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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JKJM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245283**
2.STATE VENDOR OR MEDICAID NO.
(L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/13/2017** (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)
06/30

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

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (L17)

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

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

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 09/05/2017
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/05/2017
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/24/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5283

On July 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 23, 2017, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 25, 2017. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of July 7, 201. We have determined, based on our revisits, that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 25, 2017, as of July 7, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 7, 2017.

In addition, this Department recommended to the CMS Region V Office the following enforcement remedy be imposed::

Civil money penalty for deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444

The following life safety code deficiencies previously fowarded to the CMS Region V Office for their deteremination:
- K163, - K252, - K331, - K521

Approval of the waivers was recommended.

Effective July 7, 2017, the facility is certified for 83 skilled nursing facility beds.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245283

Electronically delivered
September 5, 2017

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, MN 55792

Dear Ms. High:

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 July 7, 2017 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K163, K252, K331 and K521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 5, 2017

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, MN 55792

RE: Project Number S5283027

Dear Ms. High:

On June 14, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 19, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on May 25, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 23, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 25, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 7, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 25, 2017, as of July 7, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 7, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedy recommended in our letter of June 14, 2017:

- Civil money penalty for deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

Your request for a continuing waiver involving the deficiencies cited under K163, K252, K331 and K521 at the time of the May 25, 2017 standard extended survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 5, 2017

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, MN 55792

Re: Reinspection Results - Project Number S5283027

Dear Ms. High:

On July 13, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 25, 2017. At this time these correction orders were found corrected.

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JKJM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245283**
2.STATE VENDOR OR MEDICAID NO.
(L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/25/2017** (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)
06/30

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

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (L17)

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room
* Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kimberly Settergren, HFE NEII — 07/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 07/24/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/24/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5283

On May 25, 2017 a standard survey was completed at this facility. The most serious deficiencies were cited at a S/S level of G. The facility was not given an opportunity to correct and conditions in the facility constituted immediate jeopardy to residents health and safety. In addition, investigation of complaint number H5283019 and found to be unsubstantiated.

As a result of the survey findings, the Category 1 remedy of State monitoring is effective, June 19, 2017. In addition, we recommended the following enforcement remedy to the CMS RO for imposition:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

Furthermore, the following life safety code waivers were forwarded to the CMS Region V Office for final review and determination: K163, K252 K331 and K521. Approval of the waivers was recommended

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction and K84 Justification page detailing the waiver requests.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2017

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, MN 55792

RE: Project Numbers S5283027, H5283019

Dear Ms. High:

On May 25, 2017, 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. In addition, at the time of the May 25, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5283019 that was found to be unsubstantiated.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective June 19, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 25, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through

an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(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 On 5/21/17 to 5/25/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5283019 was completed. The complaint was not substantiated.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 157		7/7/17

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

Electronically Signed | 06/20/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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F 157	Continued From page 1 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:	F 157		

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F 157	Continued From page 2 Based on interview and document review, the facility failed to ensure resident or designee was notified of a change in treatment or condition for 3 of 4 residents (R42, R4, R95) reviewed for notification of change. Findings include: R42's family member (FM)-B was interviewed on 5/23/17, at 10:50 a.m. FM-B stated R42 did not get her last dose of an intravenous (IV) antibiotic. FM-B stated it happened over weekend, and she was not notified until Tuesday because the registered nurse (RN) was off on Monday. FM-B further stated the family wanted to be notified any time during the day or night about anything. R42's Diagnoses Report printed 5/24/17, indicated R42's diagnoses included congestive heart failure, shortness of breath, chronic kidney disease and dementia. R42's Physicians Order Report dated 1/5/17, through 5/24/17, indicated on 3/2/17, the physician ordered Invanz (an antibiotic) 1 gram (gm) via IV every 24 hours for three days. The antibiotic was to be administered between 10:30 a.m. and 12:00 p.m. R42's Medication Administration Record (MAR) dated 3/1/17, through 3/31/17, indicated R42 received the Invanz on 3/2/17, at 2:47 p.m. due to the IV needed to be changed. R42 received the Invanz as ordered on 3/3/17. R42 did not receive the Invanz on 3/4/17, because the IV infiltrated (occurs when the IV fluid or medications leak into the surrounding tissue). R42's progress notes dated 3/2/17, indicated	F 157	R42□s, R4□s, and R95□s family is aware of the changes that were made to medications. Three residents on each wing that have had medication order changes since 5/25/17 will be reviewed to assure that family was notified. If there is no documentation of family notification, family will be updated and the contact documented in the medical record. If the resident is their own responsible party, the resident will be updated and documented in the medical record. The FAMILY NOTIFICATION POLICY have been reviewed and revised. Licensed Nursing staff will be trained on expectation of family notification on 06-28-17. The IDT will review progress notes daily M-F for significant changes in orders and treatments. The IDT will audit these residents to assure that the family or self representing resident has been notified of such change and documented in the medical record. Monitoring will be completed at a consistent level (daily M-F) until compliance is achieved. Monitoring will then be completed at a level to maintain compliance as determined by the QC.	

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F 157	Continued From page 3 R42's IV was changed on the day shift 3/2/17, due to infiltration. The IV antibiotic was administered after the change was completed. R42's progress notes dated 3/4/17, indicated the registered nurse (RN) was unable to administer the last dose of Invanz on 3/4/17, due to the IV infiltrating. The IV was removed. The medical record lacked notification of R42's family. R42's progress notes dated 3/6/17, indicated the physician was updated by facsimile (fax) that R42 did not receive the last dose of the IV antibiotic. Staff asked the physician if a urinalysis (UA) was needed to check for infection, or if they should wait for any sign or symptoms of infection. R42's progress notes dated 3/7/17, indicated R42 was having increased weakness and dark foul smelling urine. The physician was updated. On 3/7/17, the progress notes indicated physician ordered a UA. R42's progress notes dated 3/8/17, indicated a urine specimen was obtained, sent to the laboratory for testing and the results were faxed to the physician. R42's progress notes dated 3/10/17, indicated the RN spoke with the physician regarding the UA results. A culture was requested to determine if R42 needed to be treated for a urinary tract infection. R42's progress notes dated 3/10/17, indicated the physician was notified of the culture results and no antibiotic was needed. On 5/24/17, at 2:00 p.m. RN-D stated it was a Saturday when R42 did not receive the last dose	F 157	The Director of Nursing is responsible.	

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F 157	Continued From page 4	F 157		

of the antibiotic. RN-D stated she recalled the situation and verified R42's family and the physician were not notified until Monday. RN-D verified the medical record lacked documentation of the notification of the family. RN-D further stated R42's family should have been notified the same day as they are very involved.

On 5/24/17, at 2:10 p.m. the director of nursing (DON) was interviewed and verified R42's family was not notified when R42 did not receive the antibiotic. The DON further stated the RN could have called her or the RN on call to put in a new IV. The DON would expect the family and the physician to be notified immediately.

The facility's Family Notification policy dated 4/1/14, directed it was the policy of the facility to notify family of changes in status or care plan as well as to obtain any ideas or suggestions the family may have. The policy directed to notify the family when there was a need to alter, discontinue or initiate a treatment.

R4's family member (FM)-C was interviewed on 5/22/17, at 2:14 p.m. FM-C stated R4 is checked every 2 months for a urinary tract infection and in February, a urinalysis was done, and the results indicated R4 had an infection. FM-C stated the physician orders to treat the infection were not communicated to the family. FM-C stated the family wanted better communication.

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R4's Face Sheet printed 5/25/17, indicated R4's diagnoses included Alzheimer's disease, enterocolities due to clostridium difficile (infection of the bowel usually related to antibiotic use), gastrointestinal hemorrhage (bleeding of the bowel or stomach) and urinary tract infections.

R4's progress notes dated 2/3/17, indicated R4 had a urine sample collected for a urinalysis (UA) and sent to the laboratory at 3:50 a.m. R4's progress notes dated 2/3/17, at 11:39 a.m. indicated R4's urinalysis results were received and faxed to the physician for review.

R4's progress notes dated 2/4/17, at 2:47 p.m. indicated R4's urine culture results were received and indicated the presence of a urinary tract infection. R4's physician orders and progress notes dated 2/4/17, indicated a physician was called and orders for Augmentin (antibiotic) were received. R4's culture results were faxed to R4's urologist. R4's progress notes lacked notification of R4's family regarding new medication orders for a urinary tract infection.

R4's physician orders and progress notes dated 2/6/17, indicated R4 received new physician orders including discontinuation of the Augmentin and a new order for Doxycycline (antibiotic of a different classification). R4's progress notes lacked notification of R4's family regarding the change in physician's medication orders.

On 5/25/17, at 10:55 a.m. registered nurse (RN)-D verified R4 had a routine urinalysis every 2 months. RN-D verified notification of the family regarding the urinalysis results and the physician medication orders was not done. RN-D stated FM-C was not notified until 2/6/17. RN-D verified

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F 157	Continued From page 6 R4's family should have been notified of the new order when it was ordered. R95's family member (FM)-A was interviewed on 5/22/17, at 12:23 p.m. FM-A stated the facility did not notify her of an eye antibiotic ordered for R95 by the physician. FM-A stated she was made aware when the nurse applied it to R95's eye lids in the family member's presence. R95's Cumulative Diagnosis List dated 5/24/17, indicated R95's diagnoses included blepharitis, an infection of the eye lids. R95's physician orders dated on 3/27/17, included Erythromycin (antibiotic) Ophthalmic ointment to be lightly smeared, half ribbon size over closed eyelids to both eyes at night for thirty days. R95's progress note dated 3/31/17, indicated a new prescription ordered by physician for treatment of the infection of the eye lids, but lacked verification of reporting the change of condition to R95's family member. On 5/23/17, at 2:50 p.m. registered nurse (RN)-D verified that notifying families and/or resident designee should be part of the first steps taken when receiving new orders.	F 157		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 241		7/7/17

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F 241	Continued From page 7 her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dignity was maintained during dining for 6 of 6 residents (R56, R8, R83, R59, R67, R95) observed who required assistance with dining. Findings include: R56's quarterly Minimum Data Set (MDS) dated 4/4/17, indicated R56 was diagnosed with hemiplegia and was independent with eating. R8's annual MDS dated 2/3/17, indicated R8 had severely impaired cognition and required supervision and oversight or cueing with eating. R83's quarterly MDS dated 3/7/17, indicated R83 had moderately impaired cognition and required extensive assistance with eating. R59's significant change MDS dated 4/25/17, indicated R59 was diagnosed with dementia, had severerly impaired cognition, and required extensive assistance with eating. R67's quarterly MDS dated 2/17/17, indicated R67 was diagnosed with dementia, had severely impaired cognition, and required supervision with eating. On 5/24/17, at 12:43 p.m. nursing assistant (NA)-D was observed in the dining room standing at a table. NA-D was moving between R56, R8,	F 241	R56 has expired. R8 continues to require supervision and oversight or cueing with eating. R83 continues to require extensive assistance with eating. R59 has expired. R67 continues to require supervision with eating. R95 continues to require extensive assistance with eating. The DINING AND FOOD SERVICE POLICY has been reviewed and revised and includes the expectations that staff sit when assisting residents with meals except when providing a single bite or sip to encourage self feeding or to provide verbal cues or encouragement only. Nursing Assistants and Licensed staff will be trained of facility expectations on 06-28-17. The Dietary Manager or designee will complete audits daily to assure that policy is being followed. Monitoring will be completed at a consistent level (daily) until compliance is	

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F 241	Continued From page 8 R83, R59 and R67 (at neighboring tables) to assist with eating and drinking. NA-D gave R56's milk from a glass, waited for her to swallow and held the glass up again. NA-D then provided a bite of food to R8 before leaving the table to hold a cup of milk for R67. NA-D waited for R67 to swallow, and offered the cup again. Upon return to the first table, NA-D encouraged R83 to eat a cookie, and encouraged R59 to finish her meal. NA-D returned to hold cups for R56 and R67. On 5/24/17, at 12:46 p.m. NA-D verified she stood and went between tables and residents. On 5/24/17, at 1:41 p.m. the director of nursing (DON) stated staff can stand if they are just encouraging residents to eat, but if they are actually assisting them to eat, she would expect them to be sitting next to the resident. R95's quarterly Minimum Data Set (MDS) dated 2/6/17, indicated R95 required extensive assistance of one person physical assistance with eating. On 5/23/17, at 8:06 a.m. R95's was observed in the dining room. Nursing assistant (NA)-D stood to the right of R95 and assisted him with eating. NA-D stood while she gave R95 a bite of food, and returned to a chair across the table from R95. R95 was assisted in this manner for the entire breakfast meal. At 8:43 a.m. NA-D left the table. At 8:44 a.m. NA-E assisted R95 with the rest of the meal in the same manner. At 8:57 a.m. NA-C verified R95 had completed the meal, and she propelled R95's wheelchair in front of the aviary. On 5/23/17, at 10:57 a.m. NA-D verified that	F 241	achieved. Monitoring will then be completed at a level to maintain compliance as determined by the QC. The Dietary Manager is responsible.	

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F 241	Continued From page 9 ideally the manner to assist R95 and other residents would have been to sit next them, socialize, and get at eye level. NA-D stated when the facility does not have enough to help feed, this is the manner in which they assist residents. On 5/24/17, at 9:45 a.m. director of nursing (DON) verified that staff were to sit next to residents when assisting them to dine. The facility's Dining and Food Service policy dated 4/1/14, directed staff to sit when assisting residents with meals and that they should be seated as near to the resident as possible.	F 241		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure pressure	F 314	R13□s had a Skin Risk Assessment completed on 1/18/17 upon identification	7/7/17

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F 314	Continued From page 10 ulcers were identified and assessments were completed to prevent the development of and worsening of pressure ulcers for 2 of 3 residents (R13, R152) reviewed for pressure ulcers. This resulted in actual harm for R13 due to development of a pressure ulcer to the right leg. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1: Nonblanchable Erythema: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 2: Partial Thickness Skin Loss: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and/or eschar (dark, dead tissue) may be visible. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer.	F 314	of the PU to ankle. Tissue Tolerance Assessments were completed 1/18/17 and 1/23/17. The most current Skin Risk Assessment was completed 5/26/17. The residents Care Plan and Kardex have been reviewed and updated to reflect all skin interventions based on Skin Risk Assessments including directions for repositioning program. R152 was discharged on 5/12/17. Current residents who have been admitted since 5/25/17, (day of exit) will be reviewed to assure that a Skin Risk Assessment and Tissue Tolerance if applicable has been completed. If one has not been done, a Skin Risk Assessment will be completed. Residents admitted prior to 5/25/17 will be reviewed at the next quarterly, annual or significant change MDS to assure that the Skin Risk Assessment has been completed. All residents who currently have braces or splints will be reviewed to assure that there are instructions for application and removal. The SPLINT AND BRACE TREATMENTS POLICY has been reviewed and revised to include clarification of application of braces, splints, and skin inspection. The IMPAIRED SKIN/TISSUE DOCUMENTATION IN MATRIX POLICY has been reviewed and remains	

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F 314	Continued From page 11 Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). R13's Face Sheet printed 5/25/17, indicated diagnoses that included closed right femur (thigh bone) fracture, acute kidney failure, and vascular dementia (caused by brain damage from impaired blood flow to your brain).	F 314	appropriate. The SKIN RISK ASSESSMENTS AND OBSERVATIONS POLICY has been reviewed and remains appropriate. The PHYSICIAN ORDERS POLICY has been reviewed and revised. Training on Impaired Skin, Skin Risk Assessments, Splints and Braces, and documentation will be completed for all licensed nursing staff on 06-28-17. The IDT will review progress notes daily (M □F) to assure that the appropriate event has created for any potential skin integrity concerns. A Skin Team has been established to meet weekly to review pressure ulcers. Audits will be completed weekly by the Skin Team or designee to assure compliance with completing Skin Risk Assessments within 24 hours of admission, that the Braden Observations are completed weekly for a total of four weeks, and event/observation opened for any skin issues identified and appropriate interventions are care planned. The team will also review any new splint or brace implemented to assure that there are instructions for application and removal. Monitoring will be completed at a consistent level (daily/weekly) until compliance is achieved.	

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F 314	Continued From page 12 R13's admission Minimum Data Set (MDS) dated 12/22/16, lacked identification of risk for pressure ulcers and presence of current unhealed pressure ulcers. need to see if identified history of The MDS also indicated R13 required extensive assistance of 2 staff for bed mobility and transfers, and had daily vocal complaints of pain. R13's quarterly MDS dated 3/23/17, indicated R13 had a severe cognitive deficit, required extensive assistance of 2 staff for bed mobility and total assistance of 2 staff for transfers. The MDS further indicated R13 was at risk for pressure ulcers, had no pressure ulcers, no healed pressure ulcers, and had no pressure ulcers on the previous assessment. The MDS also indicated interventions included a pressure device for chair and bed, but did not identify a turning and repositioning program. R13's Care Area Assessment (CAA) dated 12/22/16, indicated R13 was at increased risk for skin breakdown related to decreased mobility due to a recent right femur fracture, and incontinence of bowel and bladder. R13's care plan initiated 12/22/16, and edited 5/23/17, indicated R13 had a history of a Stage II pressure ulcer of the coccyx and a stage IV pressure ulcer to the right lower leg, and was at risk for additional pressure ulcers related to impaired mobility and incontinence of bowel and bladder. R13's care plan approaches started 12/22/16, directed staff to keep clean and dry as possible, provide incontinence care after each incontinent episode, and report any signs of skin breakdown. The care plan approaches started 1/5/17, and edited 5/23/17, directed resident to be repositioned side to side only when in bed and	F 314	Monitoring will then be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible.	

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encourage use of wedge for side lying. Care plan approaches started 1/11/17, and edited 4/20/17, directed the use of an alternating air-flow mattress with side bolsters, and treatment to pressure ulcers per orders. Care plan approaches dated 1/19/17, directed the resident to be out of bed and up for meals only and special events per family requests. Care plan approaches dated 1/26/17, directed the use of blue heel lift boots to be worn on both feet at all times except during cares for skin inspection. The care plan further directed no pressure to be placed on the right leg while in bed or wheelchair. Care plan approaches dated 3/8/17, included a foot cradle to the bed to keep blanket weight off R13's feet, and a ROHO (pressure prevention cushion with individual air cells) cushion in the wheelchair. R13's care plan further indicated R13 had increased nutrient needs related to impaired skin integrity and directed R13 to receive 4 ounces of Ensure Plus (oral supplement) four times daily to aid in wound healing. R13's care plan lacked direction for a repositioning program.

R13's Kardex/nursing assistant (NA) Care Plan Reference Sheet initiated 12/13/16, indicated R13 required extensive assist of one staff for turning in bed, and total assist of two staff for moving R13 up in bed, and to check and change R13 every two hours for incontinence. Additions to the Kardex on 12/16/16, included bilateral heel lift boots on at all times except during cares. Changes dated 1/5/17, included reposition R13 side to side only in bed. Changes dated 1/19/17, included to get R13 up in wheelchair only for meals and special events per family requests. Changes dated 1/30/17, included a wedge for positioning. Changes dated 4/20/17, included an alternating air-flow mattress with bolster sides.

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Undated changes included identification of a Stage III pressure ulcer on R13's right lower leg, and directed staff to place no pressure to the area. It also identified a ROHO cushion in wheelchair, and a foot cradle on bed to keep pressure off R13's feet from blankets. R13's Kardex lacked direction for repositioning times.

R13's facility pre-screening for admission dated 12/12/16, indicated R13's general skin condition was fragile and bruised, but indicated there were no wounds or pressure ulcer care, or repositioning program. The pre-screening form indicated R13 had a knee immobilizer, and was weight bearing as tolerated with pivoting transfers.

R13's hospital Discharge Summary dated 12/13/16, indicated R13 had been admitted to the hospital on 12/8/16, with a right femur fracture, was given a trial of an immobilizer with limited weight bearing and tolerated it well with minimal breakthrough pain medications. Surgery to repair the fracture had been considered, but due to R13's high morbidity risk and progressive decline, surgery was not performed. R13's hospital Discharge Summary did not identify any areas of skin breakdown or pressure ulcers.

R13's Interagency Referral (IAR) dated 12/13/16, included directions for Calmoseptine (menthol-zinc oxide used to treat or prevent minor skin irritations, moisture barrier) ointment to be applied with morning and nighttime cares, and three times daily as needed. The IAR indicated R13 had bruising of leg. The IAR also directed to transfer R13 with a lift, but R13 could bear touch down weight for transfers to chair only. The IAR further indicated R13 had constant, aching pain of

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the right leg. R13's IAR lacked documentation of any pressure ulcers.

R13's Head-to-Toe Skin Assessment dated 12/13/16, indicated R13 had an area measuring 1.0 x 1.1 centimeters (cm), but lacked any description of the area. A progress note dated 12/13/16, at 10:08 p.m. indicated an unidentified treatment was applied to irritated skin on the buttocks.

R13's admission Observation Report dated 12/13/16, at 5:17 p.m. indicated R13 required assistance of two staff for bed mobility, had pain expressed with non-verbal sounds, and vocal complaints of pain of the right arm and leg. The admission note for the Observation Report dated 12/13/16, indicated R13 used a hoyer lift for transfers, could have behaviors related to not wanting to move in fear of creating more pain for herself, and had no edema noted to either leg. The admission note did not identify any skin integrity concerns.

R13's physician orders dated 12/13/16, directed Calmoseptine as needed for redness. This was discontinued on 12/13/16.

R13's progress notes dated 12/14/16, at 9:48 p.m. indicated R13 had two superficial open areas on the buttocks; one in the buttock slit measured 1.3 centimeters (cm) x 0.5 cm, and the second on the left buttock that measured 1.6 cm x 1.5 cm. The progress note indicated Calmoseptine was applied and the areas would be monitored.

R13's nurse practitioner (NP) progress notes dated 12/16/16, at 7:00 a.m. indicated R13 had

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been admitted with a fractured right femur and used an immobilizer. The note further indicated R13 had pain with movement of the right leg, but was receiving both scheduled pain medication, and medication for breakthrough pain. The note also indicated R13 had good circulation, motion, sensitivity (CMS) and warmth in the right leg. The progress note indicated R13's skin had no observed lesions or open areas.

On 12/16/16, at 10:00 p.m. a Skin Integrity Event-Pressure Sore/Stasis Ulcer form indicated R13 had a Stage II pressure ulcer on the right heel. The Skin Integrity Event (SIE) form lacked description of the pressure ulcer or interventions in place for the identified pressure ulcer.

R13's progress notes dated 12/21/16, indicated a pressure ulcer on the right inner heel was identified on 12/16/16. The area was described as an intact blister measuring 2.2 cm x 2.5 cm. The right heel was further described as being boggy, and the outer ankle was dark in color. R13's care plan was updated on 12/21/16, to include blue boots to be worn, and heels to be floated off surfaces. Further progress notes on 12/21/17, indicated there was no fluid noted in the right heel blister, and R13 was at increased risk of skin breakdown according to a Braden assessment (tool used to assist in identifying risk of skin breakdown) score of 15 dated 12/21/16. R13's progress notes indicated R13 was to be repositioned every 2 hours and as necessary, and could be resistive to movement due to fear of falling. R13's medical record indicated R13's right heel pressure ulcer was not measured again, after this date, though it was periodically observed.

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R13's Skin Risk Assessment (SRA) with Braden dated 12/21/16, indicated R13 had one Stage II pressure ulcer that was not present on admission, but was identified on 12/16/16. The SRA indicated interventions included heel protectors, pressure reducing devices for chair and bed, pressure ulcer care, but lacked a turning and repositioning program. R13's SRA lacked identification of previously identified open areas in the 12/14/16, progress notes.

R13's interdisciplinary team (IDT) progress note dated 12/21/16, indicated R13 had a fracture and wore an immobilizer on the right leg, which limited R13's mobility of the right leg. The IDT note indicated interventions initiated were determined to be appropriate.

R13's progress notes dated 12/23/16, indicated a message had been left with the clinic regarding use of the immobilizer, and when or if it could be removed for R13 to receive a bath. Progress notes lacked a response from the clinic or follow up by the facility regarding the immobilizer until 1/13/17 (30 days following hospital return).

R13's medical record lacked documentation of monitoring of the right heel pressure ulcer and skin until 1/4/17, when a Stage II coccyx pressure ulcer was identified. R13's coccyx pressure ulcer area measured 3.4 cm x 3.1 cm and had an area of dark tissue that measured 1.5 cm x 1.7 cm. The progress notes indicated R13 was totally dependent on two staff for repositioning, wore a right leg immobilizer at all times, and was incontinent of bowel and bladder. R13's care plan was updated at that time to be repositioned side to side only in bed, and a Tissue Tolerance assessment (tool to assist in identifying a

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resident's tissue perfusion and tolerance to persistent pressure to determine the proper positioning time for the individual resident) was initiated.

R13's progress notes dated 1/5/17, indicated the IDT met and determined the dietician would review R13's intake and nutritional needs, the SRA and Tissue Tolerance would be initiated. The dietician note dated 1/5/17, indicated an order for a multivitamin and nutritional supplement would be requested.

R13's SRA with Braden and related progress note dated 1/6/17, indicated R13's Braden score remained at 15, indicating R13 was at risk for skin breakdown with the same risk factors previously identified. The progress note indicated R13's Stage II right inner heel pressure ulcer was healing, dry, and the skin had a tan discoloration. The note identified scar tissue from old wounds on both buttocks, and R13 reported she had wounds on her buttocks in the past. New interventions included an alternating air-flow mattress initiated that day, Ensure Plus (nutritional supplement) had been started, and a Tissue Tolerance was completed indicating resident tolerated being in one position for two hours without redness, bogginess, or warmth to any bony prominences. R13's SRA indicated R13 had two Stage II pressure ulcers, one was present on admission, though the previous assessment verified no pressure ulcers were present on admission, but was identified as being present on the prior assessment.

R13's NP progress note dated 1/10/17, indicated R13 was seen for a skin check. NP documentation indicated R13 had a Stage II

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pressure ulcer on the coccyx which had worsened, and R13 was at high risk for pressure ulcers due to being bed and chair ridden because of a hip fracture. R13's NP progress note indicated the coccyx pressure ulcer had a thick layer of slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucous-like) and eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges) covering the wound bed. The pressure ulcer measured about 1.5 cm x 1.5 cm, and was unstageable at that time. The NP spoke with a wound care NP and determined the pressure ulcer would need to be surgically debrided to heal, but the facility could try mechanical debriding with Medihoney (honey-based ointment to assist with wound healing). Nursing progress notes dated 1/10/17, indicated the NP assessed the right inner heel pressure ulcer, which was continuing to heal, had no fluid, and had a semi-hard tissue covering it. The NP directed to leave the heel ulcer open to air, and ordered Medihoney gel to coccyx pressure ulcer and cover with Mepiliex (foam dressing to assist with management of drainage and prevent maceration of wounds) to be changed every 3 days, and reassess in one week.

Physician orders dated 1/10/17 through 1/20/17, directed Medihoney to the pressure ulcer wound bed on coccyx, cover with Mepilex, and change every 3 days and as necessary. R13's physician orders dated 1/5/17, directed Ensure Plus (nutritional supplement) 2 ounces to be administered four times daily, and orders dated 1/10/17, directed a multivitamin to be administered daily.

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R13's progress notes dated 1/12/17, indicated the NP would contact the physician assistant who worked with R13 in the hospital regarding the immobilizer.

R13's progress notes dated 1/13/17, indicated the NP received direction from the orthopedic NP that R13 could be out of the immobilizer if comfortable in bed, but have it on if she were to be getting up, and during transfers until 6-8 weeks post hospitalization, and off in the wheelchair if she was comfortable. The note also indicated R13 may have a bath or shower.

R13's physician orders dated 1/13/17 to 2/12/17, directed Clindamycin HCl (antibitotic) 300 milligrams (mg) three times daily for cellulitis (infection of the skin/tissue) of the right lower limb from 1/17/17, through 1/27/17. Physician orders also directed a change in treatment to the coccyx pressure ulcer on 1/20/17, to a wet to dry dressing with skin prep to surrounding skin and cover with gauze and tape.

R13's progress notes and new SIE dated 1/16/17, indicated R13's right leg immobilizer was not removed until 1/16/17, and when the immobilizer was removed, an unstageable pressure ulcer was noted on R13's lower right leg above the ankle. The pressure ulccer measured 9.2 cm x 2.7 cm covered with eschar, and an area parallel with intact skin separating the two areas measuring 4.2 cm x 1.5 cm also covered with eschar. The surrounding tissue had erythema (red inflammation). R13 did not have any complaints of pain to the area. A Mepilex border pad was applied after R13 showered.

R13's progress notes dated 1/17/17, indicated NP

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approved leaving the immobilizer off but directed staff to support R13's right leg during transfers. R13's progress notes further indicated the IDT met and indicated R13 had a femur fracture with previous orders to wear the immobilizer at all times and was at high risk for skin breakdown. A new SRA was to be done and the dietician was to be updated.

R13's progress notes dated 1/17/17, indicated NP assessed resident skin ulcers and ordered a leg/ankle X-ray to rule out osteomyelitis (infection in the bone) and start Clindamycin (antibiotic) 300 mg three times daily for 10 days for cellulitis (skin/tissue infection). R13's progress note further indicated R13 was to have an appointment with general surgery for wound care to the right leg ulcer and the coccyx ulcer on 1/19/17. Further progress notes on 1/17/17, indicated the coccyx ulcer measured 2.0 cm x 1.5 cm with 100% slough and dark tissue in the center. R13's right heel pressure ulcer continued to have thin dry skin, but was not measured.

R13's Infection Control-Infection Report (IC-IR) initiated 1/17/17, indicated R13 had an infection of the skin of the right lower leg, treated with an antibiotic and probiotic (used to decrease risk of infection of the bowel with clostridium difficele from antibiotic use). R13's IC-IR indicated R13's X-ray reports dated 1/18/17, indicated there was no evidence of osteomyelitis.

R13's SRA with Braden dated 1/18/17, indicated R13 had two Stage II pressure ulcers and one unstageable pressure ulcer covered with eschar. R13's Braden score continued to be 15, indicating R13 was at risk for skin breakdown. Interventions at this time included a repositioning

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program. R13's related progress note dated 1/18/17, indicated R13's immobilizer was discontinued recently, as R13 did not stand at any time, and was transferred with the use of a lift while staff supported the right leg. R13's progress note indicated R13 was scheduled to see general surgery for treatment to the right leg pressure ulcer, and to determine treatment for the coccyx pressure ulcer due to ineffectiveness of the Medihoney treatment. Interventions at that time included blue lift boots to feet at all times, repositioned side-to-side only while in bed to off-load coccyx, alternating air-flow mattress, Ensure Plus supplement, and a multivitamin. A tissue tolerance was to be completed in bed and wheelchair. The wheelchair tissue tolerance was completed after R13 was out at an appointment for greater than 2 hours. The tissue tolerance determined R13 tolerated repositioning every 2 hours, so this plan of care would be continued, but due to coccyx pressure ulcer, R13's plan of care was changed to be up in wheelchair only for meals and special events per family requests.

R13's Operative Procedure Progress Note dated 1/19/17, indicated R13 had a debridement of the right lower extremity pressure ulcer and the coccyx pressure ulcer under general anesthesia. The brief post-op note indicated the coccyx pressure ulcer measured 2 cm x 1 cm x 0.5 cm, and the right lower leg pressure ulcre was down to the tendon and measured 8 cm x 3 cm x 0.5 cm.

R13's Operative Report dated 1/19/17, indicated general endotrachial tube anesthesia was administered in the operating room. The coccyx pressure ulcer was debrided to viable tissue. The right lower extremity pressure ulcer eschar was

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debrided, and necrotic (dead tissue) was found underneath. The necrotic tissue was debrided and involved tissue down to the tendons. R13 tolerated the procedure well, and was discharged back to the facility the same day.

R13's progress notes dated 1/201/7, indicated new treatment orders were received from surgeon for coccyx and right lower leg pressure ulcers. The treatment to the coccyx pressure ulcer was changed to wet to dry dressing daily, and if increased drainage let the NP know and it could be increased to twice daily. The treatment to the right lower leg pressure ulcer was changed to hydrogel dressing daily, keep wound beds moist.

R13's Braden Scale dated 1/22/17, indicated R13 remained at high risk for pressure ulcers.

R13's progress note dated 1/23/17, indicated R13 tolerated lying on right side for two hours without redness, increased warmth or bogginess to bony prominences. Further progress notes dated 1/23/17, indicated R13's right lower leg pressure ulcer measured 9.4 cm x 2.7 cm with exposed tendon and 10% slough. The note also identified a water blister measuring 2 cm x 1.9 cm located 8.5 cm superior to the pressure ulcer.

R13's progress notes dated 1/26/17, indicated R13 had been at high risk for pressure ulcers related to her immobility so would continue restorative therapy for strengthening to allow her to move more freely and independently.

R13's progress notes dated 1/26/17, indicated orders were received to apply Betadine to right heel ulcer daily.

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F 314	Continued From page 24 R13's NP progress note dated 1/27/17, indicated R13 was finishing the antibiotic treatment, and the NP viewed R13's coccyx and indicated it was healing, had red beefy base with minimal slough.. The NP was unable to view the leg pressure ulcers due to dressing just being changed, but documented there were no signs of infection. The Clindamycin was discontinued on this date. R13's progress notes dated 1/27/17, indicated R13 had a follow up appointment with the surgeon, had no change in treatment and received directives to keep pressure off debridement site and coccyx as much as possible. R13's progress notes dated 1/31/17, indicated NP assessed pressure ulcers and the following findings were documented: Right heel pressure ulcer was resolved and no longer required the Betadine treatment. Coccyx surgical wound measured 1.8 cm x 2.2 cm x 0.3 cm with 50% slough. Right lower extremity: Upper surgical wound measured 5 cm x 2.3 cm x 0.4 cm with 25% slough and 75% granulation (red healing) tissue with the tendon still exposed. Lower pressure ulcer measured 3.9 cm x 2.7 cm x 0.7 cm with 75% slough and 25% granulation tissue noted. R13's progress notes dated 2/2/17, and 2/9/17, indicated R13 had a follow-up appointments with the surgeon and had no changes in treatment. Care of the pressure ulcers was released to the NP unless there were concerns. R13's NP progress notes dated 2/14/17, indicated all wounds show improvement, but the tendon	F 314		

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exposed in the upper right leg pressure ulcer was developing a brown spot. General surgery was notified and expressed concern that it may be getting too dry, so dressing changes were to be changed to twice daily. NP progress note indicated coccyx pressure ulcer was a Stage II and the right leg pressure ulcer was a Stage III.

R13's Braden Scales dated 2/7/17, 2/15/17, and 2/21/17, continue to indicate R13 was at high risk for pressure ulcers.

R13's progress notes dated 2/16/17, indicated the coccyx pressure ulcer measured 1.5 cm x 1.4 cm x 0.2 cm with 10% slough and 90% granulation tissue, the upper right lower leg pressure ulcer measured 5.0 cm x 2.6 cm x 0.4 cm with 25% slough and 75% granulation tissue and the tendon exposed, and the lower right lower leg pressure ulcer measured 3.7 cm x 2.5 cm x 1.0 cm and was 90% slough and 10% granulation tissue.

R13's progress notes dated 2/20/17, indicated the coccyx pressure ulcer measured 1.9 cm x 1.3 cm x 0.3 cm with 10% slough and 90% granulation tissue, the upper right lower leg pressure ulcer measured 5.0 cm x 2.5 cm x 0.4 cm with 10% slough and 90% granulation tissue with the tendon still visible, and the lower right lower leg pressure ulcer measured 3.2 cm x 2.5 cm x 0.6 cm and was 90% slough and 10 % granulation tissue.

R13's NP progress notes dated 2/28/17, indicated the pressure ulcers had been making good progress with healing. Hydrogel dressings were being used to leg wounds twice daily and wet to dry packing was used daily on the coccyx, and

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R13 tolerated dressing changes well. NP documented the right leg wound continued to have healthy granulation tissue filling in the wound from the base up. NP documented the tendon was slightly brown and the surgery and wound care NP was aware. Coccyx pressure ukcer was healing with healthy tissue in the base. NP made no changes in treatment orders.

Progress notes dated 3/4/17, indicated R13's right ankle tendon appeared darker brown to a larger area of the tendon. A new fluid-filled blister was identified on the posterior side of the pressure ulcer nearer the heel and measured 3.5 cm x 1.5 cm. The blister was intact. Staff were to be informed to avoid pressure to the ankle and use extreme caution when caring for resident.

R13's progress notes dated 3/5/17, indicated the tendon in the right lower leg wound changed from dark brown to a dark yellow with a slight pearly shine. Progress notes further indicated R13's coccyx pressure ulcer had a moderate amount of serosanguinous (yellow fluid with small amounts of blood) drainage, with a small amount of teal colored drainage and fluorescent yellow colored drainage on dressing. Dressings were changed as ordered.

R13's progress notes dated 3/6/17, indicated physical therapy (PT) screened R13 for PT intervention for pressure ulcers Stage III and Stage IV. It was determined PT was not indicated at that time.

Quarterly nursing progress note dated 3/8/17, indicated R13 did not attempt to move in bed without staff assistance, Braden score was 14 indicating R13 remained at risk for skin

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breakdown, and was incontinent of bowel and bladder. R13's quarterly progress note indicated R13 had a Stage II pressure ulcer of the coccyx and Stage III pressure ulcer of the right lower leg. Interventions included heel lift boot at all times, reposition side-to-side in bed with use of a wedge, up only for meals and family request, off-load right leg pressure ulcer from surfaces at all times, foot cradle to keep heavy blankets off feet, alternating air flow mattress to bed and a ROHO cushion in wheelchair.

R13's IDT progress notes dated 3/9/17, indicated R13's Stage II pressure ulcer on the coccyx and right lower leg pressure ulcers were improving, though the tendon in R13's upper right lower leg was more exposed. R13 was scheduled with plastic surgery for a consultation regarding possible surgical interventions.

R13's NP progress notes dated 3/14/17, indicated coccyx pressure ulcer improved, and right lower leg pressure ulcer continued to slowly improve, but had a newer fluid filled blister below the lower right lower leg pressure ulcer. R13's NP note indicated R13 was scheduled for a consult regarding a possible graft over the tendon exposed in the right lower leg pressure ulcer. Dietary had reviewed and recommended zinc and vitamin C for wound healing. R13's plan of care was continued.

R13's progress notes dated 3/15/17, indicated R13 was referred to plastic surgery.

R13's plastic surgery note dated 3/20/17, indicated all wounds were improving, and had the potential to heal. An Aquacel AG dressing (helps to maintain a moist wound healing environment

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and control the bacteria to help prevent infection) was ordered.

R13's progress notes dated 3/21/17, indicated R13's coccyx pressure ulcer measured 1.0 cm x 2.3 cm x 0.1 cm with 5% slough and 95% granulation. R13's upper right lower pressure ulcer measured 4.3 cm x 2.4 cm x 0.3 cm with 30% slough and 70% granulation tissue with the exposed tendon measuring 2.7 cm x 1.2 cm. R13's lower right lower leg pressure ulcer measured 2.7 cm x 2.2 cm x 0.4 cm and was 10% slough and 90% granulation.

IDT progress notes dated 4/6/17, indicated R13's pressure ulcers were improving with the current treatment, and interventions included pressure relief, Ensure four times daily, multivitamin, and alternating air flow bed.

R13's progress note dated 4/19/17, indicated R13's coccyx pressure ulcer measured 0.5 cm x 0.2 cm x 0.2 cm with 100% granulation tissue. R13's upper right lower pressure ulcer measured 3.6 cm x 2.0 cm x 0.3 cm with 100% granulation tissue noted and a white in the center measuring 2.4 cm x 0.7 cm. R13's lower right lower leg pressure ulcer measured 2.2 cm x 1.4 cm x 0.2 cm with 100% granulation tissue.

R13's progress note dated 4/25/17, indicated plastic surgery was contacted and R13's treatment to the right lower extremity back to hydrogel gauze twice daily. Pictures of R13's wounds were sent to plastic surgeon, as follow-up appointment would be canceled if wounds were improved.

R13's progress notes dated 5/8/17, indicated

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R13's coccyx pressure ulcer had healed. Treatment was changed to Calmoseptine. R13's upper right lower leg pressure ulcer measured 3.3 cm x 1.8 cm x 0.1 cm with 100% granulation. R13's lower right lower pressure ulcer measured 1.7 cm x 1.0 cm x 0.1 cm with 100% granulation tissue.

R13's progress notes indicated pressure ulcers were monitored and assessed routinely from 1/4/17 through 5/23/17.

A Changes in Resident Care Plan communication form dated 1/30/17, directed the use of wedge for repositioning, and a communication form dated 3/21/17, directed the use of blue heel lift boots bot feet at all times except with cares for inspection and to continue to use a pillow under the right knee to elevate leg. The changes in Resident Care Plan form indicated the communication is passed through shift report three times.

On 5/22/17, at 10:55 a.m. registered nurse (RN)-B verified R13 currently had pressure ulcers on the coccyx and right lower extremity that were acquired in the facility following admission.

On 5/23/17, at 8:01 a.m. R13 was observed to be lying in bed, positioned with positioning device under the left side. R13 was gotten up for breakfast at 9:00 a.m. R13 had blue lift boots on both feet, had a ROHO cushion in the wheelchair, and an alternating air mattress on the bed. R13 was transferred with a lift and the assist of 2 staff back to bed at 10:29 a.m. after eating breakfast. Nursing assistant (NA)-A explained R13's positioning devices with the wedge, blue boots, and pillow so there is no pressure on her

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pressure ulcers. NA-A stated R13 was repositioned every 2 hours.

On 5/23/17, at 10:35 a.m. director of nursing (DON) explained R13 had her scheduled pain medication but was still painful when the blue boot was removed for the dressing change. R13 was to receive another pain medication that was ordered for breakthrough pain and they would wait at least 15 minutes for the dressing change.

On 5/23/17, at 10:58 a.m. RN-B and DON were observed during R13's dressing changes to coccyx and lower leg pressure ulcers. RN-B stated R13's coccyx pressure ulcer was healed. The small reddened area blanched (turned white when pressed, and color returned when pressure released, indicating adequate tissue perfusion or blood flow). RN-B measured R13's upper right lower pressure ulcer at 3.1 cm x 1.6 cm x less than 0.1 cm. The tendon continued to be exposed and measured 2.4 cm x 0.6 cm and the redness around the pressure ulcer extended out 2 cm from the edge of the wound. RN-B described the wound as having slight maceration (caused by moisture), and the wound base as 100% granulation tissue. RN-B measured the lower right lower leg at 1.5 cm x 1.8 cm x 0.1 cm and described it as 100% granulation tissue with 0.5 cm redness surrounding the pressure injury. RN-B applied the treatment and dressings as ordered. R13 slept through the procedure, but said, "Ouch" when the right leg was lifted to place a pillow under it, but did not offer complaints of discomfort when the right leg was in proper position.

On 5/25/17, at 10:01 a.m. RN-B was interviewed and stated upon admission a skin risk

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assessment should be done within the first 24 hours, and verified this was not for R13 until 12/21/17, seven days after admission. RN-B stated she would have put R13 on a repositioning program to be repositioned every 2 hours. RN-B verified a repositioning program was not specified for R13 on admission. RN-B stated R13 was admitted with an immobilizer on the right lower leg, and verified there were no specific physician orders regarding the use or removal of the immobilizer. RN-B verified she should have gotten clarification orders for the immobilizer, to see if it could be removed or when to remove it. RN-B stated she had attempted on 12/23/16, to clarify the immobilizer use, but did not get a response, so the nurse practitioner called to get some direction. RN-B verified R13 started a repositioning program on 1/4/17, after a Stage II coccyx pressure ulcer was identified. RN-B stated a tissue tolerance to determine a repositioning schedule for R13 should have been done right away after admission on R13 and the facility standard was, if a resident is at risk, they should be turned every 2 hours, unless it is deemed they could go longer or should go shorter. After the coccyx pressure ulcer was identified, R13 was repositioned side-to-side and the tissue tolerance was completed. RN-B stated R13's right lower leg pressure ulcers were identified on 1/16/17, when the immobilizer was removed. RN-B verified an order to allow removal of the immobilizer was obtained on 1/13/17, and the immobilizer was not removed until 1/16/17. RN-B stated the facility has started an IDT skin meeting that looks at root causes, like mattresses, linens and other things that may help to identify the root cause of skin breakdown. RN-B stated to help prevent R13's pressure ulcers, a tissue tolerance should have been done

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on admission and a clarification on removal of the immobilizer should have been obtained.

The facility policy and procedure for Impaired Skin/Tissue Documentation in Matrix Policy reviewed 4/26/16, directed upon identification of a new wound the appropriate Event is initiated, and upon identification of a pressure wound the Skin Risk Assessment/Braden is completed, reviewed and the care plan is revised as appropriate, including the Tissue Tolerance if applicable. The policy and procedure directed the RN to measure and document on the wounds weekly.

The facility policy and procedure for Skin Risk Assessments and Observations Policy reviewed 4/27/16, directed a comprehensive Skin Risk Assessment/Braden would be done upon admission and when a resident develops a pressure ulcer in the facility. The policy and procedure directed a tissue tolerance would be included as appropriate. Residents who were dependent on bed or chair mobility would be monitored for tissue tolerance while lying and sitting. A weekly Braden Scale is completed for 4 weeks after admission to monitor for changes. The policy and procedure directed a head to toe skin check is done within 8 hours of admission. A tissue tolerance would be done when a Skin Risk Assessment/Braden is completed and when an individualized repositioning schedule is determined, a daily skin inspection by the NAs and a weekly skin inspection by a licensed nurse would be completed.

R152's Face Sheet dated 4/18/17, indicated diagnoses that included diabetes, and acute

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kidney failure.

R152's admission Minimum Data Set (MDS) dated 4/25/17, indicated R152 had moderately impaired cognition, required limited assistance from one staff for bed mobility and transfers. The MDS further indicated R152 did not have any pressure ulcers.

A Head to Toe skin assessment dated 4/18/17, indicated redness between R152's buttocks, and a noted R152 was not at risk of developing a pressure ulcer.

A Skin Risk Assessment dated 4/18/17, indicated R152 did not have any unhealed pressure ulcers, had redness, but did not have any pressure ulcers present. The Braden scale (evaluation of risk) indicated not at risk for pressure ulcers, yet indicated R152 had a potential problem, and the assessment indicated to initiate a plan of care.

An admission nursing note dated 4/18/17, indicated R152 had redness in his abdominal fold, groin and in between his buttocks.

A Care Area Assessment (CAA) dated 4/25/17, indicated not to initiate a care plan due to the Braden score that indicated R152 was not at risk for the development of pressure ulcers. The CAA lacked information regarding the redness on R152's buttocks.

R152's care plan dated 4/28/17, indicated R152 had limited ability to independently complete activities of daily living related to decreased functional mobility secondary to recent illness. The care plan lacked identification of risk of pressure ulcer development or any interventions

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to reduce redness or prevent pressure ulcer development.

A 4/26/17, Braden Scale assessment indicated R152 had no skin impairment, and was not at risk for pressure ulcers.

A 5/2/17, Braden Scale assessment indicated R152 had no skin impairment, and was not at risk for pressure ulcers.

A nurse practitioner (NP) note dated 5/2/17, indicated R152 was seen for the recent development of a pressure ulcer on his coccyx. The note indicated R152 reported that the wound hurt, and R152 was now avoiding putting pressure on that area. The NP ordered Mepilex (foam dressing to assist with management of drainage and prevent maceration of wounds) to the pressure ulcer and to continue pressure relief.

A progress note dated 5/3/17, indicated R152 had developed a Stage 2 pressure ulcer on his coccyx that measured 2.0 centimeters (cm) by 0.5 cm by 0.2 cm. The surrounding skin was macerated (soft, white). The note further indicated R152 tolerated the application of the Mepilex well. An order was received that day to apply Mepilex foam border to coccyx pressure ulcer once a day on Wednesdays.

A discharge note dated 5/12/17, indicated the continued presence of a Stage 2 pressure ulcer on R152's coccyx.

On 5/24/17, at 2:14 p.m. registered nurse (RN)-A stated R152 was identified as not at risk of developing pressure ulcers on admission, but did develop a pressure ulcer on 5/3/17. RN-A stated

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the pressure ulcer was still present when R152 discharged. RN-A stated the facility found the pressure ulcer when R152 verbalized that his bottom hurt. RN-A stated the pressure ulcer was small with macerated edges, no drainage.

On 5/24/17, at 2:50 p.m. RN-C stated she completed R152's s admission skin assessment. RN-C stated she had noted redness in between R152's buttocks, but did not note if it was blanchable, but should have, and usually does. RN-C confirmed that redness may indicate R152's skin was at risk, and she should have ordered interventions to prevent pressure ulcers and to monitor the redness. RN-C confirmed she did not put prevention interventions into place nor ensure monitoring of the area.

On 5/25/17, at 8:54 a.m. the director of nursing (DON) stated an area with redness should be monitored, and interventions put in place to decrease the risk of development of pressure ulcers. The DON also stated she would have expected to have the red area identified as blanchable or not blanchable, and the clinical nurse to work to determine the cause of the redness.

The facility policy Skin Risk Assessment and Observation dated 1/1/11, directed a comprehensive skin risk assessment and Braden assessment are to be completed upon admission, including a tissue tolerance observation. In addition, the policy directed if redness or discoloration does not resolve within 15 minutes after pressure has been relieved to an area, the licensed nurse is to be notified and a tissue tolerate observation completed.

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F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431		7/7/17

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ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(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 431	Continued From page 37 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document, review the facility failed to store medications at the appropriate temperature in 1 of 3 medication refrigerators. Findings include: On 5/24/17, at 10:12 a.m. during tour of the medication refrigerators with registered nurse (RN)-E, the medication refrigerator temperature log was noted to have been as low as 34 degrees Fahrenheit (F) over the month of May. RN-E verified the contents of the refrigerator included three unopened Lantus insulin pens and eight unopened NovoLog insulin pens. Per manufacture's recommendations unopened Lantus insulin pens should be stored in a refrigerator 36 degrees F to 46 degrees F. NovoLog insulin pens should be stored in a refrigerator between 36 degrees F to 46 degrees F.	F 431	Medication that was stored in the affected refrigerator has been pulled. The STORAGE OF MEDICATION POLICY has been reviewed remains appropriate. The affected refrigerator will be replaced. Licensed staff will be trained on the STORAGE OF MEDICATION POLICY on 06-28-17. The Plant Operation Manager or designee will complete audits daily to assure that medication refrigerators are maintaining appropriate temperatures. Monitoring will be completed at a consistent level (daily) until compliance is achieved. Monitoring will then be completed at a	

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F 431	Continued From page 38 On 5/24/17, at 12:06 p.m. the director or nursing (DON) verified the temperature of the refrigerator had times when it had been lower than 36 degrees F. Medication refrigerator temperature log for May 2017 recorded six days in which temperature was outside the recommended parameters below 36 degrees. The facility's Storage of Medication policy dated 11/14, directed staff to document refrigerator temperature daily, if temperatures are found to be outside the parameters, medications were to be moved, DON and/or maintenance were to be notified.	F 431	level to maintain compliance as determined by the QC. The Director of Nursing is responsible	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		7/7/17

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F 441	Continued From page 39 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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F 441	Continued From page 40 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility failed to ensure hand hygiene was maintained for 2 of 3 residents (R18, R95) observed during personal cares. Findings include: R18's Face Sheet printed 5/25/17, indicated R18's diagnoses included Alzheimer's disease and urinary tract infection. R18's quarterly Minimum Data Set (MDS) dated 5/10/17, indicated R18 had severely impaired cognition, and required extensive assistance of two staff with personal hygiene and toilet use. The MDS also indicated R18 was frequently incontinent of urine and always incontinent of bowel. On 5/23/17, at 9:05 a.m. R18 was observed during morning cares with nursing assistants (NA)-A and NA-B. Both NAs donned gloves. NA-A lowered R18's brief. NA-B washed R18's peri area. Wearing the soiled gloves, NA-B opened and closed the bathroom door with each time she needed soapy or wet wash cloths. NA-B washed R18's buttocks. R18 was incontinent of a small amount of feces. NA-B applied a barrier cream to R18's buttocks, removed her soiled gloves and donned new gloves. NA-B did not wash or sanitize her hands. NA-A applied R18's incontinent brief and set up the wheelchair. Both	F 441	R18 and R95 have had no ill effects and remain at their prior level of functioning. This deficient practice has the potential to affect all other residents. NA-A, NA-B, and NA-C received one-to-one training regarding hand hygiene. A new HAND HYGIENE POLICY has been developed. All staff will be trained on the new policy. The Infection Preventionist or designee will complete daily audits of Nursing staff for compliance with infection control policies and procedures with a focus on hand washing. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Infection Preventionist or designee will complete weekly audits of non-nursing staff for compliance with infection control policies and procedures with a focus on	

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F 441	Continued From page 41 NAs assisted R18 to roll side to side while adjusting R18's clothes and placed the lift sling. NA-A removed her gloves and did not wash or sanitize her hands. NA-B connected the overhead lift to the sling. NA-B lifted then lowered R18 into the wheelchair, using the lift controls. NA-B moved the lift back into the bathroom, removed her gloves. NA-B did not wash or sanitize her hands. NA-B turned off the bathroom light, applied a blanket to R18' lap and offer to brush R18's teeth. R18 declined until after breakfast. NA-B combed R18's hair. NA-A washed her hands and made R18's bed. NA-B then brought R18 to the dining room for breakfast. NA-B applied R18's cover up, served R18 two glasses of juice, retrieved R18's breakfast from the dietary staff serving breakfast and served it to R18. NA-B returned to R18's room, opened drapes, applied the trash can liner, pulled the string to shut the light off and exited the room. NA-B did not wash or sanitize her hands. NA-B then went into the next room and started making the bed. NA-B washed her hands in the bathroom after making the bed in the other room. On 5/23/17, at 9:35 a.m. NA-B verified she did not wash or sanitize her hands but did change her gloves. NA-B stated she sometimes washed her hands but it was hard to get gloves on after washing or sanitizing. On 5/24/17, at 1:15 p.m. registered nurse (RN)-F the infection control nurse, stated staff should not be touching the doors during and after peri care. Staff should wash or sanitize their hands between glove changes and before exiting the resident rooms.	F 441	hand washing. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Infection Preventionist is responsible.	

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F 441	Continued From page 42	F 441		

R95's Cumulative Diagnosis List dated 12/10/15, indicated R95's diagnoses included cerebral infarction, hemiplegia affecting right side, and mild cognitive impairment.

R95's annual Minimum Data Set (MDS) dated 11/16/17, indicated R95 needed extensive to total assistance to complete activities of daily living (ADLs).

On 5/23/17, at 9:44 a.m. nursing assistant (NA)-C assisted R95 onto the bed for a nap with ceiling lift. NA-C set up supplies for incontinence care on the stand to the right of the bed, and donned gloves. NA-C rolled R95 from side to side, and tucked soiled clothing and incontinent brief under R95's left and right side. Fecal matter soiled the back of R95's shirt and pants. NA-C used personal care wipes to cleanse R95's skin of fecal matter. NA-C used a clean wipe to wipe the stool from her gloves, then proceeded to open the bed side stand table by the handle for a clean incontinence brief. NA-C placed half the clean incontinent brief under R95, turned him to his back and cleansed his front periarea. NA-C removed her gloves. NA-C donned new gloves, but NA-C did not perform hand hygiene. NA-C turned R95 and removed the soiled incontinent brief. NA-C utilized the personal cleansing wipes to remove fecal matter from R95's skin. Another staff member knocked on the door and asked if help was needed; NA-C responded no. NA-C reached over with the soiled gloved hand and turned the call light button off. After all soiled clothes, linens and products were removed from R95, NA-C removed the soiled gloves, and did

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F 441	Continued From page 43 not perform hand hygiene. NA-C went to the closet and removed clean clothing for R95. NA-C assisted R95 with dressing. When dressing was completed, NA-C put new gloves on, bagged soiled clothing and linens, removed gloves and washed hands. On 5/23/17, at 10:08 a.m. NA-C verified her gloves were contaminated, and she had not done proper hand hygiene or proper glove changes. NA-C verified she normally performs hand hygiene, but did not do it at the time. On 5/24/17, at 9:47 a.m. the director of nursing (DON) verified hand washing or sanitizing should have been conducted after removal of dirty gloves and that the environment should not be touched with dirty gloves. The facility's Hand Hygiene policy dated 11/21/16, directed staff to perform hand hygiene after the removal of gloves, when visibly soiled and after direct contact with body excretions.	F 441		
F 465 SS=B	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.	F 465		7/7/17

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F 465	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary environment in 8 of 35 resident bathrooms (Rooms 37, 41, 42, 66, 68, 69, 73, 76). Findings include: On 5/24/17, at 10:00 a.m. during the environmental tour with the plant operations manager (PM) and the housekeeping director (HD) the following environmental findings were verified: Room 37, the toilet riser bars had a blue tape like material wrapped around them. The transfer bar on the wall next to the toilet had a rough gray colored tape with the blue tape over it wrapped around the transfer bar. Both ends were lifting up and secured with a clear tape. This made both areas an uncleanable surface. Room 41, the transfer bar on the wall next to the toilet had a blue tape like material wrapped around it. Both ends of the tape were pulled away from the bar. This made the transfer bar an uncleanable surface. Room 42, the transfer bar on the wall next to the toilet had a blue tape like material wrapped around it. The ends of the tape were loose with a long hanging end. This made the transfer bar an uncleanable surface. Room 66, the transfer bar on the wall next to the toilet had a blue tape like material wrapped around it. Both ends of the tape were pulled away	F 465	The blue and gray tape has been removed from Rooms 37, 41, 42, 66, 68, 69, 73, and 76. Plant Operations will check all other rooms to assure that no other tape is present on toilet handrails or grab bars. The COMPLETE RESIDENT ROOM POLICY and CLEANING RESIDENT BATHROOMS policies have been reviewed and revised. Nursing, Therapy, and Plant Operations have been informed not to utilize such product for toilet handrails and grab bars. Housekeeping will be trained on updated policies on 6-28-17. Housekeeping will complete audits weekly on all three wings to assure that the toilet handrails and grab bars are free of tape. The Plant Operations Manager is responsible.	

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F 465	Continued From page 45	F 465		

from the bar approximately three to four inches. This made the transfer bar an uncleanable surface.

Room 68, the transfer bar on the wall next to the toilet had a rough gray colored tape like material wrapped around it. Both ends of the tape were pulled away from the bar approximately one inch. This made the transfer bar an uncleanable surface.

Room 69, the transfer bar on the wall next to the toilet had a blue tape like material wrapped around it. The bottom end of the tape was pulled away from the bar approximately two inches. This made the transfer bar an uncleanable surface.

Room 73, the horizontal and vertical transfer bars on the wall next to the toilet had rough gray colored tape like material wrapped around both of them. The top end of the tape on the vertical bar was pulled away from the bar approximately two inches. Both ends of the tape on the horizontal bar were pulled away from the bar approximately six inches. This made the transfer bar an uncleanable surface.

Room 76, the transfer bar on the wall next to the toilet had a blue tape like material wrapped around it. The bottom end of the tape was pulled away from the bar approximately six inches. This made the transfer bar an uncleanable surface.

During the tour, the PM stated the maintenance staff check the resident rooms on a regular basis. Staff also send the maintenance department repair slips. The PM further stated the non-skid strips on the transfer bars were ordered by nursing and applied by the maintenance staff.

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F 465	Continued From page 46 The facility was currently using the blue tape because it was better and was removable. The gray tape had adhesive and was difficult to remove. The HD stated she was unaware of how to clean the tape on the transfer bars. The HD further stated if the tape was removable it could be removed when the resident discharged from the facility. The facility's Complete Resident Room policy dated 4/14, directed a complete cleaning of the resident room was to be done about every eight weeks or more often if needed. The policy directed to clean and sanitize the bathroom as directed on the Cleaning Resident Bathrooms policy. (This policy was not provided by the facility).	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Michael's Health and Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/20/2017

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 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Thsi facility was inspected as one building. St Michael's Health and Rehab Center's is a one-story building constructed in 1967, that was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this inspection the building was inspected as a Type V(000), which meets the standard. The facility to include the original 1967 building and the two additions have a full basement. The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 83 beds. At the time of the survey the census was 76. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 163 SS=C	NFPA 101 Interior Nonbearing Wall Construction Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install non-combustible framing, above the ceiling, in two locations in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3. This deficient practice could effect 30 of the 76 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 AM and 2:30 PM on 05/23/2017, it was observed that in two areas above the ceiling in tub rooms of "A & B" wings limited combustible framing material has been used. This observation has been cited prior to this inspection during both a Federal Monitoring	K 163	Annual Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division)	6/30/17

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ST MICHAELS HEALTH & REHAB CENTER	**1201 8TH STREET SOUTH** **VIRGINIA, MN 55792**

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K 163	Continued From page 3 Survey on 03/19/2013, and during the state agency inspections, and has been address through the issuance of an annual wavier for each inspection date. This deficient practice was confirmed by the Maintenance Supervisor.	K 163		
K 252 SS=C	NFPA 101 Number of Exits - Corridors Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to provided proper means of egress from the basement storage area under the "A" wing, in accordance with the NFPA Life Safety Code 101 2012 edition section 19.2.1. This deficient practice could effect all occupants as well as an undetermined number of staff, and visitors that would need to evacuate this area in an emergency. Note: residents are not allowed in this area. Findings include: On facility tour between 10:30 AM and 2:30 PM on 05/23/2017, it was observed that the storage area in the basement, under the "A" wing, only	K 252	Annual Waiver Requested (CMS-2786R to be mailed to MN State Fire Marshall Division)	6/30/17

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K 252	Continued From page 4 has one exit. This area is approximately 7, 290 square feet in size. Rooms over 2,500 square feet require two remote exits. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on 03/19/2013, and during the state agency inspections and has been address through the issuance of an annual wavier for each inspection date. This deficient practice was confirmed by the Maintenance Supervisor.	K 252		
K 331 SS=F	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient practice could effect all 40 of 76 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 AM and 2:30 PM	K 331	Annual Waiver Requested (CMS-2786R to be mailed to MN State Fire Marshall Division)	6/30/17

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K 331	Continued From page 5 on 05/23/2017, it was observed that the facility has carpet applied to the corridor walls on both levels, within 12 inches of the floor. This observation has been cited prior to this inspection during both a Federal Monitoring Survey on 03/19/2013, and during the state agency inspection on 03/12/2014, 02/10/2015, and 04/05/2016. At the time of the inspection the facility had corrected this condition throughout the "C" wing, and has submitted an annual wavier, at the time of this inspection the removal has still not been completed. This deficient practice was confirmed by the Maintenance Supervisor.	K 331		
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm	K 345	The Plant Operations Manager verified with ESC Systems and the 2nd duct had been sensitivity tested on 10-13-2016. ESC confirmed that there was a clerical error in the report. A corrected report was	5/24/17

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K 345	Continued From page 6 Code 2010 edition, section 7-3.2.1. This deficient practice could affect 76 of 76 residents,as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:30 AM and 2:30 PM on 05/23/2017, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was found that the smoke detector sensitivity test report show that only 1 of 2 duct smoke detectors had been sensitivity tested during the fire alarm smoke detector sensitivity test conducted on 10/13/2016. This deficient practice was confirmed by the Maintenance Supervisor.	K 345	received on 5/24/17 and sent to the fire marshal that completed the inspection via email on 5/24/17. At the next annual inspection the Plant Manager will verify that the Fire Alarm and Life Safety System Inspection Certificate is accurate at the time of issuance. The Plant Manager is responsible	
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on	K 363		5/24/17

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K 363	Continued From page 7 corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 2 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition. This deficient practice could affect 20 of 76 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:30 AM and 2:30 PM on 05/23/2017, observations revealed that the corridor door to the activity's storage closet located by resident room 22 did not fully close and latch when tested during the facility survey. This deficient practice was confirmed by the	K 363	The latch on the two doors has been repaired and is now operable and the doors close fully. The Plant Operations Manager or designee will conduct weekly audits to assure that the latch is working properly and the door close fully. The Plant Operations Manager is responsible.	

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K 363	Continued From page 8 Maintenance Supervisor.	K 363		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, that the facility has failed to install the facility's heating and ventilation in accordance with the NFPA Life Safety Code 101 2012 edition section 19.5.2.1 and NFPA 90A 19.5.2.2. This deficient practice could effect 76 of 76 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 AM and 2:30 PM on 05/23/2017, it was observed and confirmed by interview, with the Director of Maintenance that there are corridors being used as a return air plenum in the "A & B" wings. This deficient practice was confirmed by the Maintenance Supervisor.	K 521	Annual Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division)	6/30/17
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		5/24/17

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K 712	Continued From page 9 conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 20 of 20 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 AM and 2:30 PM on 05/23/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not transmit a fire alarm signal to the alarm monitoring company for 2 of 12 fire drills This deficient practice was confirmed by the Maintenance Supervisor.	K 712	The Plant Operations Manager confirmed that the fire alarm signal to the alarm monitoring company was transmitted by him later in the same day that the drill was conducted because a coded alarm was used instead of an audible alarm at the time that the drill was completed on midnight shift. The Fire Drill Documentation Form has been updated to include documentation of a non-audible alarm and further documentation of the transmission of the fire alarm signal to the alarm monitoring company after 6:00 a.m. when residents are not sleeping. The Administrator or designee will audit midnight drills quarterly to ensure that transmission of the fire alarm signal to the alarm monitoring company has been documented. The Administrator is responsible.	