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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D1D3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245327**
2.STATE VENDOR OR MEDICAID NO.
(L2) **448415000**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE HEALTH CENTER**
(L4) **312 EAST GEORGE ST PO BOX 136**
(L5) **IVANHOE, MN** (L6) **56142**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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 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

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245327	A. Building B. Wing	9/30/2015

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE HEALTH CENTER	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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/11/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/11/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **09/11/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/11/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/11/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/11/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/16/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/16/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	10/01/2015	03048	09/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/12/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245327	01 - MAIN BUILDING 01	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE HEALTH CENTER	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	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0076	08/11/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GS/kfd	10/01/2015	35482	09/18/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 8/11/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D1D3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

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(L3) **DIVINE PROVIDENCE HEALTH CENTER**
(L4) **312 EAST GEORGE ST PO BOX 136**
(L5) **IVANHOE, MN** (L6) **56142**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 09/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

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;

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

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

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

DEPARTMENT CONTACT

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

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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	F-225 **Corrective action as it applies to others:** 9/11/15 approved kmt 9/11/15 The policy and procedure of abuse was reviewed with a change to time of reporting; previous policy states immediately within 24 hours. Current/updated policy has "within 24 hours" removed. All types of abuse (suspected or actual) need to be reported immediately with an investigation process to start from the moment of allegation is reported. Policy reviewed at annual general education with all staff and with each new hire. Will review policy again at upcoming staff meeting in September. **Immediate corrective action:** DON will review with each nurse 1:1 policy and procedure for reporting and investigating by September 11th, 2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tom Bryan	Administrator	9/8/15

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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Minnesota Department of Health
Marshall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ 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

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate and immediately report to the State agency allegations of suspected abuse/neglect for 1 of 1 resident (R9) reviewed and who reported an allegation of potential abuse/neglect. Findings include: During initial interview with R9 on 8/10/15, at 9:44 a.m. R9 was questioned whether abuse had ever occurred, R9 stated, "There was this one guy that was pushing on my legs and back hard while doing cares. After completing cares he wiped my bottom then put the dirty towel on my bedside table. I told him I eat there and didn't want it put there." R9 stated after making the comment to the staff member about the rough cares and the placement of the towel on his bedside table the staff member stated, "Shut up you old fart, you can't tell me what to do". R9 stated he had reported the incident to the nurse but didn't recall her name. R9 further stated he had reported to	F 225	All alleged occurrences of suspected abuse or neglect will be thoroughly investigated by the Director of Nursing and/or designee in accordance to policy. Prior to the completion of the investigation, the Administrator and Social Services Director/designee will review the investigation to ensure completion of investigation which will include: relevant dates and times, summary of all investigative interviews with all staff involved in incident, identification of alleged staff member(s), identification of the resident(s) interventions implemented to prevent a recurrence of the incident. Administrator/designee or Director of Nursing/Designee will be responsible for reporting all incidents with the state. All investigative summaries of incidents of alleged abuse/neglect will be reviewed by the Quality Assurance committee monthly for interdisciplinary team input and recommendations with ongoing practice. **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. **Correction will be monitored:** 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 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	F 225		

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F 225	Continued From page 3 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 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 a lift for 2 hours. RN-A stated she believed that R9 was credible and had reported the incident to the nurse assigned the shift the incident had allegedly 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 to 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 incidents on 8/11/15, at 6:25 p.m. R9 was asked whether he recalled the conversation about staff being rough. R9 stated he recalled talking about staff being rough and putting a soiled towel on his	F 225		

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F 225	Continued From page 4 bed side table and stated, "Where I eat". R9 also stated staff had stated, "Shut up you old fart, you can't do nothing about it." R9 further stated he didn't recall exactly when it happened but stated he had reported it to the nurse. R9 also verified he had reported to the nurse that he had been left in the mechanical lift for a long period of time. R9 stated, "I don't want to cause problems". The facility Vulnerable Adult policy revised 8/1/09, identified abuse in section B. as conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to the following: 1. Hitting, slapping pinching, biting, or corporal punishment of the vulnerable adult. 2. Use of repeated or malicious oral, written, gestured or technologically produced communication or language toward a vulnerable adult or the treatment of a vulnerable adult which should be considered by a reasonable person to be disparaging, use of repeated or malicious oral, written, or derogatory, humiliating, harassing, or threatening. 3. Use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion. Neglect was identifies as follows in the policy: a. Failure or omission by the caretaker to supply the vulnerable adult with care or services including, but not limited to food, clothing, shelter, health care, or supervision which is: 1. Reasonable and necessary to obtain or maintain the vulnerable adults physical and mental health or safety. 2. Which is not the result of an accident or therapeutic conduct	F 225		

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F 225	Continued From page 5 Section V. of the facility's Vulnerable Adult Plan identified the following investigation procedure: 1. All alleged or suspected neglect, abuse, mistreatment, or misappropriation of property will be cause for a thorough investigation to be conducted by the management of the facility. 2. Staff and volunteers must report any incidents or suspicions of abuse without fear of retaliation from facility staff or others. 3. An incident of abuse or suspected incident of abuse must be reported to a charge nurse who will examine the resident and thoroughly document his/her findings. Reports may also be made to the Director of Nursing, Social Services Designee, or the Administrator. 4. The delegated supervisor/manager will complete the appropriate forms. Notification and documentation is completed on the Abuse Report form. 5. The Director of Nursing and Administrator will be notified immediately of the suspected maltreatment, abuse or neglect. 6. A complete investigation of the incident will be completed by the administrator. The internal investigation is to make a determination if the incident is reportable or not reportable. 7. The investigation will include at least the following: a. A review of the completed complaint form or incident report b. An interview with the person(s) reporting the incident. c. An interview with the resident if possible. d. A review of the resident's medical record. e. An interview with the resident's roommate, family members, and visitors. f. A review of all the circumstances surrounding the incident.	F 225		

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an abuse prohibition policy that identified immediate reporting of suspected abuse to the State agency, and staff failed to implement a thorough investigation for 1 of 1 resident (R9) reviewed who had reported potential abuse/neglect incidents. Findings include: When the facility policy was reviewed it was noted that an internal investigation would be conducted prior to reporting the suspected abuse/neglect to the State agency. The documented policy was as follows: The facility's Vulnerable Adult policy revised 8/1/09, defined abuse in section B. as conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to the following: 1. Hitting, slapping pinching, biting, or corporal punishment of the vulnerable adult. 2. Use of repeated or malicious oral, written, gestured or technologically produced communication or language toward a vulnerable adult or the treatment of a vulnerable adult which	F 226	F-226 **Corrective action as it applies to others:** Policy and procedure for abuse prevention was reviewed on 9/2/15 and remains current with no changes initiated to policy and procedure. **Immediate corrective action:** The Director of Nursing and department heads were re-educated on policy and procedure for Abuse Prevention on 09/03/15 with respect to completing the investigation process and reporting per policy guidelines. **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. **Correction will be monitored:** Administrator and/or designee. **Completion Date:** September 11th, 2015	

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F 226	Continued From page 7 should be considered by a reasonable person to be disparaging, use of repeated or malicious oral, written, or derogatory, humiliating, harassing, or threatening. 3. Use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion. Neglect was identifies as follows in the policy: a. Failure or omission by the caretaker to supply the vulnerable adult with care or services including, but not limited to food, clothing, shelter, health care, or supervision which is: 1. Reasonable and necessary to obtain or maintain the vulnerable adults physical and mental health or safety. 2. Which is not the result of an accident or therapeutic conduct Section V. of the facility's Vulnerable Adult policy identified the following investigative procedure: 1. All alleged or suspected neglect, abuse, mistreatment, or misappropriation of property will be cause for a thorough investigation to be conducted by the management of the facility. 2. Staff and volunteers must report any incidents or suspicions of abuse without fear of retaliation from facility staff or others. 3. An incident of abuse or suspected incident of abuse must be reported to a charge nurse who will examine the resident and thoroughly document his/her findings. Reports may also be made to the Director of Nursing, Social Services Designee, or the Administrator. 4. The delegated supervisor/manager will complete the appropriate forms. Notification and documentation is completed on the Abuse Report form. 5. The Director of Nursing and Administrator will be notified immediately of the suspected	F 226		

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F 226	Continued From page 8 maltreatment, abuse or neglect. 6. A complete investigation of the incident will be completed by the administrator. The internal investigation is to make a determination if the incident is reportable or not reportable. 7. The investigation will include at least the following: a. A review of the completed complaint form or incident report b. An interview with the person(s) reporting the incident. c. An interview with the resident if possible. d. A review of the resident's medical record. e. An interview with the resident's roommate, family members, and visitors. f. A review of all the circumstances surrounding the incident. During initial interview with R9 on 8/10/15, at 9:44 a.m. R9 was questioned whether abuse had ever occurred, R9 stated, " There was this one guy that was pushing on my legs and back hard while doing cares. After completing cares he wiped my bottom then put the dirty towel on my bedside table. I told him I eat there and didn't want it put there." R9 stated after making the comment to the staff member about the rough cares and the placement of the towel on his bedside table the staff member stated, "Shut up you old fart, you can't tell me what to do". R9 stated he had reported the incident to the nurse but didn't recall her name. R9 further stated he had reported to 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	F 226		

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F 226	Continued From page 9 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 adminstrator 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	F 226		

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F 226	Continued From page 10 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 a lift for 2 hours. RN-A stated she believed that R9 was credible and had reported the incident to the nurse assigned the shift the incident had allegedly 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 to 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 incidents on 8/11/15, at 6:25 p.m. R9 was asked whether he recalled the conversation about staff being rough. R9 stated he recalled talking about staff being rough and putting a soiled towel on his bed side table and stated, "Where I eat". R9 also stated staff had stated, "Shut up you old fart, you can't do nothing about it." R9 further stated he didn't recall exactly when it happened but stated he had reported it to the nurse. R9 also verified he had reported to the nurse that he had been left in the mechanical lift for a long period of time. R9	F 226		

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F 226	Continued From page 11 stated, "I don't want to cause problems".	F 226		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This 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	F 278	F-278 **Corrective action as it applies to others:** MDS nurse to address improper coding of skin concerns related to R-2 with reflection of care to resident plan of care. MDS nurse to review manual for proper coding prior to making correction to MDS. Director of Nursing Services to review MDS correction prior to submission. **Immediate corrective action:** MDS RN to modify R2 assessment of coding of MDS to correctly reflect assessment by RN with re-submission. **Recurrence will be prevented by:** Director of Nursing to review MDS coding prior to MDS batch submission. Education for MDS nurse by Director of Nursing Services and review updates and changes related to the MDS process. **Correction will be monitored by:** Director of Nursing/Designee. **Completion Date:** September 11th, 2015	

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F 278	Continued From page 12 (R2) reviewed for non-pressure related skin conditions. Findings include: R2 was admitted on 3/11/15, with diagnoses obtained from physician orders and included: swelling/mass/lump in chest, history (hx) personal fall, and skin malignancy. During initial observation on 8/10/15, at 2:30 p.m. R2 was noted to have bright reddened skin (scalded appearance) on her face, scalp and hands with multiple scabbed areas of varying sizes noted on the occipital area of the scalp and on her face. R2 indicated this was cancer and she was receiving a treatment on the "sores". On 8/11/15, at 7:45 p.m. R2 was observed to have an open and bleeding, scabbed area on her right cheek. The area was approximately pencil eraser in size. During observation on 8/11/15, at 7:58 p.m. registered nurse (RN)-C performed R2's skin treatment, using clean technique to cleanse the affected areas, and apply ointment as per MD order. Review of R2's paper and electronic medical record contained the following: Physician (MD) order dated 3/16/15, [on admission]: Water plus Vinegar 50% of each. Please soak scalp and affected areas once a day. Physician orders (MD) dated and signed: 7/20/15: Use soap and water once daily to affected scalp and if white hypertrophilic (raised scabbing) skin occurs use 1:1 dilute vinegar and water soaking daily for 15 minutes.	F 278		

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	245327	A. BUILDING _____ B. WING _____	08/12/2015

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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).	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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	F 279	F-279 **Corrective action as it applies to others:** 9/11/15 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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F 279	Continued From page 14 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care for 2 of 3 residents (R21 and R2) reviewed for non pressure related conditions. Findings include: 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: (1) On 3/30/15, at 7:00 p.m. a progress note identified R21 with a 2 centimeter (cm) skin tear on her right hand. R21 was unable to identify cause of skin care. Edges were approximated. No signs or symptoms of infection noted. Open to air. Refused band aid and antibiotic ointment. No active bleeding. Denies pain. (2) On 6/12/15 at 10:41 a.m. R21 was identified with a skin tear on her right forearm 2 cm long and 1.9 cm wide. A bandage was observed to be saturated with serosanguinous (clear red tinged) drainage. Skin tear cleansed with soap and warm water and dried. Steri-strips, Tegaderm and elastic netting applied	F 279	updated with MDS correction and re-submission to be completed by MDS nurse with oversight from Director of Nursing. **Recurrence will be prevented by:** 1 weekly random audit of care plan will be conducted for 90 days to ensure resident care plans address and accurately reflect and actual/potential skin concerns/conditions with problem, goal, and resident specific interventions in place. Audit results will be reviewed monthly with Quality Assurance committee for their input and recommendations for continued monitoring. **Correction will be monitored by:** Director of Nursing Services and/or Designee. **Completion Date:** September 11th, 2015	

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F 279	Continued From page 15 (3) On 6/30/15, at 3:58 p.m. R21 was identified to have a Transparent dressing in place on her right forearm with no signs or symptoms of infection. (4) On 7/7/15, at 4:06 p.m. licensed practical nurse (LPN)-A documented she turned around to pat R21's arm on the way out of room and her watch caught on R21's left forearm. R21 started immediately bruising at site of contact. Resident kept rubbing on it. (5) On 8/5/15 at 8:31 p.m. a progress note identified R21's daughter was notified of incident (incident not described). The note identified R21 had Steri-strips and transparent dressing in place left forearm. No explanation of origin of injury. During interview on 8/11/15, at 1:41 p.m. registered nurse (RN)-B stated R21 arms are frequently "bruised up" as resident bangs around her arms in the bed. RN-B stated R21 kept boxes and other items in her bed and would bang 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 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) verified the medical	F 279		

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F 279	Continued From page 16 record lacked a plan of care related to the non-pressure skin concerns. During initial observation on 8/10/15, at 2:30 p.m. R2 was noted to have bright reddened skin (scalded appearance) on her face, scalp and hands with multiple scabbed areas noted on the occipital area of the scalp. R2's lower eyelids were drooping and were bright red in appearance. R2 indicated this was cancer and she was receiving a treatment. On 8/11/15, at 7:45 p.m. R2 was observed to have an open and bleeding, lesion on her right cheek. The area was approximately pencil eraser in size. R2 indicated she becomes anxious and begins picking at the scabbed areas. During observation on 8/11/15, at 7:58 p.m. registered nurse (RN)-C completed R2's skin treatment using antibiotic ointment and clean technique. RN-C further stated Vaseline is used if the scabbed areas have no signs of infection, but if there are indications of infection present than the antibiotic ointment is applied to the infected areas. Review of R2's paper and electronic medical record contained the following: Physician (MD) order dated 3/16/15: Water plus Vinegar 50% of each. Please soak scalp and affected areas once a day. Physician orders (MD) dated and signed: 7/20/15: Use soap and water once daily to affected scalp and if white hypertrophilic (raised scabbing) skin occurs use 1:1 dilute vinegar and water soaking daily for 15 minutes.	F 279		

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F 279	Continued From page 17 Review of the most recent plan of care dated 3/17/15, lacked reference to skin care for reddened/scabbed areas in both the electronic and paper record. The lack of care planing for skin issues was verified by licensed practical nurse (LPN)-C. The most recent Minimal Data Set (MDS)assessment dated 6/18/15 indicated R2 had a Brief Interview of Mental Status(BIMS) score of 5/15 which indicated severe cognitive impairment. No skin conditions were coded as present on the MDS assessment dated 6/18/15. During interview on 8/12/15, at 12:30 p.m. the director of nursing (DON) verified the plan of care did not address R2's skin issues. The DON further indicated she would expect the care plan to address R2's cancerous skin issues with the inclusion of treatments and monitoring in place. The DON further verified the MDS did not include coding of the cancerous skin lesions and that she would have expected the non pressure related skin issues to be coded in the assessment.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide laboratory services as	F 282	F-282 **Immediate Corrective action:** R9 medications and lab work reviewed with primary medical doctor to ensure completion of necessary lab work has been updated with copy of results in resident paper chart. R9 TSH (thyroid blood test) completed. Medical doctor to address and document response to pharmacist recommendations. Medical doctor to document reason for not running labs;	9/11/15

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F 282	Continued From page 18 directed by the care plan for 1 of 5 residents (R9) 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, 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.	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 updated on 9/3/15 with copy of updated policy given to Ivanhoe Medical Center and Avera Medical Group which services our facility. Copy of procedure and policy also given to all doctors that provide services within our facility. Facility nurses updated on policy and procedure changes to ensure all labs are drawn, run, addressed, and a copy of noted result in resident paper chart. **Recurrence will be prevented by:** Director of Nursing Services to do random weekly audits of lab orders and testing results 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 monitoring. Director of Nursing to do weekly pharmacy review audits on current residents to ensure primary medical doctor has addressed pharmacy recommendations and documented their response. **Correction will be monitored by:** Director of Nursing Services and/or Designee.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 19 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and monitor skin issues for 1 of 3 residents (R21) reviewed who had a history of bruising and skin tears. Findings include: 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: (1) On 3/30/15, at 7:00 p.m. a progress note identified R21 with a 2 centimeter (cm) skin tear on her right hand. R21 was unable to identify cause of skin care. Edges were approximated. No signs or symptoms of infection noted. Open to air. Refused band aid and antibiotic ointment. No active bleeding. Denies pain. (2) On 6/12/15 at 10:41 a.m. R21 was identified	F 309	F-309 **Immediate Corrective action:** R21 given sleeve protectors to assist in protecting thin/fragile skin that bruises easily. R21 stores a lot of items in her bed along the wall that she does not want moved as it provides a sense of security and that is the way R21 has done things for a long time stated by 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. **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. **Recurrence will be prevented by:** Director of Nursing Services to do random weekly audits on five resident charts X 90 days. Audit results will be reviewed monthly with Quality Assurance committee for their input and recommendations for continued monitoring.	

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F 309	Continued From page 20 with a skin tear on her right forearm 2 cm long and 1.9 cm wide. A bandage was observed to be saturated with serosanguinous (clear red tinged) drainage. Skin tear cleansed with soap and warm water and dried. Steri-strips, Tegaderm and elastic netting applied (3) On 6/30/15, at 3:58 p.m. R21 was identified to have a Transparent dressing in place on her right forearm with no signs or symptoms of infection. (4) On 7/7/15, at 4:06 p.m. licensed practical nurse (LPN)-A documented she turned around to pat R21's arm on the way out of room and her watch caught on R21's left forearm. R21 started immediately bruising at site of contact. Resident kept rubbing on it. (5) On 8/5/15 at 8:31 p.m. a progress note identified R21's daughter was notified of incident (incident not described). The note identified R21 had Steri-strips and transparent dressing in place left forearm. No explanation of origin of injury. During interview on 8/11/15, at 1:41 p.m. registered nurse (RN)-B stated R21 arms are frequently "bruised up" as resident bangs around her arms in the bed. RN-B stated R21 kept boxes and other items in her bed and would bang 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	F 309	**Correction will be monitored by:** Director of Nursing Services and/or Designee. **Completion Date:** September 11th, 2015	

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F 309	Continued From page 21 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.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a comprehensive assessment so that interventions could be	F 315	F-315 **Immediate Corrective action:** Bladder assessment to correlate with resident plan of care to accurately reflect resident status and needs to be met to achieve the highest level of functioning with maintenance care. **Corrective action as it applies to others:** Resident will have a 3 day bowel and bladder diary upon admission and re-admission, and quarterly reviews per facility procedure and protocol. Individual resident care plan to accurately reflect any noted skin issues/concerns. All resident care plans reviewed by MDS nurse and Director of Nursing.	

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F 315	Continued From page 22 implemented to manage bladder incontinence for 1 of 1 resident (R2) reviewed for urinary incontinence. Findings include: R2 had diagnoses which included: muscle weakness, malaise and fatigue, edema, history (hx) personal fall and osteoporosis. R2's most recent Minimum Data Set (MDS) assessment dated 6/18/15, indicated a Brief Interview of Mental Status (BIMS) of 5/15 which indicated severe cognitive impairment. . R2's activities of daily living (ADLs) indicated -extensive assistance needed with bed mobility, transfers, walking in room/hall and toileting. MDS documentation indicated R2 was frequently incontinent of bladder (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) and also indicated there was no current toileting program. No further bladder assessment was available for review which identified the type of incontinence and patterns of incontinence so an individualized program or interventions could be implemented. Documentation completed by nursing assistants on a daily per shift basis for July and August 2015 indicated multiple episodes of bladder incontinence; (29 times in July and 19 times from Aug 1-11,2015). The most recent care plan dated 3/17/15, listed a potential for bowel (fecal) incontinence, Hx of bowel incontinence, immobility. Interventions included: Toileting: take resident to the bathroom every two hours, and PRN if requested by resident or observed to be restless by staff	F 315	**Recurrence will be prevented by:** Director of Nursing Services to do random weekly audits on 2 resident charts X 90 days. Audit results will be reviewed monthly with Quality Assurance committee for their input and recommendations for continued monitoring. Working with TENA program to implement 7 day bladder records and 3 day bowel records and develop resident specific toileting programs to best meet resident needs to achieve highest level of functioning. Representative from TENA will come to this facility and train staff on how to properly track bowel and bladder records and for licensed nursing staff to interpret results accurately. **Correction will be monitored by:** Director of Nursing Services and/or Designee. **Completion Date:** September 11th, 2015 for care plan review and updates. October 23rd to implement TENA program. **Correction will be monitored by:** Director of Nursing Services and/or Designee. **Completion Date:** September 16th, 2015	

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F 315	Continued From page 23 preceding need to go to the bathroom. The plan of care did not reference any interventions related to the urinary incontinence problem. In addition NA-A indicated this intervention was from when R2 had been ill following admission and was no longer pertinent. During observation on 8/10/15, at 2:00 p.m. R2 was seated in her recliner located in her room with legs elevated. At 2:30 p.m. staff [nursing assistant] asked R2 how she was doing, but did not offer assistance to the toilet. At 3:00 p.m. R2 remained seated in recliner in room. During an observation on 8/11/15, at 12:00 p.m. R2 was observed seated in her recliner with her feet elevated eating her noon meal. At 12:35 p.m. staff removed the meal tray from the room and did not offer toileting assistance. At 1:00 p.m. R2 remained seated in the recliner with feet elevated. No toileting assistance had yet been offered by staff. On 8/11/15, at 2:00 p.m. (2 hours later) R2 remained seated in the recliner in her room and stated she has "accidents" at times. No toileting assistance had been offered by staff. During an interview on 8/11/15, at 5:48 p.m. nursing assistant NA-A indicated R2 requested toileting on an inconsistent basis and is usually incontinent after sleeping. NA-A also indicated the incontinent brief was usually wet when R2 was assisted with toileting. NA- A further indicated incontinent episodes have occurred more frequently during the night shift. NA-A verified that she was unaware if R2 was currently on any scheduled toileting program. During an interview on 8/12/15, at 11:44 a.m. licensed practical nurse (LPN)-C indicated she	F 315		

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	245327	A. BUILDING _____ B. WING _____	08/12/2015

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F 315	Continued From page 24 was not aware of R2's bladder incontinence episodes. During an interview on 8/12/15, at 11:32 a.m. NA-B also confirmed she was unaware whether R2 was on a scheduled toileting program and further indicated R2 has incontinent episodes of bladder. During interview with the director of nursing (DON) on 8/12/15, at 12:30 p.m. it was verified the care plan did not address R2's bladder incontinence and a toileting schedule or plan had not been developed to reduce episodes of bladder incontinence. The DON further indicated she would expect the care plan to include the problem of incontinence and have interventions in place to reduce the occurrence. The DON also confirmed there had not been an accurate and complete assessment of bladder incontinence so the appropriate interventions could be developed.	F 315		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	F-329 **Immediate Corrective action:** Medical doctor ordered lab test of a TSH (thyroid blood test) on R9 to monitor therapeutic level related to the use of drug Synthroid. Medical doctor contacted in regards to pharmacy review for response. R5 Digoxin levels evaluated per lab draw with medical doctor response to pharmacy review request completed.	

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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 faciltiy 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, 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	F 329	R20 started on medication Trazodone every evening at hour of sleep for insomnia without a sleep monitoring completed with licensed nursing staff charting by exception on resident sleep pattern if resident not sleeping. **Corrective action as it applies to others:** Director of Nursing developed policy and procedure to initiate sleep monitoring prior to starting a medication prescribed for sleep, with follow up sleep monitoring7-14 days after 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 16th, 2015. **Recurrence will be prevented by:** Director of Nursing Services to do random weekly audits on 2 resident charts X 90 days. Audit results will be reviewed monthly with Quality Assurance committee for their input and recommendations for continued monitoring. **Correction will be monitored by:** Director of Nursing Services and/or Designee.	

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F 329	Continued From page 26 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). The laboratory test results identified that R9 had low TSH levels noted. During review of the monthly pharmacy reviews dated 4/24/15, the pharmacist recommended a TSH level be completed for R9. Documentation was lacking in the record to indicate the physician had responded to the recommendation. 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. During interview on 8/12/15, at 10:49 a.m. the director of nursing (DON) stated there had been a problem with physicians responding to the recommendations by the consultant pharmacist and the medical director had been aware of the concern. Review of the physician's orders dated 3/25/15, indicated an order for Trazodone 50 milligrams (mg) every bedtime for insomnia. R20's care area assessment (CAA), dated 6/3/15, indicated use of sedative/hypnotic and the care	F 329	**Completion Date:** September 16th, 2015	

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F 329	Continued From page 27 plan was updated to monitor for effects. R20's care plan dated 6/3/15, identified R20 at risk for injury related to psychotropic medications and the approach included: medications per medical doctor's orders, discuss trial reduction of medications as indicated to achieve the lowest possible dose and periodically review behaviors to ensure resident is receiving the appropriate dose. The care plan also identified R20 as having a disturbed sleep pattern related to unfamiliar environment. Review of R20's medical record lacked documentation that sleep monitoring was being done. Review of the monthly pharmacy reviews dated 4/23/15 and 6/26/15, indicated the pharmacist recommended a trial dose reduction of the Trazodone. Documentation was lacking in the record to indicate the physician had responded to the recommendations. During interview on 8/11/15, at 1:50 p.m. with registered nurse (RN)-B stated R20 takes Trazodone due to not sleeping well related to temperature either being too cold or hot in his room at night. RN-B stated R20 was always complaining about the temperature in his room so they thought he wasn't sleeping well so they decided to put him on Trazodone. RN-B stated they do not complete sleep assessments nor sleep monitoring on their residents. During interview on 8/11/15, at 3:31 p.m. the director of nursing (DON) stated they talk to residents or their family members about the residents sleep and if they want something to help sleep. She also stated the RN's and licensed practical nurses (LPN's) consult each	F 329		

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F 329	Continued From page 28 other if the resident needs something to sleep. The DON admitted that she didn't know whether 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.	F 329		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	**APPROVED** *By Gary Schroeder at 8:47 pm, Sep 16, 2015* RECEIVED SEP 15 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Byfield | TITLE: Administrator | (X6) DATE: 8/15/15

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Divine Providence Health Center is a one-story building, constructed in 1967. It has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an outpatient medical clinic and an assisted living facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching 90-minute fire-rated door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with battery-operated smoke alarms. The facility has a capacity of 25 beds and had a census of 22 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1. FINDINGS INCLUDE: On 8/11/2015 between 11:30 AM and 1:30 PM, observation revealed: There was no sign present on the door of the oxygen storage room near the Nurses Station indicating that oxygen was stored within this room. This finding was confirmed with the Chief Building	K 076	On 8/11/2015 a 8"x11" red paper was placed on the oxygen storage door, at the nurse's station. It states "Oxygen Gas Stored Within: No Smoking." A permanent sign will be ordered To replace the current sign The Environmental Service Supervisor, designee &/or the Administrator will ensure Compliance by auditing the building 1x per month to ensure all oxygen signs are present & appropriate Completion date 8/11/15	

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K 076	Continued From page 3 Engineer at the time of discovery.	K 076		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00339	A. BUILDING: _____ B. WING _____	08/12/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 10th, 11th and 12th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review 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: R2 was admitted on 3/11/15, with diagnoses obtained from physician orders and included: swelling/mass/lump in chest, history (hx) personal fall, and skin malignancy. During initial observation on 8/10/15, at 2:30 p.m. R2 was noted to have bright reddened skin (scalded appearance) on her face, scalp and hands with multiple scabbed areas of varying sizes noted on the occipital area of the scalp and on her face. R2 indicated this was cancer and she was receiving a treatment on the "sores". On 8/11/15, at 7:45 p.m. R2 was observed to have an open and bleeding, scabbed area on her right cheek. The area was approximately pencil eraser in size.	2 550		

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	00339	A. BUILDING: _____ B. WING _____	08/12/2015

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2 550	Continued From page 2 During observation on 8/11/15, at 7:58 p.m. registered nurse (RN)-C performed R2's skin treatment, using clean technique to cleanse the affected areas, and apply ointment as per MD order. Review of R2's paper and electronic medical record contained the following: Physician (MD) order dated 3/16/15, [on admission]: Water plus Vinegar 50% of each. Please soak scalp and affected areas once a day. Physician orders (MD) dated and signed: 7/20/15: Use soap and water once daily to affected scalp and if white hypertrophilic (raised scabbing) skin occurs use 1:1 dilute vinegar and water soaking daily for 15 minutes. 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). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to assessment revisions. The DON or	2 550		

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2 550	Continued From page 3 designee, could provide training for all nursing staff related to the acquaracy of MDS information/assessments. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents 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 Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care for 2 of 3 residents (R21 and R2) reviewed for non pressure related conditions. Findings include: 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.	2 560		

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2 560	Continued From page 4 During review of R21's medical record progress notes the following entries were noted: (1) On 3/30/15, at 7:00 p.m. a progress note identified R21 with a 2 centimeter (cm) skin tear on her right hand. R21 was unable to identify cause of skin care. Edges were approximated. No signs or symptoms of infection noted. Open to air. Refused band aid and antibiotic ointment. No active bleeding. Denies pain. (2) On 6/12/15 at 10:41 a.m. R21 was identified with a skin tear on her right forearm 2 cm long and 1.9 cm wide. A bandage was observed to be saturated with serosanguinous (clear red tinged) drainage. Skin tear cleansed with soap and warm water and dried. Steri-strips, Tegaderm and elastic netting applied (3) On 6/30/15, at 3:58 p.m. R21 was identified to have a Transparent dressing in place on her right forearm with no signs or symptoms of infection. (4) On 7/7/15, at 4:06 p.m. licensed practical nurse (LPN)-A documented she turned around to pat R21's arm on the way out of room and her watch caught on R21's left forearm. R21 started immediately bruising at site of contact. Resident kept rubbing on it. (5) On 8/5/15 at 8:31 p.m. a progress note identified R21's daughter was notified of incident (incident not described). The note identified R21 had Steri-strips and transparent dressing in place left forearm. No explanation of origin of injury. During interview on 8/11/15, at 1:41 p.m. registered nurse (RN)-B stated R21 arms are frequently "bruised up" as resident bangs around her arms in the bed. RN-B stated R21 kept	2 560		

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2 560	Continued From page 5 boxes and other items in her bed and would bang 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 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) verified the medical record lacked a plan of care related to the non-pressure skin concerns. During initial observation on 8/10/15, at 2:30 p.m. R2 was noted to have bright reddened skin (scalded appearance) on her face, scalp and hands with multiple scabbed areas noted on the occipital area of the scalp. R2's lower eyelids were drooping and were bright red in appearance. R2 indicated this was cancer and she was receiving a treatment. On 8/11/15, at 7:45 p.m. R2 was observed to have an open and bleeding, lesion on her right cheek. The area was approximately pencil eraser in size. R2 indicated she becomes anxious and begins picking at the scabbed areas. During observation on 8/11/15, at 7:58 p.m. registered nurse (RN)-C completed R2's skin treatment using antibiotic ointment and clean technique. RN-C further stated Vaseline is used	2 560		

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2 560	Continued From page 6 if the scabbed areas have no signs of infection, but if there are indications of infection present than the antibiotic ointment is applied to the infected areas. Review of R2's paper and electronic medical record contained the following: Physician (MD) order dated 3/16/15: Water plus Vinegar 50% of each. Please soak scalp and affected areas once a day. Physician orders (MD) dated and signed: 7/20/15: Use soap and water once daily to affected scalp and if white hypertrophilic (raised scabbing) skin occurs use 1:1 dilute vinegar and water soaking daily for 15 minutes. Review of the most recent plan of care dated 3/17/15, lacked reference to skin care for reddened/scabbed areas in both the electronic and paper record. The lack of care planing for skin issues was verified by licensed practical nurse (LPN)-C. The most recent Minimal Data Set (MDS)assessment dated 6/18/15 indicated R2 had a Brief Interview of Mental Status(BIMS) score of 5/15 which indicated severe cognitive impairment. No skin conditions were coded as present on the MDS assessment dated 6/18/15. During interview on 8/12/15, at 12:30 p.m. the director of nursing (DON) verified the plan of care did not address R2's skin issues. The DON further indicated she would expect the care plan to address R2's cancerous skin issues with the inclusion of treatments and monitoring in place. The DON further verified the MDS did not include coding of the cancerous skin lesions and that she	2 560		

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2 560	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.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on 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 hypothyroidism on the physician orders and was	2 565		

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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 procedures related to ensuring the care plan for 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 the written plan of care.	2 565		

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2 565	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and monitor skin issues for 1 of 3 residents (R21) reviewed who had a history of bruising and skin tears. Findings include: 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	2 830		

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2 830	Continued From page 10 notes the following entries were noted: (1) On 3/30/15, at 7:00 p.m. a progress note identified R21 with a 2 centimeter (cm) skin tear on her right hand. R21 was unable to identify cause of skin care. Edges were approximated. No signs or symptoms of infection noted. Open to air. Refused band aid and antibiotic ointment. No active bleeding. Denies pain. (2) On 6/12/15 at 10:41 a.m. R21 was identified with a skin tear on her right forearm 2 cm long and 1.9 cm wide. A bandage was observed to be saturated with serosanguinous (clear red tinged) drainage. Skin tear cleansed with soap and warm water and dried. Steri-strips, Tegaderm and elastic netting applied (3) On 6/30/15, at 3:58 p.m. R21 was identified to have a Transparent dressing in place on her right forearm with no signs or symptoms of infection. (4) On 7/7/15, at 4:06 p.m. licensed practical nurse (LPN)-A documented she turned around to pat R21's arm on the way out of room and her watch caught on R21's left forearm. R21 started immediately bruising at site of contact. Resident kept rubbing on it. (5) On 8/5/15 at 8:31 p.m. a progress note identified R21's daughter was notified of incident (incident not described). The note identified R21 had Steri-strips and transparent dressing in place left forearm. No explanation of origin of injury. During interview on 8/11/15, at 1:41 p.m. registered nurse (RN)-B stated R21 arms are frequently "bruised up" as resident bangs around her arms in the bed. RN-B stated R21 kept boxes and other items in her bed and would bang	2 830		

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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 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 related to non pressure related skin conditions 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		

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2 830	Continued From page 12 provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to conduct a comprehensive assessment so that interventions could be implemented to manage bladder incontinence for 1 of 1 resident (R2) reviewed for urinary incontinence. Findings include: R2 had diagnoses which included: muscle weakness, malaise and fatigue, edema, history	2 910		

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2 910	Continued From page 13 (hx) personal fall and osteoporosis. R2's most recent Minimum Data Set (MDS) assessment dated 6/18/15, indicated a Brief Interview of Mental Status (BIMS) of 5/15 which indicated severe cognitive impairment. . R2's activities of daily living (ADLs) indicated -extensive assistance needed with bed mobility, transfers, walking in room/hall and toileting. MDS documentation indicated R2 was frequently incontinent of bladder (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) and also indicated there was no current toileting program. No further bladder assessment was available for review which identified the type of incontinence and patterns of incontinence so an individualized program or interventions could be implemented. Documentation completed by nursing assistants on a daily per shift basis for July and August 2015 indicated multiple episodes of bladder incontinence; (29 times in July and 19 times from Aug 1-11,2015). The most recent care plan dated 3/17/15, listed a potential for bowel (fecal) incontinence, Hx of bowel incontinence, immobility. Interventions included: Toileting: take resident to the bathroom every two hours, and PRN if requested by resident or observed to be restless by staff preceding need to go to the bathroom. The plan of care did not reference any interventions related to the urinary incontinence problem. In addition NA-A indicated this intervention was from when R2 had been ill following admission and was no longer pertinent. During observation on 8/10/15, at 2:00 p.m. R2 was seated in her recliner located in her room	2 910		

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2 910	Continued From page 14 with legs elevated. At 2:30 p.m. staff [nursing assistant] asked R2 how she was doing, but did not offer assistance to the toilet. At 3:00 p.m. R2 remained seated in recliner in room. During an observation on 8/11/15, at 12:00 p.m. R2 was observed seated in her recliner with her feet elevated eating her noon meal. At 12:35 p.m. staff removed the meal tray from the room and did not offer toileting assistance. At 1:00 p.m. R2 remained seated in the recliner with feet elevated. No toileting assistance had yet been offered by staff. On 8/11/15, at 2:00 p.m. (2 hours later) R2 remained seated in the recliner in her room and stated she has "accidents" at times. No toileting assistance had been offered by staff. During an interview on 8/11/15, at 5:48 p.m. nursing assistant NA-A indicated R2 requested toileting on an inconsistent basis and is usually incontinent after sleeping. NA-A also indicated the incontinent brief was usually wet when R2 was assisted with toileting. NA- A further indicated incontinent episodes have occurred more frequently during the night shift. NA-A verified that she was unaware if R2 was currently on any scheduled toileting program. During an interview on 8/12/15, at 11:44 a.m. licensed practical nurse (LPN)-C indicated she was not aware of R2's bladder incontinence episodes. During an interview on 8/12/15, at 11:32 a.m. NA-B also confirmed she was unaware whether R2 was on a scheduled toileting program and further indicated R2 has incontinent episodes of bladder. During interview with the director of nursing	2 910		

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2 910	Continued From page 15 (DON) on 8/12/15, at 12:30 p.m. it was verified the care plan did not address R2's bladder incontinence and a toileting schedule or plan had not been developed to reduce episodes of bladder incontinence. The DON further indicated she would expect the care plan to include the problem of incontinence and have interventions in place to reduce the occurrence. The DON also confirmed there had not been an accurate and complete assessment of bladder incontinence so the appropriate interventions could be developed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for incontinence to assure they are receiving the necessary treatment/services to reduce incontinence. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for further issues with incontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist	21540		

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21540	Continued From page 16 believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN 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, 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.	21540		

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21540	Continued From page 17 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). The laboratory test results identified that R9 had low TSH levels noted. During review of the monthly pharmacy reviews dated 4/24/15, the pharmacist recommended a TSH level be completed for R9. Documentation was lacking in the record to indicate the physician had responded to the recommendation. 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. During interview on 8/12/15, at 10:49 a.m. the director of nursing (DON) stated there had been a problem with physicians responding to the recommendations by the consultant pharmacist. Review of the physician's orders dated 3/25/15, indicated an order for Trazodone 50 milligrams (mg) every bedtime for insomnia. R20's care area assessment (CAA), dated 6/3/15, indicated use of sedative/hypnotic and the care plan was updated to monitor for effects.	21540		

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21540	Continued From page 18 R20's care plan dated 6/3/15, identified R20 at risk for injury related to psychotropic medications and the approach included: medications per medical doctor's orders, discuss trial reduction of medications as indicated to achieve the lowest possible dose and periodically review behaviors to ensure resident is receiving the appropriate dose. The care plan also identified R20 as having a disturbed sleep pattern related to unfamiliar environment. Review of R20's medical record lacked documentation that sleep monitoring was being done. Review of the monthly pharmacy reviews dated 4/23/15 and 6/26/15, indicated the pharmacist recommended a trial dose reduction of the Trazodone. Documentation was lacking in the record to indicate the physician had responded to the recommendations. During interview on 8/11/15, at 1:50 p.m. with registered nurse (RN)-B stated R20 takes Trazodone due to not sleeping well related to temperature either being too cold or hot in his room at night. RN-B stated R20 was always complaining about the temperature in his room so they thought he wasn't sleeping well so they decided to put him on Trazodone. RN-B stated they do not complete sleep assessments nor sleep monitoring on their residents. During interview on 8/11/15, at 3:31 p.m. the director of nursing (DON) stated they talk to residents or their family members about the residents sleep and if they want something to help sleep. She also stated the RN's and licensed practical nurses (LPN's) consult each other if the resident needs something to sleep. The DON admitted that she didn't know whether	21540		

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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 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 place. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21540		

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21990	Continued From page 20	21990		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop an abuse prohibition policy that identified immediate reporting of suspected abuse to the State agency and staff failed to implement a thorough investigation for 1 of 1 resident (R9) reviewed and who reported potential abuse/neglect incidents. Findings include: When the facility policy was reviewed it was noted that an internal investigation would be conducted prior to reporting the suspected abuse/neglect to the State agency. The documented policy was as	21990		

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21990	Continued From page 21 follows: The facility Vulnerable Adult Act, revised 8/1/09, identified abuse in section B. as conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to the following: 1. Hitting, slapping pinching, biting, or corporal punishment of the vulnerable adult. 2. Use of repeated or malicious oral, written, gestured or technologically produced communication or language toward a vulnerable adult or the treatment of a vulnerable adult which should be considered by a reasonable person to be disparaging, use of repeated or malicious oral, written, or derogatory, humiliating, harassing, or threatening. 3. Use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion. Neglect was identifies as follows in the policy: a. Failure or omission by the caretaker to supply the vulnerable adult with care or services including, but not limited to food, clothing, shelter, health care, or supervision which is: 1. Reasonable and necessary to obtain or maintain the vulnerable adults physical and mental health or safety. 2. Which is not the result of an accident or therapeutic conduct Section V. of the facilities Vulnerable Adult Plan identified the following investigation procedure: 1. All alleged or suspected neglect, abuse, mistreatment, or misappropriation of property will be cause for a thorough investigation to be conducted by the management of the facility. 2. Staff and volunteers must report any incidents or suspicions of abuse without fear of retaliation	21990		

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21990	Continued From page 22 from facility staff or others. 3. An incident of abuse or suspected incident of abuse must be reported to a charge nurse who will examine the resident and thoroughly document his/her findings. Reports may also be made to the Director of Nursing, Social Services Designee, or the Administrator. 4. The delegated supervisor/manager will complete the appropriate forms. Notification and documentation is completed on the Abuse Report form. 5. The Director of Nursing and Administrator will be notified immediately of the suspected maltreatment, abuse or neglect. 6. A complete investigation of the incident will be completed by the administrator. The internal investigation is to make a determination if the incident is reportable or not reportable. 7. The investigation will include at least the following: a. A review of the completed complaint form or incident report b. An interview with the person(s) reporting the incident. c. An interview with the resident if possible. d. A review of the resident's medical record. e. An interview with the resident's roommate, family members, and visitors. f. A review of all the circumstances surrounding the incident. During initial interview with R9 on 8/10/15, at 9:44 a.m. R9 was questioned whether abuse had ever occurred, R9 stated, " There was this one guy that was pushing on my legs and back hard while doing cares. After completing cares he wiped my bottom then put the dirty towel on my bedside table. I told him I eat there and don't want it put there." R9 stated after making the comment to	21990		

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21990	Continued From page 23	21990		

the staff member about the rough cares and the placement of the towel on his bedside table the staff member stated, "Shut up you old fart, you can't tell me what to do". R9 stated he had reported the incident to the nurse but didn't recall her name. R9 further stated he had reported to nursing about being 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 and entry dated 4/20/15, at 3:32 p.m. which identified R9 approached the social service designee (SSD) and shared a concern he 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. 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,

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21990	Continued From page 24	21990		

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 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 incidents on 8/11/15, at 6:25 p.m. R9 was asked

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21990	Continued From page 25 whether he recalled the conversation about staff being rough. R9 stated he recalled talking about staff being rough and putting a soiled towel on his bed side table, "Where I eat". R9 recalled staff stating, " Shut up you old fart, you can't do nothing about it." R9 further stated he didn't recall exactly when it happened but reported it to the nurse. R9 also verified he had reported to the nurse that he had been left in the mechanical lift for long periods of time. R9 then went on to say, "I don't want to cause problems". SUGGESTED METHOD FOR CORRECTION: The director of nursing and/or administrator could establish procedures, update policies and educate staff to ensure that polices are followed when reporting and investigating abuse/neglect complaints. The DON could monitor for compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21990		