to the Director Designee, or the Additional to the Director of the notified immediated maltreatment, abuse of the completed by the aninvestigation is to more incident is reportable. The investigation is to minimize the incident is reportable. A review of the complete of the incident.  In all leged or sumistreatment of a subject of the notified in the notified	acility's Vulnerable Adult Plan ving investigation procedure: aspected neglect, abuse, aspected neglect, abuse, aspected investigation to be management of the facility. He are must report any incidents as without fear of retaliation of others. The buse or suspected incident of orted to a charge nurse who sident and thoroughly indings. Reports may also be or of Nursing, Social Services dministrator. Supervisor/manager will oppriate forms. Notification and completed on the Abuse Report.  Nursing and Administrator will ately of the suspected se or neglect. Estigation of the incident will be administrator. The internal make a determination if the ole or not reportable. In will include at least the the completed complaint form with the person(s) reporting with the resident if possible. The resident's medical record. With the resident's roommate, and visitors.	F	225			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED		
		245327	B. WING			08/-	12/2015		
	PROVIDER OR SUPPLIER	d CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE 📆	(X5) COMPLETION DATE		
F 226 SS=D	policies and proced mistreatment, negle	ETC POLICIES  velop and implement written	F 2	26	F-226  Corrective action as it applies to ot  Policy and procedure for abuse previewed on 9/2/15 and remains cu no changes initiated to policy and p	se prevention was ains current with and procedure.			
	by: Based on interview facility failed to dever policy that identified suspected abuse to failed to implement of 1 resident (R9) repotential abuse/neg. Findings include: When the facility potential an internal inversion to reporting the State agency. Tollows: The facility's Vulner 8/1/09, defined abuse	AT is not met as evidenced  y and document review, the elop an abuse prohibition I immediate reporting of the State agency, and staff a thorough investigation for 1 eviewed who had reported elect incidents.  Alicy was reviewed it was noted estigation would be conducted estigation would be conducted estigation would be conducted estigation would policy was as able Adult policy revised se in section B. as conduct dent or therapeutic conduct	ment review, the use prohibition agency, and staff investigation for 1 to had reported hts.  Recurrence will be prevented by:  Continue to educate new hires upon hire date in new employee orientation. Continue to review procedure and policy at annual education; if any procedure and policy changes are made; update all staff at the time of change prior to implication.				for t to ate		
	as defined in this second reasonably be physical pain or injuincluding, but not lir 1. Hitting, slapping punishment of the v 2. Use of repeated gestured or technol communication or letter the second reasonable the second reasonable that	ection, which produces or e expected to produce ary or emotional distress nited to the following: pinching, biting, or corporal rulnerable adult. or malicious oral, written,	·		Administrator and/or designee.  Completion Date:  September 11 <sup>th</sup> , 2015				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADDRESS.		K2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED		
		245327	B. WING			08/	12/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		D BE	(X5) COMPLETION DATE			
F 226	should be consider be disparaging, us written, or derogate threatening.  3. Use of any average unreasonable confisculation.  Neglect was identifia. Failure or omiss the vulnerable aduincluding, but not liberable and including, but not liberable and including but not liberable a	red by a reasonable person to e of repeated or malicious oral, ory, humiliating, harassing, or rsive or deprivation procedure, inement, or involuntary fies as follows in the policy: sion by the caretaker to supply It with care or services mited to food, clothing, shelter, ervision which is: d necessary to obtain or rable adults physical and afety.	F 2	226					
	or suspicions of ab from facility staff of 3. An incident of a abuse must be rep will examine the re document his/her f made to the Direct Designee, or the A 4. The delegated s complete the appro documentation is of form. 5. The Director of	use without fear of retaliation others. buse or suspected incident of orted to a charge nurse who sident and thoroughly indings. Reports may also be or of Nursing, Social Services							

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Manestoa Department of Health

Marin di

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245327	B. WING		-	08/1	12/2015
	PROVIDER OR SUPPLIER PROVIDENCE HEALT		STREET ADDRESS, CITY, STATE, ZIP COD 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	completed by the a investigation is to rincident is reportal 7. The investigation following:  a. A review of or incident report b. An interview the incident. c. An interview d. A review of e. An interview family members, a f. A review of surrounding the incident.  During initial interva.m. R9 was quest occurred, R9 state that was pushing of doing cares. After bottom then put the table. I told him I detere." R9 stated at the staff member a placement of the testaff member state can't tell me what is reported the incident her name. R9 further nursing once that I lift for long periods.  R9's quarterly Miniassessment dated Brief Interview for	se or neglect. estigation of the incident will be administrator. The internal make a determination if the ole or not reportable. on will include at least the the completed complaint form with the person(s) reporting with the resident if possible. The resident's medical record. With the resident's roommate, and visitors. all the circumstances	F	226			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	12/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	12/2010
DIVINE PROVIDENCE HEALTH CENTER  312 EAST GEORGE ST PO BOX 136  IVANHOE, MN 56142	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
further identified R9 had no indicators of delirium and had no behavior indicators. The MDS also identified R9 was free of hallucinations or delusions.  During review of R9's medical record there was an entry dated 4/20/15, at 3:32 p.m. which identified R9 had approached the social service designee (SSD) and shared a concern he'd had over the weekend on the evening of 4/19/15. The SSD stated she communicated R9's concern to the charge nurse, registered nurse (RN)-A and the administrator. The SSD note indicated follow up to R9's concern was in progress.  During review of the facility incident reports and vulnerable adult reports no reports for the described incident/concern could be located.  During interview with the director of nursing (DON) and the administrator on 8/11/15 at 2:00 p.m., they verified they both had started at the facility following these allegations. The DON and administrator verified after review of the facility's documents, that there had not been an investigation conducted. The administrator stated they were aware there had previously been some confusion related to vulnerable adult reporting, but that these allegations would have been appropriate to report immediately to the administrator and State agency. Both the DON and the administrator had been newly employed the past couple months.  During interview on 8/11/15, at 3:41 p.m. the SSD stated she recalled R9 complaining of a night staff being rough. SSD stated she reported the complaint to both the administrator and charge nurse as required. The SSD verified she had no	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/	12/2015	
	PROVIDER OR SUPPLIER PROVIDENCE HEALT	H CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 112 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142	1 00/	12/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 226	documentation of the could not verify who occurred and/or who reported to outside.  During phone intended 4:37 p.m. RN-A state complaining that state him in a lift for 2 hours that R9 was credible incident to the nurse incident had alleged the nurse that the coreported. RN-A state duty to document the administrator since facility at the time.	he details of the complaint and either an investigation had hether the incident was State agencies as required.  View with RN-A on 8/11/15, at sted she recalled R9 aff neglected him by leaving ours. RN-A stated she believed le and had reported the se assigned the shift the dly occurred. RN-A informed complaint needed to be sted she informed the nurse on the incident and to give it to the other was not a DON at the RN-A further stated she felt the nerable adult issue and needed	F	226				
	administrator verifice the complaint and verifice the complaint and vereporting had occur stated he was not at the male staff telling.  When interviewed a incidents on 8/11/19 whether he recalled being rough. R9 st staff being rough at bed side table and stated staff had stated staff had stated can't do nothing abdidn't recall exactly he had reported to the had reported to the state of the staff had reported to the st	a 8/11/15, at 5:00 p.m. the ed there was no follow up to verified no investigation nor rred. The administrator further aware of the complaint about g R9 to "Shut up".  again regarding the noted 5, at 6:25 p.m. R9 was asked d the conversation about staff ated he recalled talking about nd putting a soiled towel on his stated, "Where I eat". R9 also ted, "Shut up you old fart, you out it." R9 further stated he when it happened but stated o the nurse. R9 also verified the nurse that he had been left ift for a long period of time. R9						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/	12/2015
	PROVIDER OR SUPPLIER	H CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 /ANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 226 F 278 SS=D	Continued From pastated, "I don't wan 483.20(g) - (j) ASS ACCURACY/COOF The assessment massessment was participation of head A registered nurse each assessment was participation of head A registered nurse assessment is commodered assessment must subject to a civil massessment in a subject to a civil massessment assessment in a subject to a civil massessment assessment in a subject to a civil massessment assessment assessment assessment assessment assessment.	age 11 t to cause problems". ESSMENT RDINATION/CERTIFIED tust accurately reflect the must conduct or coordinate with the appropriate lith professionals. must sign and certify that the appleted. completes a portion of the sign and certify the accuracy of assessment. and Medicaid, an individual who agly certifies a material and a resident assessment is coney penalty of not more than assessment; or an individual who agly causes another individual and false statement in a ant is subject to a civil money at than \$5,000 for each ent does not constitute a	F 2	2226	F-278  Corrective action as it applies to ot MDS nurse to address improper cook concerns related to R-2 with reflect to resident plan of care. MDS nurse manual for proper coding prior to more correction to MDS. Director of Nurse to review MDS correction prior to so Immediate corrective action:  MDS RN to modify R2 assessment of MDS to correctly reflect assessment re-submission.  Recurrence will be prevented by:  Director of Nursing to review MDS of to MDS batch submission. Education nurse by Director of Nursing Service review updates and changes related process.  Correction will be monitored by:  Director of Nursing/Designee.	ding of slion of cato revien aking ing Serviubmissic fooding property of the coding propert	ore  of  with
	by: Based on observa review the facility fa	NT is not met as evidenced tion, interview and document ailed to accurately code the (MDS) for 1 of 3 residents			<b>Completion Date:</b> September 11 <sup>th</sup> , 2015		

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245327	B. WING		O.S	3/12/2015		
	PROVIDER OR SUPPLIER PROVIDENCE HEALTI	d CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 278	(R2) reviewed for n conditions.  Findings include:  R2 was admitted or obtained from phys swelling/mass/lump fall, and skin maligr During initial observation R2 was noted to ha (scalded appearanch hands with multiple sizes noted on the con her face. R2 included she was receiving a On 8/11/15, at 7:45 have an open and bright cheek. The arrest in size.  During observation registered nurse (R treatment, using cleaffected areas, and order.  Review of R2's pap record contained the	on-pressure related skin  a 3/11/15, with diagnoses ician orders and included: in chest, history (hx) personal nancy. vation on 8/10/15, at 2:30 p.m. we bright reddened skin be) on her face, scalp and scabbed areas of varying occipital area of the scalp and dicated this was cancer and a treatment on the "sores". p.m. R2 was observed to bleeding, scabbed area on her ea was approximately pencil  on 8/11/15, at 7:58 p.m. N)-C performed R2's skin can technique to cleanse the apply ointment as per MD  er and electronic medical	F2	, and the second				
	Physician orders (M 7/20/15: Use soap a affected scalp and i	plus Vinegar 50% of each. and affected areas once a day.  ID) dated and signed: and water once daily to f white hypertrophilic (raised ars use 1:1 dilute vinegar and for 15 minutes.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/	12/2015	
	PROVIDER OR SUPPLIER	1 CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 278	Continued From page 13  The most recent quarterly Minimal Data Set (MDS) assessment dated 6/18/15, did not have documentation of any skin condition coded (e.g. cancer lesion). The cancerous lesions were present when R2 was admitted.  Nursing assistant (NA)-A was interviewed on 8/11/15, at 5:46 p.m. and indicated R2 has fragile skin, in addition to cancer located on scalp and receives treatment daily to avoid scabbing and buildup of the secretions.  During interview on 8/12/15, at 12:30 p.m. the director of nursing (DON) verified the MDS should have been coded to include R2's non-pressure related skin issues that were present at the time of admission (3/11/15).  483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS		F2	278				
F 279 SS=D			F 2	279	F-279 Corrective action as it applies to ot	thers:	9/11/15	
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under				Resident care plans will be reviewed to ensure each care plan addresses and skin potential/actual concerns.  Immediate corrective action:  Resident care plans for R2 and R21 were updated to include non-pressure related conditions to reduce pressure related potential concerns with identification of problem, goal, and resident specific interventions related to skin frailty and risk of tears and/or bruising.  Care plan to reflect on R2 skin issues related to cancerous lesion to correlate with MDS coding of non-pressure related skin issues. Care plan			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245327	B. WING			08/1	12/2015
	PROVIDER OR SUPPLIER  PROVIDENCE HEALTH	d CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 /ANHOE, MN 56142		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 279	under §483.10(b)(4)  This REQUIREMENT by: Based on observation review the facility fator 2 of 3 residents non pressure related.  Findings include:  During initial observation. R21 noted to be extremities. The browns at multiple stage from dark purple to areas of her bilaters.	the right to refuse treatment.).  NT is not met as evidenced tion, interview and document alled to develop a plan of care (R21 and R2) reviewed for a conditions.  Vation on 8/10/15, at 11:12 have bruising of bilateral upper uising was widespread and ges of healing. Bruises ranged yellow and covered large al forearms.	F		updated with MDS correction and resubmission to be completed by MDS oversight from Director of Nursing.  Recurrence will be prevented by:  1 weekly random audit of care plan conducted for 90 days to ensure resulans address and accurately reflect actual/potential skin concerns/conducted problem, goal, and resident specific interventions in place. Audit results reviewed monthly with Quality Assucommittee for their input and recommendations for continued monthly controlled by:  Director of Nursing Services and/or	will be sident ca and litions will be urance	re ith
	identified R21 with a on her right hand. For cause of skin care. No signs or symptodir. Refused band a active bleeding. December 1.2 on 6/12/15 at 10 with a skin tear on land 1.9 cm wide. A saturated with sero drainage. Skin tear	0:41 a.m. R21 was identified her right forearm 2 cm long A bandage was observed to be sanguinous (clear red tinged) r cleansed with soap and ed. Steri-strips, Tegaderm and			Completion Date: September 11 <sup>th</sup> , 2015		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED		
		245327	B. WING	i		08/	12/2015		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142			•			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	) BE	(X5) COMPLETION DATE		
F 279	(3) On 6/30/15, at have a Transparer forearm with no si  (4) On 7/7/15, at 4 nurse (LPN)-A dopat R21's arm on watch caught on Fimmediately bruisikept rubbing on it.  (5) On 8/5/15 at 8 identified R21's da (incident not deschad Steri-strips ar left forearm. No end of the properties	3:58 p.m. R21 was identified to not dressing in place on her right gns or symptoms of infection.  3:06 p.m. licensed practical cumented she turned around to the way out of room and her R21's left forearm. R21 started ng at site of contact. Resident  331 p.m. a progress note aughter was notified of incident ribed). The note identified R21 at transparent dressing in place explanation of origin of injury.  3:11/15, at 1:41 p.m.  RN)-B stated R21 arms are drup" as resident bangs around ad. RN-B stated R21 kept ems in her bed and would bang boxes and perhaps her grab dresses and perhaps her gra		279					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/	12/2015
	PROVIDER OR SUPPLIER PROVIDENCE HEALT	H CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142			12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	record lacked a planon-pressure skin of the scalded appearance hands with multiple occipital area of the were drooping and R2 indicated this was receiving a treatmet. On 8/11/15, at 7:45 have an open and lacked. The area was in size. R2 indicated begins picking at the During observation registered nurse (Rate at the scabbed area but if there are indicated than the antibiotic confected areas.  Review of R2's paparecord contained the Physician (MD) ord Vinegar 50% of each affected areas once Physician orders (Masser).	vation on 8/10/15, at 2:30 p.m. ave bright reddened skin ce) on her face, scalp and scabbed areas noted on the escalp. R2's lower eyelids were bright red in appearance. as cancer and she was ent.  p.m. R2 was observed to pleeding, lesion on her right as approximately pencil eraser ed she becomes anxious and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.  on 8/11/15, at 7:58 p.m. and the scabbed areas.	F2	279			
	7/20/15: Use soap a affected scalp and i	and water once daily to if white hypertrophilic (raised urs use 1:1 dilute vinegar and	•				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245327	B. WING			08/	12/2015	
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 279	3/17/15, lacked re reddened/scabbed and paper record.	age 17 st recent plan of care dated ference to skin care for d areas in both the electronic. The lack of care planing for erified by licensed practical	F:	279	·			
F 282 SS=D	R2 had a Brief Interscore of 5/15 which impairment. No spresent on the MIDuring interview of director of nursing did not address R further indicated sto address R2's cainclusion of treatm. The DON further coding of the cand would have expect skin issues to be 483.20(k)(3)(ii) SEPERSONS/PER OF The services proving the provided accordance with example.	t dated 6/18/15 indicated erview of Mental Status (BIMS) th indicated severe cognitive kin conditions were coded as DS assessment dated 6/18/15.  In 8/12/15, at 12:30 p.m. the (DON) verified the plan of care 2's skin issues. The DON he would expect the care plan ancerous skin issues with the nents and monitoring in place. Verified the MDS did not include berous skin lesions and that she ted the non pressure related coded in the assessment. ERVICES BY QUALIFIED CARE PLAN ided or arranged by the facility by qualified persons in each resident's written plan of ENT is not met as evidenced	F	282	F-282 Immediate Corrective action: R9 medications and lab work review primary medical doctor to ensure of necessary lab work has been update of results in resident paper chart. R (thyroid blood test) completed. Me to address and document response	completion ced with R9 TSH edical do	on of copy	
		w and document review the ovide laboratory services as			pharmacist recommendations. Meeto document reason for not runnin	dical doc	tor	

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GENTERO POR MEDICARE & MEDICARD SERVICES				OMB 110. 0938-0391					
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245327	B. WING		08/12/2015				
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
DIVINE PROVIDENCE HEALTH CENTER			1 -	12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION				
F 282	Continued From page 18 directed by the care plan for 1 of 5 residents (R9) reviewed for unnecessary medications. Findings include:		F.282	making notation that he/she has reviewed all current medications/orders and reviewed last labs as it relates.  Corrective action as it applies to others:  Laboratory Services policy reviewed and					
	R9 was identified with a diagnosis of hypothyroidism on the physician orders and was prescribed Levothyroxine Sodium (Synthroid) 0.025 micrograms (mcg), 1 tablet orally each day, for thyroid dysfunction.  R9's plan of care dated 5/5/15, identified R9 at risk for potential of further altered metabolic			updated on 9/3/15 with copy of upon given to Ivanhoe Medical Center and Medical Group which services our for for procedure and policy also given that provide services within our factures updated on policy and procedures.	updated policy and Avera r facility. Copy n to all doctors acility. Facility ocedure				
	should be complete and any signs or sy should be reported review of R9's medi	ypothyroidism and that lab work red as ordered by the physician ymptoms hypo/hyperthyroidism d to the physician. During dical record a Thyroid one (TSH) laboratory test was red.		changes to ensure all labs are draw addressed, and a copy of noted restressident paper chart.  Recurrence will be prevented by:  Director of Nursing Services to do raweekly audits of lab orders and test	ult in andom ing results				
	director of nursing ( evidence of a labora in the current medic	On 8/12/15, at 10:30 a.m. the DON provided the most recent TSH level documented for R9 which was dated 2/13/13 (30 months ago). This aboratory test identified that R9 had low TSH		to ensure the lab orders have been completed, addressed appropriately according to test results, noted, and filed in paper chart X 90 days. Audit results will be reviewed monthly with Quality Assurance committee for their input and recommendations for continued					
	most recent TSH le was dated 2/13/13			monitoring. Director of Nursing to do weekly pharmacy review audits on current residents to ensure primary medical doctor has addressed pharmacy recommendations and documented					
F 309	During review of the monthly pharmacy reviews it was noted on 4/24/15 that the pharmacist recommended a TSH level be completed for R9. 483.25 PROVIDE CARE/SERVICES FOR		F 309	their response.  Correction will be monitored by:  Director of Nursing Services and/or Designee.					

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		245327	B. WING			08/-	12/2015	
	PROVIDER OR SUPPLIER PROVIDENCE HEALTI	H CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE COM			(X5) COMPLETION DATE	
F 309 SS=D	page 15			309	F-309 Immediate Corrective action: R21 given sleeve protectors to assist protecting thin/fragile skin that bruin R21 stores a lot of items in her bed awall that she does not want moved provides a sense of security and that R21 has done things for a long time	ses easi along th as it t is the v	e way	
					R21 (states R21 bumps her arms into her belongings). Weekly skin audits completed on all residents with licensed nurse signature that she has completed skin assessment on residents assigned bath day; if resident has more than one bath per week, resident body audit will be completed on the first bath of the week with the week beginning on Sunday.			
	During initial observation on 8/10/15, at 11:12 a.m. R21 noted to have bruising of bilateral upper extremities. The bruising was widespread and was at multiple stages of healing. Bruises ranged from dark purple to yellow and covered large areas of her bilateral forearms.  During review of R21's medical record progress notes the following entries were noted:				Corrective action as it applies to others:  Director of Nursing developed procedure and policy on weekly body audits in correlation with resident weekly bath day. Resident care plan to accurately reflect any noted skin issues/concerns.			
	(1) On 3/30/15, at 7 identified R21 with a on her right hand. F cause of skin care. No signs or sympto air. Refused band a active bleeding. De	:00 p.m. a progress note a 2 centimeter (cm) skin tear 321 was unable to identify Edges were approximated. ms of infection noted. Open to id and antibiotic ointment. No			Recurrence will be prevented by:  Director of Nursing Services to do raweekly audits on five resident chart Audit results will be reviewed mont Quality Assurance committee for thand recommendations for continue monitoring.	Nursing Services to do random its on five resident charts X 90 days. Its will be reviewed monthly with urance committee for their input mendations for continued		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245327	B. WING			08/	12/2015	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 309	with a skin tear on and 1.9 cm wide. saturated with sendrainage. Skin tea warm water and delastic netting app (3) On 6/30/15, at have a Transparer forearm with no signature (LPN)-A door pat R21's arm on the watch caught on Fimmediately bruisis kept rubbing on it.  (5) On 8/5/15 at 8: identified R21's da (incident not described R21's arm left forearm. No end of the properties of the prope	A her right forearm 2 cm long A bandage was observed to be osanguinous (clear red tinged) ar cleansed with soap and ried. Steri-strips, Tegaderm and lied  3:58 p.m. R21 was identified to nt dressing in place on her right gns or symptoms of infection.  3:66 p.m. licensed practical cumented she turned around to the way out of room and her right's left forearm. R21 started ng at site of contact. Resident  3:31 p.m. a progress note aughter was notified of incident ribed). The note identified R21 and transparent dressing in place explanation of origin of injury.  1:41 p.m. RN)-B stated R21 arms are a up" as resident bangs around ad. RN-B stated R21 kept tems in her bed and would bang boxes and perhaps her grab at R21 was very active at times are sewing, knitting etc. RN-B are was any interventions in place of R21 getting bruising and skin at she was not aware of any attributed to be severed to be a severed to be a sup and the sup and the severed to be a sup and the sup and the severed to be a sup and the sup	F3	609	Correction will be monitored by: Director of Nursing Services and/o Completion Date: September 11 <sup>th</sup> , 2015	<sup>*</sup> Designe	ee.	

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Event ID: D1D311

Facility ID: 00339

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245327	B. WING			08/-	12/2015
NAME OF PROVIDER OR SUPPLIER  DIVINE PROVIDENCE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142			-,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315 SS=D	non-pressure related skin tears. Further, tracking the progresidentified bruises.  During review of Raidentified interventing pressure ulcer risk problem, goal, or infrailty and risk of skin tercord for hursing expect the plan of continuity and skin tercord lacked and a non-pressure skin of 483.25(d) NO CATI RESTORE BLADD Based on the resident who enters indwelling catheter resident's clinical or catheterization was who is incontinent of treatment and servinfections and to refunction as possible.  This REQUIREMENT by:  Based on interview facility failed to continuity fa	assessment for risk factors for ed skin conditions, bruising and there was no evidence of esion and/or healing of the 21's 6/11/15 plan of care ons for the reduction of but failed to identify any terventions related to skin in tears or bruising.  8/12/15, at 10:14 a.m. the (DON) stated she would eare to identify risk factors for ears. It was verified the medical assessment or care plan for concerns. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a sthe facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder		315	F-315  Immediate Corrective action:  Bladder assessment to correlate wiplan of care to accurately reflect reand needs to be met to achieve the level of functioning with maintenar Corrective action as it applies to or Resident will have a 3 day bowel ardiary upon admission and re-admis quarterly reviews per facility proceprotocol. Individual resident care paccurately reflect any noted skin issues/concerns. All resident care previewed by MDS nurse and Direct	sident stephise highest nee care.  thers:  Ind bladdession, and dure and blan to blans	atus er d
	by: Based on interview facility failed to con-	and document review the duct a comprehensive			accurately reflect any noted skin issues/concerns. All resident care p	olans	rsing.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	245327 B. WING					08/	12/2015	
NAME OF PROVIDER OR SUPPLIER  DIVINE PROVIDENCE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 315	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG CROSS-REFERENCED TO THE APPR		corandom cs X 90 days. Conthly with their input ued corogram to s and 3 day ent specific resident needs coning. Come to this properly track for licensed accurately.  cor Designee.		
	potential for bowel bowel incontinence included: Toileting: every two hours, ar	e most recent care plan dated 3/17/15, listed a cential for bowel (fecal) incontinence, Hx of vel incontinence, immobility. Interventions uded: Toileting: take resident to the bathroom ry two hours, and PRN if requested by dent or observed to be restless by staff			Director of Nursing Services and/or Designee.  Completion Date:  September 16 <sup>th</sup> , 2015			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/-	12/2015
	PROVIDER OR SUPPLIER	H CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142				·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	of care did not refet to the urinary incor NA-A indicated this R2 had been ill foll longer pertinent.  During observation was seated in her with legs elevated. assistant] asked R not offer assistance remained seated in During an observation R2 was observed and did not offer to p.m. staff removed and did not offer to p.m. R2 remained elevated. No toileting offered by staff. Or later) R2 remained room and stated sl toileting assistant of the incontinent after slettle incontinent brief was assisted with the incontinent episode frequently during the seates with th	go to the bathroom. The plan brence any interventions related attinence problem. In addition intervention was from when owing admission and was no at on 8/10/15, at 2:00 p.m. R2 recliner located in her room At 2:30 p.m. staff [nursing 2 how she was doing, but did to the toilet. At 3:00 p.m. R2 recliner in room.  Ition on 8/11/15, at 12:00 p.m. R2 recliner in room.  Ition on 8/11/15, at 12:00 p.m. R2 recliner in room.  Ition on 8/11/15, at 12:00 p.m. R2 recliner in room.  Ition on 8/11/15, at 12:00 p.m. R2 recliner with her go her noon meal. At 12:35 reated in the recliner with feet in assistance had yet been a 8/11/15, at 2:00 p.m. (2 hours seated in the recliner in her has "accidents" at times. No en had been offered by staff.  If on 8/11/15, at 5:48 p.m. R4-A indicated R2 requested in the recliner in her has "accidents" at times. No en had been offered by staff.  If on 8/11/15, at 5:48 p.m. R4-A indicated R2 requested in the recliner in her has "accidents" at times. No en had been offered by staff.  If on 8/11/15, at 5:48 p.m. R4-A indicated R2 requested in the recliner in her has "accidents" at times. No en had been offered by staff.  If on 8/11/15, at 5:48 p.m. R4-A indicated R2 requested in the recliner indicated are shave occurred more in en ight shift. NA-A verified are if R2 was currently on any	F	315			
		v on 8/12/15, at 11:44 a.m. nurse (LPN)-C indicated she					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245327	B. WING		· ·	08/	12/2015
	PROVIDER OR SUPPLIER	H CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION)  TA			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	episodes.  During an interview NA-B also confirme R2 was on a sched	age 24 12's bladder incontinence of on 8/12/15, at 11:32 a.m. ed she was unaware whether luled toileting program and 2 has incontinent episodes of	F	315			
F 329 SS=E	(DON) on 8/12/15, the care plan did not incontinence and a not been developed bladder incontinence indicated she would include the problem interventions in plate. The DON also contaccurate and compincontinence so the could be developed.	EGIMEN IS FREE FROM	F	329	F-329		
	unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its usadverse conseques should be reduced combinations of the Based on a compreresident, the facility	ag regimen must be free from a. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any e reasons above.  The presence of nces which indicate the dose or discontinued; or any e reasons above.			Immediate Corrective action:  Medical doctor ordered lab test of (thyroid blood test) on R9 to moni therapeutic level related to the use Synthroid. Medical doctor contact to pharmacy review for response.  R5 Digoxin levels evaluated per lab medical doctor response to pharm request completed.	tor e of drug ed in reg o draw w	gards

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/-	12/2015
	PROVIDER OR SUPPLIER PROVIDENCE HEALTH	d CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From page 25 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor the effectiveness of medications for 3 of 5 residents (R9, R5 and R20) who were reviewed for unnecessary medications.  Findings include:  R9 was identified with a diagnosis of hypothyroidism on the physician orders and was prescribed Levothyroxine Sodium (Synthroid) 0.025 micrograms (mcg), 1 tablet orally each day,			329	R20 started on medication Trazodor evening at hour of sleep for insomn sleep monitoring completed with licensing staff charting by exception sleep pattern if resident not sleeping.  Corrective action as it applies to other dependence of Nursing developed policens procedure to initiate sleep monitoring starting a medication prescribed for follow up sleep monitoring 7-14 day	ia witho censed on reside g. hers: y and ing prior	ut a ····· ent to
					starting medication with quarterly evaluating during seven day reference period in correlation with minimal data sets. Licensed staff educated with policy and protocol changes related to pharmacy reviews and medical doctor follow up along with required assessment and monitoring of sleep prior to starting and during course of taking a sleep aide at monthly mandatory nursing meeting to be held on Wednesday September 16 <sup>th</sup> , 2015.  Recurrence will be prevented by:		
	for thyroid dysfunction.  R9's plan of care dated 5/5/15, identified R9 at risk for potential of further altered metabolic status related to hypothyroidism and that lab work should be completed as ordered by the physician and any signs or symptoms hypo/hyperthyroidism should be reported to the physician. During review of R9's medical record a Thyroid Stimulating Hormone (TSH) laboratory test was unable to be located.				Director of Nursing Services to do raweekly audits on 2 resident charts? Audit results will be reviewed mont Quality Assurance committee for thand recommendations for continue monitoring.  Correction will be monitored by:  Director of Nursing Services and/or	( 90 days hly with eir input d	t
	During interview on	8/11/15, at 6:30 p.m. the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	COMPLETED		
		245327	B. WING	i	·	08/	12/2015
	PROVIDER OR SUPPLIER	H CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142	1 00/	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	evidence of a labor in the current medishe would contact recent TSH report.  On 8/12/15, at 10:3 most recent TSH is was dated 2/13/13 laboratory test resured. TSH levels noted.  During review of the dated 4/24/15, the TSH level be computed was lacking in the had responded to 1.  R5 had current phymg once daily. The dated 6/29/15 doctor in the record to ind During review of the physician had recommendation.  During interview of the physician director of nursing problem with physician directors and the medical diconcern.  Review of the physiciated an order (mg) every bedtime	(DON) verified there was no ratory report for the TSH value cal record. The DON indicated the clinic to get the most  30 a.m. the DON provided the evel documented for R9 which (30 months ago). The ults identified that R9 had low  e monthly pharmacy reviews pharmacist recommended a pleted for R9. Documentation record to indicate the physician the recommendation.  In scician order for Digoxin 0.125 is monthly pharmacy review umented that R5 have a ked since evidence was lacking icate it had been monitored. The medical record it was noted not yet responded to the  18/12/15, at 10:49 a.m. the (DON) stated there had been a cians responding to the by the consultant pharmacist rector had been aware of the sician's orders dated 3/25/15, for Trazodone 50 milligrams		329	Completion Date: September 16 <sup>th</sup> , 2015		
		edative/hypnotic and the care					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMPLETED	
		245327	B. WING	à		08/	12/2015
	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 329	plan was updated R20's care plan darisk for injury relate and the approach medical doctor's or medications as incompossible dose and to ensure resident dose. The care playing a disturbed unfamiliar environmenter ord lacked doctor monitoring was been decided to indicate the recommended at the recommendation of the properties of the more at night. Recomplaining about they thought he was decided to put him they do not complete provided the residents or their fresidents sleep and help sleep. She as the process of the plant of the process of the	ated 6/3/15, identified R20 at ed to psychotropic medications included: medications per rders, discuss trial reduction of dicated to achieve the lowest periodically review behaviors is receiving the appropriate an also identified R20 as I sleep pattern related to ment. Review of R20's medical umentation that sleep sing done.  Athly pharmacy reviews dated I5, indicated the pharmacist rial dose reduction of the mentation was lacking in the the physician had responded to ons.  In 8/11/15, at 1:50 p.m. with RN)-B stated R20 takes not sleeping well related to r being too cold or hot in his I-B stated R20 was always at the temperature in his room so asn't sleeping well so they in on Trazodone. RN-B stated ete sleep assessments nor		329			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245327	B. WING	i		08/1	12/2015
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	other if the resider The DON admitted R20 requested so DON then stated t is sleeping at nigh explaining they on not sleeping well. report the sleep st communicated so report and/or docu confirmed no slee prior to starting sle confirmed the phy consulting pharma dose reductions a problem.  During interview o stated they don't o and only chart by  During interview o DON reiterated th	Int needs something to sleep. In that she didn't know whether mething to sleep or not. The chat staff monitor if the resident of and document by exception, and document if the resident is DON also stated during shift eatus of a resident is monitoring is done by verbal fumenting by exception. DON proposes as a completed expressed and failed to address the eacist's recommendations for trial and this has been an ongoing on 8/12/15, at 12:40 p.m. LPN-B do any ongoing sleep monitoring exemption.  In 8/12/15, at 1:08 p.m. the ey document sleep by exception did they don't have a sleep		329			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245327 B. WING 08/11/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 DIVINE PROVIDENCE HEALTH CENTER IVANHOE, MN 56142 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) INITIAL COMMENTS K 000 K 000 FIRE SAFETY **APPROVED** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE By Gary Schroeder at 8:47 pm, Sep 16, 2015 DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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, on August 11, 2015. At the time of this survey. Divine Providence Health Center was found not to be 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** MIN DEPT. OF PUBLIC SAFETY Health Care Fire Inspections STATE FIRE MARSHAL DIVISION State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

BACH

Administrator

(X6) DATE

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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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/11/2015	
	PROVIDER OR SUPPLIER	H CENTER	d	31	TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 (ANHOE, MN 56142		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	By email to: Marian.Whitney@s <mailto:marian.wh 1.="" 2-hour="" 2.="" 3.="" <mailto:angela.kap="" a="" actual,="" alarms.="" and="" angela.kappenman="" are="" assemblies.="" basement,="" be="" building,="" by="" co="" constructe="" corr="" correct="" corridors="" defici="" deficiency="" department="" description="" detection="" determined="" divine="" door="" equippe="" facility="" find="" fire="" following="" for="" fully="" has="" home="" i="" if="" in="" info="" is="" m="" medical="" mus="" name="" notificat="" nursing="" of="" opening="" or="" outpatient="" plan="" positive="" pre="" prevent="" protectives="" providence="" reoccurre="" responsible="" rooms="" self-closing,="" smoke="" td="" the="" the<="" to="" v="" which=""><td>tate.mn.us itney@state.mn.us&gt; and n@state.mn.us ppenman@state.mn.us&gt;  RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency.  pposed, completion date.</td><td>κ.</td><td>000</td><td></td><td></td><td></td></mailto:marian.wh>	tate.mn.us itney@state.mn.us> and n@state.mn.us ppenman@state.mn.us>  RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency.  pposed, completion date.	κ.	000			

PRINTED: 08/26/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245327 08/11/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 EAST GEORGE ST PO BOX 136 DIVINE PROVIDENCE HEALTH CENTER IVANHOE, MN 56142 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) IO SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY K 000 | Continued From page 2 K 000 The requirement at 42 CFR, Subpart 483,70(a) is NOT MET as evidenced by: On 8/11/2015 a 8"x11" red paper K 076 NFPA 101 LIFE SAFETY CODE STANDARD K 076 SS=D was placed on the oxygen storage Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. door, at the nurse's station. (a) Oxygen storage locations of greater than It states "Oxygen Gas 3,000 cu.ft. are enclosed by a one-hour separation. Stored Within: No Smoking." (b) Locations for supply systems of greater than A permanent sign will be ordered 3,000 cu.ft. are vented to the outside. NFPA 99 4,3,1,1,2, 19,3,2,4 To replace the current sign The Environmental Service This STANDARD is not met as evidenced by: Supervisor, designee &/or the Based on observation, the facility was storing medical gas cylinders in a manner not in Administrator will ensure conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1. Compliance by auditing the FINDINGS INCLUDE: building 1x per month to On 8/11/2015 between 11:30 AM and 1:30 PM. ensure all oxygen signs are observation revealed: present & appropriate There was no sign present on the door of the oxygen storage room near the Nurses Station Completion date 8/11/15 indicating that oxygen was stored within this room. This finding was confirmed with the Chief Building

PRINTED: 08/26/2015 **FORM APPROVED** OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONST ING 01 - MAI	TRUCTION N BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245327	B. WING			08/	11/2015
	PROVIDER OR SUPPLIER	H CENTER		312 EAST	DDRESS, CITY, STATE. ZIP CODE I GEORGE ST PO BOX 136 E, MN 56142		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 0022

August 24, 2015

Mr. Timothy Byrne, Administrator Divine Providence Health Center 312 East George St Po Box 136 Ivanhoe, Minnesota 56142

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5327025

Dear Mr. Byrne:

The above facility was surveyed on August 10, 2015 through August 12, 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Divine Providence Health Center August 24, 2015 Page 2 and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

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 me.

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,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

If continuation sheet 1 of 26

Minneso	ta Department of He	alth			, 0,	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00339	B. WING		08/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIVINE F	PROVIDENCE HEALTI	1 CENTER	GEORGE S , MN 56142	T PO BOX 136		÷
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tag alle number indicated below. In a several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota D	this Department's s and the following or When corrections a date, make a copy original to the Minn Division of Complia	th and 12th, 2015 surveyors of taff, visited the above provider prection orders are issued. The completed, please sign and of these orders and return the esota Department of Health, nice Monitoring, Licensing and				
_ABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00339	B. WING		08/1	2/2015	
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2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deposition of the Minnesota Deposition of the Minnesota MN Rumber and MN Rumber and MN Rumber and MN Rumber and MN Rumber arule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	this Department's s and the following of When corrections a date, make a copy original to the Minn	th and 12th, 2015 surveyors of taff, visited the above provider prection orders are issued. are completed, please sign and of these orders and return the esota Department of Health, ance Monitoring, Licensing and					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE COMP	SURVEY LETED	
		00339	B. WING		08/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIVINE F	PROVIDENCE HEALTH	1 CENTER	GEORGE S MN 56142	T PO BOX 136		
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2 000	Continued From pa	ge 1	2 000			
		m; 12 Civic Center Plaza, co, Minnesota 56001.				
2 550	MN Rule 4658.0400 Resident Assessme	O Subp. 4 Comprehensive ent; Review	2 550			
	Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents (R2) reviewed for non-pressure related skin conditions.					
	Findings include:					
	conditions.					

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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	During observation registered nurse (R treatment, using cla affected areas, and order.  Review of R2's paparecord contained the Physician (MD) ord admission]: Water Please soak scalp Physician orders (N 7/20/15: Use soap affected scalp and scabbing) skin occu water soaking daily The most recent que (MDS) assessment documentation of a	on 8/11/15, at tN)-C performed an technique I apply ointment of apply ointment of and electronic following:  I are dated 3/16/plus Vinegar Sand affected and affected and and water oncif white hyperticurs use 1:1 diluter or 15 minute ouarterly Minima dated 6/18/15	ed R2's skin to cleanse the nt as per MD nic medical 15, [on 50% of each. reas once a day. signed: e daily to rophilic (raised ute vinegar and s. al Data Set, did not have				
	cancer lesion). The present when R2 w Nursing assistant (I 8/11/15, at 5:46 p.r fragile skin, in addit and receives treath and buildup of the signary buring interview on director of nursing have been coded to related skin issues of admission (3/11/ SUGGESTED MET The director of nursidevelop and impler related to assessmi	e cancerous le ras admitted.  NA)-A was interedient and indicate tion to cancer lent daily to avecretions.  8/12/15, at 12/(DON) verified or include R2's that were presented to the properties of the properties of the properties of the properties of the properties are considered to the properties of the properties of the properties of the properties are cancer and properties are c	erviewed on ed R2 has located on scalp void scabbing 2:30 p.m. the the MDS should non-pressure sent at the time RRECTION: designee, could and procedures				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00339		B. WING		08/	12/2015
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIVINE P	PROVIDENCE HEALTH	H CENTER		GEORGE S , MN 56142	T PO BOX 136		
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2 550	Continued From pa	ge 3		2 550			
	designee, could prostaff related to the a information/assessi assessment and as perform random au	acquaracy of MDS ments. The quality surance committed dits to ensure com	e could pliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION:	wenty-one				
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents			2 560			
	Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).						
	This MN Requirements by: Based on observation review the facility farmer for 2 of 3 residents non pressure relate	on, interview and d illed to develop a p (R21 and R2) revie	ocument lan of care				
	Findings include:						
	During initial observa.m. R21 noted to hextremities. The browns at multiple stagfrom dark purple to areas of her bilaters	nave bruising of bila uising was widespro ges of healing. Brui yellow and covered	ateral upper ead and ses ranged				

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 560	Continued From pa	ge 4	2 560			
	During review of R2 notes the following	21's medical record progress entries were noted:				
	identified R21 with a on her right hand. F cause of skin care. No signs or sympto	7:00 p.m. a progress note a 2 centimeter (cm) skin tear R21 was unable to identify Edges were approximated. ms of infection noted. Open to aid and antibiotic ointment. No enies pain.				
	with a skin tear on I and 1.9 cm wide. A saturated with sero drainage. Skin tear	0:41 a.m. R21 was identified her right forearm 2 cm long A bandage was observed to be sanguinous (clear red tinged) r cleansed with soap and ed. Steri-strips, Tegaderm and ed				
	have a Transparent	8:58 p.m. R21 was identified to dressing in place on her right ns or symptoms of infection.				
	nurse (LPN)-A docu pat R21's arm on the watch caught on R2	06 p.m. licensed practical umented she turned around to be way out of room and her 21's left forearm. R21 started g at site of contact. Resident				
	identified R21's dau (incident not descril had Steri-strips and	of p.m. a progress note alghter was notified of incident oed). The note identified R21 I transparent dressing in place planation of origin of injury.				
	registered nurse (R frequently "bruised	8/11/15, at 1:41 p.m. N)-B stated R21 arms are up" as resident bangs around I. RN-B stated R21 kept				

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 560	boxes and other ite her arms into the boars. RN-B stated working on stuff like was asked if there to reduce the risk of tears. RN-B stated communication with measures i.e. arm so tears. RN-B stated communication with measures i.e. arm so tears. RN-B stated communication with measures i.e. arm so tears. RN-B stated communication with measures i.e. arm so tears. RN-B stated communication with measures i.e. arm so tears. RN-B stated communication with measures i.e. arm so tears. Roughly and risk of sk problem, goal, or infrailty and risk	ms in her bed and would bang oxes and perhaps her grab R21 was very active at times e sewing, knitting etc. RN-B was any interventions in place of R21 getting bruising and skin she was not aware of any resident about protective sleeves.  21's 6/11/15 plan of care ons for the reduction of but failed to identify any terventions related to skin in tears or bruising.  8/12/15, at 10:14 a.m. the DON) verified the medical of care related to the concerns.  vation on 8/10/15, at 2:30 p.m. we bright reddened skin on her face, scalp and scabbed areas noted on the escalp. R2's lower eyelids were bright red in appearance. as cancer and she was nt.  p.m. R2 was observed to obleeding, lesion on her right as approximately pencil eraser and she becomes anxious and	2 560			

Minnesota Department of Health

STATE FORM D1D311 If continuation sheet 6 of 26

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00339	B. WING		08/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
DIVINE F	PROVIDENCE HEALTH	1 CENTER	GEORGE S MN 56142	T PO BOX 136		
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2 560	Continued From pa	ge 6	2 560			
	but if there are indic	s have no signs of infection, cations of infection present intment is applied to the				
	Review of R2's pap record contained th	er and electronic medical e following:				
		er dated 3/16/15: Water plus ch. Please soak scalp and e a day.				
	7/20/15: Use soap a affected scalp and i	MD) dated and signed: and water once daily to if white hypertrophilic (raised ars use 1:1 dilute vinegar and for 15 minutes.				
	3/17/15, lacked refereddened/scabbed and paper record.	recent plan of care dated erence to skin care for areas in both the electronic The lack of care planing for ified by licensed practical				
	R2 had a Brief Inter score of 5/15 which impairment. No ski	nimal Data Set dated 6/18/15 indicated rview of Mental Status(BIMS) indicated severe cognitive in conditions were coded as S assessment dated 6/18/15.				
	director of nursing (did not address R2' further indicated sh to address R2's car inclusion of treatmet The DON further versions.	8/12/15, at 12:30 p.m. the DON) verified the plan of care s skin issues. The DON e would expect the care plan accrous skin issues with the ents and monitoring in place. Erified the MDS did not include erous skin lesions and that she				

Minnesota Department of Health

STATE FORM D1D311 If continuation sheet 7 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
	00339	B. WING		08/1	2/2015	
ROVIDER OR SUPPLIER		, ,	,			
ROVIDENCE HEALTH	1 CENTER		T PO BOX 136			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE	
would have expected skin issues to be considered to find the policy and procedurector of nursing (develop and implemented to care plandesignee, could prostaff related to the trevisions. The qualicommittee could perform the procedure compliance.	ed the non pressure related oded in the assessment.  CHOD OF CORRECTION: sing or designee could assure redures are reviewed The DON) or designee, could nent policies and procedures revisions. The DON or revide training for all nursing imeliness of care plan ty assessment and assurance reform random audits to	2 560				
Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident  This MN Requirements by: Based on interview facility failed to providirected by the care reviewed for unneces Findings include: R9 was identified w	ent is not met as evidenced and document review the ride laboratory services as plan for 1 of 5 residents (R9) essary medications.	2 565				
	ROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR LS  Continued From pa  would have expecte skin issues to be co  SUGGESTED MET The director of nursing ( develop and implent related to care plant designee, could prostaff related to the t revisions. The qualicommittee could prostaff related to t	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  would have expected the non pressure related skin issues to be coded in the assessment.  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed 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.  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 interview and document review the facility failed to provide laboratory services as directed by the care plan for 1 of 5 residents (R9) reviewed for unnecessary medications.	ROVIDER OR SUPPLIER  ROVIDENCE HEALTH CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  would have expected the non pressure related skin issues to be coded in the assessment.  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed 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.  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 interview and document review the facility failed to provide laboratory services as directed by the care plan for 1 of 5 residents (R9) reviewed for unnecessary medications.  Findings include:  R9 was identified with a diagnosis of	A BUILDING:    DIAMPS	A BUILDING:    00339	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER  DIVINE PROVIDENCE HEALTH CENTER  312 EAST GEORGE ST PO BOX 136  IVANHOE, MN 56142    PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S RLAN OF CORRECTION		IT OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA TION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  DIVINE PROVIDENCE HEALTH CENTER    XSUMMARY STATEMENT OF DEFICIENCIES   12 EAST GEORGE ST PO BOX 136   1/2/15   1/2/1								
DIVINE PROVIDENCE HEALTH CENTER   312 EAST GEORGE ST PO BOX 136   IVANHOE, MN 56142     DIVINE PROVIDENCE HEALTH CENTER   SUMMARY STATEMENT OF DEFICIENCIES   TO PREFIX   GEORGE DEFICIENCY MUST BE PRECEDED BY FULL   PROVIDENT PLAN OF CORRECTION (EACH ODRRECTIVE ACTION SHOULD BE GEOLULATORY OR LSC IDENTIFYING INFORMATION)   DIPREFIX   TAG   TO THE APPROPRIATE   DATE   DATE   DATE			00339		B. WING		08/1	2/2015
XAI ID   PROVIDERS PLAN OF CORRECTION   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION   (EACH DEPOCENCY MUST BE PRECEDED BY FULL PREDULATORY OR LSC DENTIFYING INFORMATION)   PRETERY TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY	NAME OF I	PROVIDER OR SUPPLIER			, ,	,		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  2 565  Continued From page 8 prescribed Levothyroxine Sodium (Synthroid) 0.025 micrograms (mcg), 1 tablet orally each day, for thyroid dysfunction.  R9's plan of care dated 5/5/15, identified R9 at risk for potential of further altered metabolic status related to hypothyroidism and that lab work should be completed as ordered by the physician and any signs or symptoms hypo/hyperthyroidism should be reported to the physician. During review of R9's medical record a Thyroid Stimulating Hormone (TSH) laboratory test was unable to be located.  During interview on 8/11/15, at 6:30 p.m. the director of nursing (DON) verified there was no evidence of a laboratory report for the TSH value in the current medical record. The DON indicated she would contact the clinic to get the most recent TSH report.  On 8/12/15, at 10:30 a.m. the DON provided the most recent TSH level documented for R9 which was dated 2/13/13 (30 months ago). This laboratory test identified that R9 had low TSH levels noted.  During review of the monthly pharmacy reviews it was noted on 4/24/15 that the pharmacist recommended a TSH level be completed for R9.  SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and	DIVINE F	PROVIDENCE HEALTI	H CENTER			1 PO BOX 136		
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each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by	2 565	prescribed Levothy 0.025 micrograms of for thyroid dysfunct.  R9's plan of care darisk for potential of status related to hy should be complete and any signs or sy should be reported review of R9's med Stimulating Hormor unable to be locate.  During interview on director of nursing of evidence of a labor in the current medical she would contact to trecent TSH report.  On 8/12/15, at 10:3 most recent TSH lewas dated 2/13/13 laboratory test iden levels noted.  During review of the was noted on 4/24/recommended a TS SUGGESTED MET The director of nursing or design to educate staff and supprocedures related each individual resign of oducate staff and supprocedures staff and	roxine Sodium (mcg), 1 table ion.  ated 5/5/15, ic further altered pothyroidism and as ordered imptoms hypoto to the physici ical record and ical record and ical record. The clinic to get a monthly phase of the ph	lentified R9 at a metabolic and that lab work by the physician hyperthyroidism an. During Thyroid ratory test was  30 p.m. the at there was no or the TSH value to DON indicated at the most  ON provided the led for R9 which go). This had low TSH  armacy reviews it armacist ampleted for R9.  RRECTION: designee as and he care plan for levelop a system onitoring system	2 565			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00339	B. WING	·····	08/1	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIVINE F	PROVIDENCE HEALTI	HCENIER	GEORGE S , MN 56142	T PO BOX 136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 9	2 565			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident				
	by: Based on observati review the facility fa skin issues for 1 of	ent is not met as evidenced ion, interview and document alled to identify and monitor 3 residents (R21) reviewed of bruising and skin tears.				
	Findings include:					
	a.m. R21 noted to hextremities. The browns at multiple stagfrom dark purple to areas of her bilaters					
	During review of R2	21's medical record progress				

Minnesota Department of Health STATE FORM

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00339	B. WING		08/1	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIVINE I	PROVIDENCE HEALTI	H CENTER	GEORGE S , MN 56142	T PO BOX 136		
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2 830	notes the following  (1) On 3/30/15, at 7 identified R21 with on her right hand. For cause of skin care. No signs or symptotair. Refused band a active bleeding. Defended in the second signs of symptotair. Refused band a active bleeding. Defended in the second symptotair. Refused band a active bleeding. Defended in the second symptotic	entries were noted: 7:00 p.m. a progress note a 2 centimeter (cm) skin tear R21 was unable to identify Edges were approximated. oms of infection noted. Open to aid and antibiotic ointment. No enies pain. 0:41 a.m. R21 was identified her right forearm 2 cm long A bandage was observed to be sanguinous (clear red tinged) or cleansed with soap and led. Steri-strips, Tegaderm and	2 830			

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NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   STREET ADDRESS, CITY, STATE, ZIP CODE   STATE ADDRESS, CITY, S	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
DIVINE PROVIDENCE HEALTH CENTER   312 EAST GEORGE ST PO BOX 136   IVANHOE, MN 56142			00339		B. WING		08/	12/2015
XANHOE, MN 56142   XANHOE, MN 56142   XANHOE, MN 56142   XANHOE, MR 56142   XANHOE, MR 56142   XANHOE, ACCOMPLETE OF DEFICIENCY MUST BE PRECEDED BY DULL REGULATORY OR LSE (DENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS REFERENCE OF A PROPRIATE DAYS. RN-B stated R21 was very active at times working on stuff like sewing, knitting etc. RN-B was asked if there was any interventions in place to reduce the risk of R21 getting bruising and skin tears. RN-B stated she was not aware of any communication with resident about protective measures i.e. arm sleeves.    During review of R21's medical record there was no evidence of an assessment for risk factors for non-pressure related skin conditions, bruising and skin tears. Further, there was no evidence of tracking the progression and/or healing of the identified bruises.    During review of R21's 6/11/15 plan of care identified interventions for the reduction of pressure ulcer risk but failed to identify any problem, goal, or interventions related to skin frailty and risk of skin tears or bruising.    During interview on 8/12/15, at 10:14 a.m. the director of nursing (DON) stated she would expect the plan of care to identify risk factors for bruising and skin tears. It was verified the medical record lacked and assessment or care plan for non-pressure skin concerns.    SUGGESTED METHOD FOR CORRECTION: The director of nursing and/or designee could establish procedures, educate staff and audit to ensure that residents individualized needs are being met. The director of nursing or designee, could review and revise policies and procedures	NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  CONTINUED FROM INSTITUTION OF THE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 11  her arms into the boxes and perhaps her grab bars. RN-B stated R21 was very active at times working on stuff like sewing, knitting etc. RN-B was asked if there was any interventions in place to reduce the risk of R21 getting bruising and skin tears. RN-B stated she was not aware of any communication with resident about protective measures i.e. arm sleeves.  During review of R21's medical record there was no evidence of an assessment for risk factors for non-pressure related skin conditions, bruising and skin tears. Further, there was no evidence of tracking the progression and/or healing of the identified interventions for the reduction of pressure ulcer risk but failed to identify any problem, goal, or interventions related to skin frailty and risk of skin tears or bruising.  During interview on 8/12/15, at 10:14 a.m. the director of nursing 0000) stated she would expect the plan of care to identify risk factors for bruising and skin tears. It was verified the medical record lacked and assessment or care plan for non-pressure skin concerns.  SUGGESTED METHOD FOR CORRECTION: The director of nursing and/or designee could estated bish procedures, educate staff and audit to ensure that residents individualized needs are being met. The director of nursing or designee, could review and revise policies and procedures.	DIVINE F	PROVIDENCE HEALTH	H CENTER			T PO BOX 136		
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and conduct assessments and could provide staff education related to the care of resident.  The director of nursing or designee could develop an audit tool to ensure appropriate care is	2 830	her arms into the bebars. RN-B stated working on stuff like was asked if there to reduce the risk of tears. RN-B stated communication with measures i.e. arm so tears. RN-B stated communication with measures i.e. arm so tears. Further, tracking the progressidentified bruises.  During review of R2 identified bruises.  During review of R2 identified bruises.  During review of R2 identified intervention pressure ulcer risk problem, goal, or in frailty and risk of sk problem, goal, or in frailty and risk of sk problem, goal, or in frailty and risk of sk problem, goal, or in frailty and risk of sk problem, goal, or in frailty and risk of sk problem. Surgest the plan of condirector of nursing and skin terecord lacked and a non-pressure skin of SUGGESTED MET. The director of nurse establish procedure ensure that residen being met. The director of nurse and conduct assess staff education related to non press and conduct assess and conduct assess and conduct assess and conduct	exes and perhaps R21 was very active sewing, knitting exas any intervention R21 getting bruists she was not award resident about probleves.  21's medical record assessment for risk and skin conditions, there was no evidesion and/or healing and/or healing the state of the terventions related in tears or bruising and/or designers. It was verified assessment or care concerns.  THOD FOR CORP assessment or care concerns.	ve at times etc. RN-B ons in place sing and skin e of any rotective  d there was k factors for bruising and lence of ng of the  of care on of fy any d to skin g.  a.m. the would factors for d the medical re plan for  RECTION: ee could nd audit to eeds are designee, procedures conditions I provide resident. ould develop				

Minnesota Department of Health

STATE FORM D1D311 If continuation sheet 12 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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2 830	Continued From pa	ge 12	2 830			
	provided.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.0525 Incontinence	5 Subp. 5 A.B Rehab -	2 910			
	have a continuous programment to reconnect unnecessary use of comprehensive results home must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident who receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the fatheters. Based on the ident assessment, a nursing that: ho enters a nursing home greatheter is not catheterized solinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to the infections and to restore as the program of t				
	by: Based on interview facility failed to condassessment so that implemented to ma	and document review the duct a comprehensive tinterventions could be nage bladder incontinence for reviewed for urinary				
	Findings include:					
		which included: muscle and fatigue, edema, history				

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00339	B. WING		08/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIVINE F	PROVIDENCE HEALTH	1 CENTER	GEORGE S MN 56142	T PO BOX 136		
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2 910	(hx) personal fall ar R2's most recent M assessment dated Interview of Mental indicated severe coactivities of daily liviextensive assistant ransfers, walking in documentation indicincontinent of bladdurinary incontinence continent voiding) and current toileting.  No further bladder areview which identified and patterns of incorprogram or interver Documentation condon a daily per shift lindicated multiple eincontinence; (29 tin Aug 1-11,2015).  The most recent capotential for bowel incontinence included: Toileting: every two hours, and resident or observed preceding need to go of care did not refer to the urinary incom NA-A indicated this R2 had been ill follolonger pertinent.	inimum Data Set (MDS) 6/18/15, indicated a Brief Status (BIMS) of 5/15 which gnitive impairment. R2's ing (ADLs) indicated ce needed with bed mobility, n room/hall and toileting. MDS cated R2 was frequently ler (7 or more episodes of e, but at least one episode of and also indicated there was program.  assessment was available for fied the type of incontinence ontinence so an individualized ations could be implemented. Inpleted by nursing assistants basis for July and August 2015	2 910			
		ecliner located in her room				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00000	B. WING		00/	10/0045
NAME OF	PROVIDER OR SUPPLIER	00339		STATE, ZIP CODE	08/	12/2015
		312 FA	, , ,	ST PO BOX 136		
DIVINE F	PROVIDENCE HEALTI	H CENTER IVANHO	DE, MN 56142			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	age 14	2 910			
	assistant] asked R2	At 2:30 p.m. staff [nursing 2 how she was doing, but did e to the toilet. At 3:00 p.m. R recliner in room.	2			
	R2 was observed s feet elevated eating p.m. staff removed and did not offer to p.m. R2 remained s elevated. No toiletir offered by staff. On later) R2 remained room and stated sh	tion on 8/11/15, at 12:00 p.m. seated in her recliner with her g her noon meal. At 12:35 the meal tray from the room ileting assistance. At 1:00 seated in the recliner with feeing assistance had yet been 8/11/15, at 2:00 p.m. (2 hour seated in the recliner in her he has "accidents" at times. No had been offered by staff.	t 's			
	nursing assistant N toileting on an incordincent after slet the incontinent brie was assisted with transcontinent episode frequently during the	on 8/11/15, at 5:48 p.m. IA-A indicated R2 requested insistent basis and is usually eeping. NA-A also indicated if was usually wet when R2 oileting. NA- A further indicates have occurred more are night shift. NA-A verified are if R2 was currently on any program.	ed			
	licensed practical n	on 8/12/15, at 11:44 a.m. nurse (LPN)-C indicated she 32's bladder incontinence				
	NA-B also confirme R2 was on a sched	on 8/12/15, at 11:32 a.m. ed she was unaware whether luled toileting program and 2 has incontinent episodes of				
	During interview with	th the director of nursing				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 910	the care plan did not incontinence and a not been developed bladder incontinence indicated she would include the problem interventions in place. The DON also confaccurate and compincontinence so the could be developed. SUGGESTED MET The director of nursiall residents at risk they are receiving the treatment/services director of nursing or random audits of the appropriate care and to reduce the risk for incontinence.	at 12:30 p.m. it was verified of address R2's bladder toileting schedule or plan had to reduce episodes of the. The DON further dexpect the care plan to a of incontinence and have the to reduce the occurrence. It is immed there had not been an lete assessment of bladder appropriate interventions the incontinence to assure the necessary to reduce incontinence. The or designee, could conduct the delivery of care; to ensure the services are implemented; or further issues with	2 910			
21540	(21) days.  MN Rule 4658.1315	CORRECTION: Twenty-one Subp. 2 Unnecessary Drug	21540			
	monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist				

AND DIAN OF CODDECTION IN INDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00339	B. WING		08/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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21540	believes the resider adversely affected, matter to the medical medical director is the medical director is the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician the consulting phandirectly to the QAA.  This MN Requirements by:  Based on interview facility failed to more medications for 3 of who were reviewed.  Findings include:  R9 was identified whypothyroidism on the prescribed Levothyrous for thyroid dysfunctions. R9's plan of care darisk for potential of status related to hypshould be complete and any signs or syshould be reported review of R9's medical directors.	ant's quality of life is being the pharmacist must refer the all director for review if the not the attending physician. If redetermines that the attending have adequate justification for attending physician does not not matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter that is not met as evidenced and document review the nitor the effectiveness of for sesidents (R9, R5 and R20) for unnecessary medications.  The physician orders and was roxine Sodium (Synthroid) mcg), 1 tablet orally each day, on.  The physician and that lab work and as ordered by the physician mptoms hypo/hyperthyroidism to the physician. During fical record a Thyroid ne (TSH) laboratory test was not the physician or the control of the physician or the control of the physician.	21540			

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

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21540	Continued From pa	ge 17		21540			
	director of nursing ( evidence of a labor in the current medic she would contact t recent TSH report.	8/11/15, at 6:30 p.n (DON) verified there atory report for the Total record. The DON the clinic to get the r	was no FSH value I indicated nost				
	most recent TSH le was dated 2/13/13	0 a.m. the DON provel documented for (30 months ago). This identified that R9	R9 which he				
	dated 4/24/15, the p TSH level be comp was lacking in the r	e monthly pharmacy charmacist recommodeted for R9. Docume ecord to indicate the ne recommendation	ended a nentation e physician				
	R5 had current physician order for Digoxin 0.125 mg once daily. The monthly pharmacy review dated 6/29/15 documented that R5 have a Digoxin level checked since evidence was lacking in the record to indicate it had been monitored. During review of the medical record it was noted the physician had not yet responded to the recommendation.						
	director of nursing ( problem with physic	8/12/15, at 10:49 at (DON) stated there because responding to by the consultant ph	nad been a the				
	Review of the physician's orders dated 3/25/15, indicated an order for Trazodone 50 milligrams (mg) every bedtime for insomnia.						
	indicated use of sec	sessment (CAA), da dative/hypnotic and o monitor for effects	the care				

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DIVINE F	PROVIDENCE HEALTI	H CENTER		GEORGE S , MN 56142	T PO BOX 136		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 18		21540			
	R20's care plan data risk for injury relate and the approach in medical doctor's or medications as indipossible dose and properties to ensure resident in dose. The care play having a disturbed unfamiliar environmer record lacked documentoring was being Review of the mont 4/23/15 and 6/26/15 recommended a triat Trazodone. Documer record to indicate the	d to psychotroncluded: medders, discuss cated to achie periodically respectively respectively. The control of t	opic medications dications per trial reduction of eve the lowest eview behaviors e appropriate ed R20 as related to of R20's medical at sleep  reviews dated he pharmacist tion of the lacking in the				
	the recommendation  During interview on registered nurse (R. Trazodone due to recommendation of temperature either room at night. RN-complaining about they thought he was decided to put him they do not comple sleep monitoring or During interview on director of nursing (residents or their faresidents or their faresidents sleep and help sleep. She als licensed practical nother if the resident The DON admitted	8/11/15, at 1 N)-B stated Foot sleeping we being too cold B stated R20 the temperatusen't sleeping won Trazodone te sleep asse a their resident (DON) stated mily member I if they want so stated the laurses (LPN's) a needs some	R20 takes rell related to d or hot in his was always ure in his room so well so they e. RN-B stated ssments nor ats.  31 p.m. the they talk to s about the something to RN's and ) consult each thing to sleep.				

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NAME OF PROVIDER OR SUPPLIER  DIVINE PROVIDENCE HEALTH CENTER  DIVINE PROVIDENCE HEALTH CENTER  312 EAST GEORGE ST PD BOX 138  (PANDE, MN 56142  (PAPID (EACH DEFICIENCE) ST (PERCENCIES) (EACH DEFICIENCE) ST (PERCENCIES) (EACH DEFICIENCE) ST (PERCENCIES) (EACH DEFICIENCE) MIST BE REFECEDED BY PLLINE, REGULATORY OR LSC IDENTIFYING INFORMATION)  21540  Continued From page 19  R20 requested something to sleep or not. The DON then stated that staff monitor if the resident is sleeping at night and document by exception, explaining they only document if the resident is not sleeping well. DON also stated during shift report the sleep status of a resident is communicated so monitoring is done by verbal report and/or documenting by exception. DON confirmed no sleep assessments are completed prior to starting sleep medication. The DON also confirmed they donysician had failed to address the consulting pharmacists recommendations for trial dose reductions and this has been an ongoing problem.  During interview on 8/12/15, at 12:40 p.m. LPN-B stated they don't do any ongoing sleep monitoring and only chart by exemption.  During interview on 8/12/15, at 1:08 p.m. the DON retterated they document sleep by exception and she confirmed they don't have a sleep monitoring system.  SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
DIVINE PROVIDENCE HEALTH CENTER   312 EAST GEORGE ST PO BOX 136   IVANHOE, MN 56142			00339	B. WING		08/	12/2015
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  Continued From page 19  R20 requested something to sleep or not. The DON then stated that staff monitor if the resident is sleeping at night and document by exception, explaining they only document if the resident is not sleeping well. DON also stated during shift report the sleep status of a resident is communicated so monitoring is done by verbal report and/or documenting by exception. DON confirmed no sleep assessments are completed prior to starting sleep medication. The DON also confirmed the physician had failed to address the consulting pharmacist's recommendations for trial dose reductions and this has been an ongoing problem.  During interview on 8/12/15, at 12:40 p.m. LPN-B stated they don't do any ongoing sleep monitoring and only chart by exemption.  During interview on 8/12/15, at 1:08 p.m. the DON reiterated they document sleep by exception and she confirmed they don't have a sleep monitoring system.  SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in			1 CENTER 312 EAS	T GEORGE S			
R20 requested something to sleep or not. The DON then stated that staff monitor if the resident is sleeping at night and document by exception, explaining they only document if the resident is not sleeping well. DON also stated during shift report the sleep status of a resident is communicated so monitoring is done by verbal report and/or documenting by exception. DON confirmed no sleep assessments are completed prior to starting sleep medication. The DON also confirmed the physician had failed to address the consulting pharmacist's recommendations for trial dose reductions and this has been an ongoing problem.  During interview on 8/12/15, at 12:40 p.m. LPN-B stated they don't do any ongoing sleep monitoring and only chart by exemption.  During interview on 8/12/15, at 1:08 p.m. the DON reiterated they document sleep by exception and she confirmed they don't have a sleep monitoring system.  SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	OULD BE	COMPLETE
TIME PERIOD FOR CORRECTION: Twenty one (21) days	21540	R20 requested som DON then stated the is sleeping at night explaining they only not sleeping well. I report the sleep state communicated so report and/or docur confirmed no sleep prior to starting sleet confirmed the physic consulting pharmace dose reductions and problem.  During interview on stated they don't do and only chart by expending interview on DON reiterated they and she confirmed monitoring system.  SUGGESTED MET The Director of Nurwork with the medic pharmacist to ensure importance of monimedications. The Drandomly audit residuadequate monitoring place.  TIME PERIOD FOR	nething to sleep or not. The at staff monitor if the resident and document by exception, document if the resident is DON also stated during shift tus of a resident is monitoring is done by verbal menting by exception. DON assessments are completed by medication. The DON also ician had failed to address the cist's recommendations for triad this has been an ongoing  8/12/15, at 12:40 p.m. LPN-B any ongoing sleep monitoring exemption.  8/12/15, at 1:08 p.m. the y document sleep by exception they don't have a sleep  THOD FOR CORRECTION: sing (DON) or designee could cal director and consultant re medications were reviewed remedications and monitoring. The toring for unnecessary in the staff were educated on the toring for unnecess				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00339	B. WING		08/1	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DIVINE F	PROVIDENCE HEALTH	1 CENTER	GEORGE S , MN 56142	T PO BOX 136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 20	21990			
21990	MN St. Statute 626 Maltreatment of Vul	557 Subd. 4 Reporting - nerable Adults	21990			
	immediately make a entry point. Use of for the deaf or other considered an oral point may not requirextent possible, the content to identify the caregiver, the nature maltreatment, any emaltreatment, the noreporter, the time, or incident, and any of reporter believes must the suspected malting reporter may disclosin section 13.02, and section 144.335, to comply with this substitute of the suspected abuse to failed to implement of 1 resident (R9) repotential abuse/neg Findings include:  When the facility pothat an internal investion to reporting the	and document review the elop an abuse prohibition I immediate reporting of the State agency and staff a thorough investigation for 1 eviewed and who reported				

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AND DIANIOE CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00339		B. WING		08/	12/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/	12/2010
	PROVIDENCE HEALTI	J CENTED			T PO BOX 136		
DIVINE	THOUIDENCE REALIT	TCENTER	IVANHOE	, MN 56142			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21990	follows: The facility Vulneral identified abuse in a not an accident or to in this section, which reasonably be experient or injury or emotion limited to the follow and th	ble Adult Act, revised section B. as conduct as the produces or could ected to produce phy al distress including, ing: pinching, biting, or could enter able adult. or malicious oral, who is a vulnerable adult and a vulnerable act of as follows in the pion by the caretaker the with care or service mitted to food, clothin ervision which is: I necessary to obtain able adults physical fety. I result of an accident	et which is as defined sical pain but not corporal ritten, ulnerable dult which person to cious oral, asing, or cocedure, ry colicy: to supply es g, shelter, and t or lult Plan cedure: use, operty will be acility.	21990			

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00339	B. WING		08/1	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DIVINE I	PROVIDENCE HEALTI	H CENTER	GEORGE S MN 56142	T PO BOX 136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	from facility staff or 3. An incident of al abuse must be repowill examine the residocument his/her firmade to the Director Designee, or the Add. The delegated scomplete the approdocumentation is conform.  5. The Director of I be notified immedia maltreatment, abuse 6. A complete invecompleted by the a investigation is to mincident is reportab 7. The investigation following:  a. A review of tor incident report b. An interview the incident. c. An interview the incident. c. An interview of the ending members, and for a review of the ending members, and for a review of a surrounding the incident report and the put the table. I told him I ending the incident report and the put the table. I told him I ending the incident report and the put the table. I told him I ending the incident report and the put the table. I told him I ending the incident report and interview family members, and the put the table. I told him I ending the incident report and the put the table. I told him I ending the incident report and the put the table. I told him I ending the incident report and the put the table. I told him I ending the incident report and the put the table. I told him I ending the incident report and the put the table.	others. Duse or suspected incident of corted to a charge nurse who sident and thoroughly andings. Reports may also be for of Nursing, Social Services diministrator. Dupervisor/manager will appriate forms. Notification and completed on the Abuse Report.  Nursing and Administrator will ately of the suspected are or neglect. Stigation of the incident will be administrator. The internal make a determination if the le or not reportable. In will include at least the the completed complaint form with the person(s) reporting with the resident if possible. The resident's medical record. With the resident's roommate, and visitors.	21990			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00339	B. WING		08/	12/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DIVINE I	PROVIDENCE HEALTH	I CENTER	T GEORGE ST E, MN 56142	F PO BOX 136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21990	the staff member al placement of the to staff member stated can't tell me what to reported the incider her name. R9 furth nursing about being long periods (2 hou R9's quarterly Minir assessment dated Brief Interview for N 14/15, indicating go further identified R9 and had no behavior identified R9 was froblematically designee (SSD) and over the weekend, The SSD stated shot to the charge nurse the administrator. For During review of the vulnerable adult reposed incident/or During interview with (DON) and the administrator verified documents, that the investigation conduction of the	count the rough cares and the wel on his bedside table the d, "Shut up you old fart, you odo". R9 stated he had not to the nurse but didn't recall the stated he had reported to gleft in the mechanical lift for rs on one occasion).  The mum Data Set (MDS)  5/16/15, identified R9 with a Mental Status ((BIMS) score of rood cognition skills. The MDS of had no indicators of delirium or indicators. The MDS also the december of hallucinations or the social service of shared a concern he had fon the evening of 4/19/15. The communicated R9's concerns, registered nurse (RN)-A and the second of the concern was in progress. The director of nursing the state of the director of nursing the second of the director of the second of the director of nursing the second of the director of the second of the director of the second of the facility's the director of the facility the director of the				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
00339 B. WING	08/12/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
DIVINE PROVIDENCE HEALTH CENTER  312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AND	CTION SHOULD BE COMPLETE D THE APPROPRIATE DATE
but that these allegations would have been appropriate to report immediately to the administrator and State agency. Both the DON and the administrator had been newly employed the past couple months.  During interview on 8/11/15, at 3:41 p.m. the SSD stated she recalled R9 complaining of night staff being rough. SSD stated she reported the complaint to both the administrator and charge nurse as required. The SSD verified she had no documentation of the details of the complaint and could not verify whether an investigation had occurred and/or whether the incident was reported to outside State agencies as required.  During phone interview with RN-A on 8/11/15, at 4:37 p.m. RN-A stated she recalled R9 complaining that staff neglected him by leaving him in the lift for 2 hours. RN-A stated she believed that R9 was credible and reported the incident to the nurse assigned the shift the incident to the nurse assigned the shift the incident occurred. RN-A informed the nurse that the complaint needed to be reported. RN-A stated she informed the nurse on duty to document the incident and give it to the administrator since there was not a DON at the facility at the time. RN-A further stated she felt the concern was a vulnerable adult issue and needed to be investigated.  During interview on 8/11/15, at 5:00 p.m. the administrator verified there was no follow up to the complaint and verified no investigation nor reporting had occurred. The administrator further stated he was not aware of the complaint about the male staff telling R9 to "Shut up".  When interviewed again regarding the noted	

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NAME OF PROVIDER OR SUPPLIER STREET ADD		DRESS, CITY, ST	TATE, ZIP CODE		
DIVINE PROVIDENCE HEALTH CENTER				PO BOX 136	
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21990	Continued From page 25		21990		
	whether he recalled the conversation being rough. R9 stated he recalled staff being rough and putting a soil bed side table, "Where I eat". R9 restating, "Shut up you old fart, you nothing about it." R9 further stated recall exactly when it happened but the nurse. R9 also verified he had nurse that he had been left in the new "I don't want to cause problems".  SUGGESTED METHOD FOR COINTHE director of nursing and/or admictable stablish procedures, update educate staff to ensure that police when reporting and investigating all complaints. The DON could monitor compliance.	I talking about ed towel on his recalled staff can't do I he didn't treported it to reported to the nechanical lift vent on to say,  RRECTION:  ninistrator e policies and s are followed ouse/neglect			
	TIME PERIOD FOR CORRECTION days.	N: Seven (7)			

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