MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: K89M
Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245277**

2. STATE VENDOR OR MEDICAID NO. (L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **08/26/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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): On August 26, 2014 a Post Certification Revisit (PCR) was completed to verify correction of deficiencies reissueda the time of the July 21, 2014 PCR pursuant to the May 23, 2014 standard survey, effective August 19, 2014. As a result remedies recommended to the CMS Region V office will not be imposed. Effective August 19, 2014, the facility is certified for 76 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 09/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 10/13/2014 (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 **04/01/1985** (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 **07/03/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245277

October 13, 2014

Mr. David Vandergon, Administrator
St Raphaels Health & Rehab Center
601 Grant Avenue
Eveleth, MN 55734

Dear Mr. Vandergon:

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 August 19, 2014 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 19, 2014

Mr. David Vandergon, Administrator
St Raphaels Health & Rehab Center
601 Grant Avenue
Eveleth, MN 55734

RE: Project Number S5277023

Dear Mr. Vandergon:

On August 5, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 10, 2014. (42 CFR 488.422)

On August 5, 2014, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 23, 2014. (42 CFR 488.417 (b))

In addition, in our letter of August 5, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 23, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on May 23, 2014 , and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on July 21, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On August 26, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 21, 2014, as of August 19, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 19, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of August 5, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 23, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 23, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 23, 2014, is to be rescinded.

In our letter of August 5, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 23, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 19, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245277	A. Building B. Wing	8/26/2014

Name of Facility	Street Address, City, State, Zip Code
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	**08/19/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**08/19/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	**08/19/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**08/19/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PLH/mm	09/17/2014	29625	08/26/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/23/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: K89M

Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245277**
2. STATE VENDOR OR MEDICAID NO. (L2) **175197200**
3. NAME AND ADDRESS OF FACILITY
   - (L3) **ST RAPHAELS HEALTH & REHAB CENTER**
   - (L4) **601 GRANT AVENUE**
   - (L5) **EVELETH, MN** (L6) **55734**
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 **07/21/2014** (L34)
7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
   - 01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA
8. ACCREDITATION STATUS: __ (L10)
   - 0 Unaccredited, 1 TJC, 2 AOA, 3 Other

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION
    - From (a) :
    - To (b) :
12. Total Facility Beds **76** (L18)
13. Total Certified Beds **76** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:

- __ 2. Technical Personnel
- __ 3. 24 Hour RN
- __ 4. 7-Day RN (Rural SNF)
- __ 5. Life Safety Code
- __ 6. Scope of Services Limit
- __ 7. Medical Director
- __ 8. Patient Room Size
- __ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 — Chris Elmgren, HFE NEII — Date: 08/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Mark Meath, Enforcement Specialist — Date: 09/02/2014 (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 **04/01/1985** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)
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
27. ALTERNATIVE SANCTIONS
    - A. Suspension of Admissions: (L44)
    - B. Rescind Suspension Date: (L45)
28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **07/03/2014** (L33)

DETERMINATION APPROVAL

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

CCN: 24-5277

On July 21, 2014, a Post Certification Revisit (PCR) was completed. The PCR determined deficiencies issued pursuant to the May 23, 2014 survey had not been corrected. As a result this of the PCR findings, this Department imposed the Category 1 remedy of State Monitoring, effective August 6, 2014.

In addtion we recommended to the CMS Region V Office that the following enforcement remedy be imposed:

-Mandatory Denial of Payment for New Admissions (MDPNA), effective August 23, 2014

If MDPNA goes into effect the facility would be subject to a two year loss of NATCEP beginning August 23, 2014.

Refer to the CMS 2567b for both health and life safety code and the CMS 2567 (for health only) along with the facility's plan of correction. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 1, 2014

Mr. David Vandergon, Administrator
St. Raphael's Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number S5277023

Dear Mr. Vandergon:

On June 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 23, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 21, 2014, the Minnesota Department of Health and on June 25, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 23, 2014. The deficiencies not corrected are as follows:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective August 6, 2014. (42 CFR 488.422)

However, as we notified you in our letter of June 5, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 23, 2014.

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 23, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 23, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 23, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Raphaels Health & Rehab Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 23, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services

Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802
Telephone: (218) 302-6151   Fax: (218) 723-2359

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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 allegation of compliance and/or 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 23, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

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

INFORMAL DISPUTE RESOLUTION

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

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

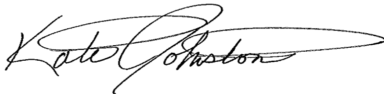
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING ______ B. WING ______	R 07/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	**601 GRANT AVENUE EVELETH, MN 55734**

(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 A post certification resurvey (PCR) was completed on 7/21/14 by surveyors of the Minnesota Department of Health to follow-up on the citations issued for the survey exit 5/20/14. There were one or more deficiencies that were found to be in compliance and these can be found on the CMS2567B. The deficiencies that have not been found to be in compliance at the time of this PCR and these can be found on this CMS2567 form. 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, a second on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment	{F 157}		8/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE 08/14/2014

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.

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

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	245277	A. BUILDING ______ B. WING ______	R 07/21/2014

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{F 157}	Continued From page 1 significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility did not ensure physician notification related to discharge and catheter care for 1 of 3 residents (R104) reviewed as new admissions. Findings include: R104's physician was not notified when the urinary catheter removed prior to leaving the facility against medical advice (AMA). According to the hospital discharge summary dated 6/26/14, R104 was treated for se[sis from an urinary tract infection (UTI), severe failure to thrive (FTT) and chronic liver failure. R104 was admitted with a foley catheter, according to the discharge summary. The summary indicated staff attempted	{F 157}	F 157 Notify of Changes Resident 104 no longer resides in the facility. Residents with an accident in which results in injury and / or has the potential for requiring physician intervention, a significant change in the resident□s physical, mental, or psychological status, a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility, a change in room or roommate assignment, or a change in resident rights under Federal or State law or regulations dating June 26, 2014 or later have been reviewed for	

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{F 157}	Continued From page 2 to remove the catheter but R104 was unable to void and the catheter was reinserted. R104 left the facility AMA on 7/7/14. A nursing progress note dated 7/5/14 identified R104 was admitted for therapy and had a history of leaving AMA. On 7/7/14 at 9:43 am progress notes indicated R104 refused her medications stating she was nauseous. R104 refused anti-nausea medication when it was offered. At 12:42 pm R104 refused therapy stating she wouldn't participate until the catheter was removed. At 3:40 pm resident and family spoke with nursing about ramifications of AMA discharge. At 4:56 pm R104 discharged AMA with family. There was no evidence the physician was notified regarding status of catheter or the resident request for discharge. On 7/22/14 at 10:25 am RN-A stated the nurse practitioner (NP) was at the facility the morning of 7/7/14. They were uncertain if R104 would actually leave as social service and nursing was working with R104 and family to stay in the facility until strong enough for discharge. RN-A stated she sent an email regarding R104's discharge to the NP on 7/7/14; however, the NP did not respond until 7/8/14. At 10:55 am RN-A clarified the AMA discharge form dated as signed by R104, facility staff and the physician on 7/7/14 was actually signed by the physician on 7/9/14. RN-A further stated she received a verbal order from the nurse practitioner to remove the catheter but there was just no time to document it. On 7/21/14 at 4:05 pm the director of nursing was unable to provide any additional information.	{F 157}	notification and this continues to be audited during daily IDT meetings. DON or designee will complete audits for notifications during the daily IDT meetings. DON or designee will complete audits for notification for daily IDT meetings for 4 weeks and then 3 times a week for 4 weeks. And then audits will be completed weekly. Nursing staff have reviewed the Changes in Condition □ Status Notification Policy. Compliance will be achieved by 8-19-14	
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	{F 279}		8/19/14

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{F 279}	Continued From page 3 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not develop comprehensive temporary care plans for 2 of 3 residents (R104, R79) reviewed as new admissions. Findings include: R104 did not have a care plan to address catheter use or safety needs due to weakness. According to the hospital discharge documentation dated 6/26/14 R104 had diagnoses including sepsis with a urinary tract infection (UTI), severe failure to thrive (FTT) and anxiety. The documents also identified R104 was alert and oriented with a foley catheter. Hospital	{F 279}	F 279 Comprehensive Care Plan Resident 104 no longer resides in the facility. Resident 79 has had a pain care plan developed. Residents currently taking a narcotic analgesic have been reviewed for a pain care plan. Other residents will have a pain assessment completed upon new identification of pain and following the RAI process. Residents admitted on or after 7-21-14 have been reviewed for a safety plan. All kardexes have been reviewed and are	

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{F 279}	Continued From page 4 staff attempted to remove the catheter but R104 was unable to void. The notes directed the receiving facility to arrange an appointment with urology. R104 discharged on 7/7/14. R104's admission assessment dated 6/27/14 revealed she was continent of bowel and had a catheter. It further revealed she required limited assistance from one person for toileting. The bowel and bladder assessment dated 6/29/14 revealed R104 was continent of bowel and bladder and required the assistance of 1 to 2 staff "depending on her weakness level." Review of R104's Fall Risk Assessment dated 6/27/14 revealed her to be at risk for falls. A progress note dated 6/29/14 stated R104 required assist of 1-2 staff for toileting depending on her weakness level. A progress note for 6/30/14 revealed R104, "Almost fell and she is very afraid of falling." On 7/1/14 R104 progress notes identified R104 was lowered to the floor in the bathroom while being assisted with perineal cares following bowel incontinence. On 7/5/14 R104 requested assistance to void and was reminded she had a catheter. She was then, "Helped to relax and resident then did let urine pass in tubing." On 7/7/14 R104 refused to participate in therapy unless the catheter was removed. On 7/7/14, R104 discharged against medical advice. R104's temporary care plan indicated continence of bowel and bladder and the area and did not address the foley catheter. The temporary care plan directed 2 assist with all transfers and ambulation with stand by assistance of 1 person and the wheeled walker. An undated temporary fall care plan directed staff to keep the call light	{F 279}	accurate. Residents with events continue to be reviewed at the daily IDT meetings. Changes in Condition - Notification Policy, Medication and Treatment Orders Policy, Event Policy, Pain Management Policy, Fall Policy, Interim Care Plan Policy and the NAR Resident Reference Sheet (KARDEX) Policy have been reviewed with nursing. Temporary care plans are created from admission information and are updated daily/or as needed, as assessments are completed or concerns arise. Process changes now include completion of the assessment, then completion of the care plan. All care plans will be update as assessments are completed or as new issues are identified; following the nursing process. The RAI manager or designee will audit all admission comprehensive care plans to assure all triggered areas of concern have a care plan decision beginning 8-11-14 following the RAI process. Auditing will continue until compliance is achieved and then will be completed randomly to assure compliance is maintained. The RAI manager is part of the IDT morning meetings and has good knowledge of the residents. An Admission Assessment Checklist has been developed to assist with the admission process and shift to shift communication and has been reviewed with nursing. DON or designee will complete audits for notifications during the daily IDT meetings. DON or designee will complete	

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{F 279}	Continued From page 5 in reach, use gripper socks, keep room free of clutter and staff assist to bathroom. The care plan did not address the level of assistance required for transfers, toileting or risk of falls. On 7/21/14 at 2:00 pm RN-A verified the temporary care plan was current at the time R104's discharge. On 7/21/14 at 3:10 pm the director of nursing (DON) stated R104 did not require specific interventions because the nursing care needs were just "nursing 101." The DON further stated R104 was so weak that she was admitted on a gurney. The facility policy for Interim (Temporary) Care Plan effective 5/1/09 identified these plans of cares should be developed within 24 hours of admission based on admission information from admitting facility and initial assessment information. The policy further clarified the purpose of the interim plan was to guide the provision of care from the time of admission to ensure staff met resident needs. R79 was admitted on 7/4/14, following a total left hip arthroplasty. Other diagnoses included chronic inflammatory demyelinating polyneuritis and previous gastric bypass. Social service notes on 7/8/14 revealed R79 to be alert and oriented. R79's pain assessment completed 7/6/14 indicated them most severe pain was rated 8 out of 10. According to resident report medications help to manage the pain as did elevating the left leg, rest and ice. Staff was to observe for verbal and non-verbal signs of pain and report to the nurse. The nurse was to provide pain medications and utilize non-pharmacological interventions. The 7/19/14 pain assessment identified, "Pain ranging from a 6-9 depending on activity level and	{F 279}	audits for notification for daily IDT meetings for 4 weeks and then 3 times a week for 4 weeks. And then audits will be completed weekly. Correction date will by 8-19-14	

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{F 279}	Continued From page 6 time of day." Assessment otherwise unchanged. Record review revealed R79 had no care plan for managing her pain. R79's current pain medications included Tylenol 325 mg 2 tablets four times a day; lidocaine 5% patch 1 patch on in am and off at night; and Norco 5-325 mg 1-2 tablets every 4-6 hours as needed for pain. Review of nursing progress notes identified when R79 received pain medications on a routine basis she was better able to care for herself and had more flexibility in addition to a decrease in pain. Physician orders dated 7/17/14, changed routine narcotic pain medications to as needed (PRN) and to taper narcotic pain medications. R79, interviewed on 7/21/14 at 4:20 p.m., stated, "The pain is still horrible." R79 had long standing issue with pain and had been taking narcotic pain and antianxiety medications on a regular basis at home. R79 stated the scheduled Norco was much more helpful. R79 rated pain at 7-9 most of the time without the routine pain medication. R79 stated physical therapy provided several non-pharmacological interventions which were very effective. When asked if any non-pharmacological interventions were utilized by nursing staff, R79 stated they were not. Review of progress notes and treatment records supported this statement. Interview with the director of nursing (DON) on 7/21/14, at 3:45 pm verified there was no care plan in place to manage R79's pain. The DON believed the pain management plan for R79 was effective as she could ask for pain interventions when she needed them.	{F 279}		

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{F 309}	Continued From page 7	{F 309}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure a comprehensive pain management program was developed and effectively implemented for 1 of 3 residents reviewed (R79) with pain. Findings include: R79 was admitted on 7/4/14, following a total left hip arthroplasty. Other diagnoses included chronic inflammatory demyelinating polyneuritis and previous gastric bypass. Social service notes on 7/8/14 revealed R79 to be alert and oriented. R79's pain assessment completed 7/6/14 revealed the worst pain was rated 8 out of 10 and medications help to manage the pain as did elevating the left leg, rest and ice. Staff was to observe for verbal and non-verbal signs of pain and report to the nurse. The nurse was to provide pain medications and utilize non-pharmacological interventions. The 7/19/14 pain assessment identified pain ranging from a 6-9 depending on activity level and time of day with no additional changes.	{F 309}	F 309 Provide for highest level of well being Resident 79 has had a pain assessment completed, care plan revised on 7/21/14. Residents currently taken a narcotic analgesic have been reviewed for a pain care plan. The EMAR order for narcotic analgesics will now include the task for obtaining a pain scale prior to medication and post medication for effectiveness, and this has been reviewed with nursing. Process changes now include completion of the assessment, then completion of the care plan. Care plans will be update as assessments are completed, or as new issues are identified; following the nursing process. An Admission Assessment Checklist has been developed to assist with the admission process and shift to shift communication and has been reviewed with nursing. The RAI manager or designee will audit all	8/19/14

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{F 309}	Continued From page 8 R79's current pain medications included Tylenol 325 mg 2 tablets four times a day; lidocaine 5% patch 1 patch on in am and off at night; and Norco 5-325 mg 1-2 tablets every 4-6 hours as needed for pain. Review of nursing progress notes from 7/4-22/14 revealed R79 continued to have pain on a daily basis. Progress notes on 7/15/14, indicated scheduled narcotic pain medications were more effective. R79 was, "Having a better time doing adl's [activities of daily living], etc. for herself." Nursing notes on 7/16/14 indicated R79 had "Less pain with the [pain] meds now being scheduled." Physician orders from a 7/17/14, appointment directed narcotic medication tapered and included orders for as needed narcotic pain medications. Progress notes on 7/17/14, indicated R79 was upset over the lack of scheduled narcotic medications. R79 stated she had "Less pain and more flexibility" with routine narcotic pain medications. There was no plan to taper the narcotics while still effectively managing pain. Interview with R79 on 7/21/14 at 4:20 pm revealed ongoing problems with pain management. R79 stated the pain was still horrible. R79 had long standing issues with pain and as a result had utilized "marriage" of morphine, OxyContin and Xanax that she took twice a day for a long time to get moving in the morning and to sleep at night along with Tylenol during the day. R79 stated,"It was the only thing that worked." R79 stated that Norco scheduled was much more helpful but the pain currently, "runs a 7-9 most of the time." R79 stated physical therapy provided several non-pharmacological interventions which were very effective. When	{F 309}	admission comprehensive care plans to assure all triggered areas of concern have a care plan decision beginning 8-11-14 following the RAI process. Auditing will continue until compliance is achieved and then will be completed randomly to assure compliance is maintained. The RAI manager is part of the IDT morning meetings and has good knowledge of the residents. Changes in Condition - Notification Policy, Medication and Treatment Orders Policy, Event Policy, Pain Management Policy, Fall Policy, Interim Care Plan Policy and the NAR Resident Reference Sheet (KARDEX) Policy have been reviewed with nursing. DON or designee will complete audits for notifications during the daily IDT meetings. DON will complete audits for notification for daily IDT meetings for 4 weeks and then 3 times a week for 4 weeks. And then audits will be completed weekly. Correction date will by 8-19-14	

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{F 309}	Continued From page 9 asked about non-pharmacological interventions provided by nursing staff, there were none. R79 stated she asked for an ice pack one evening and was told they didn't have access to those kinds of things. The nurse then came back with a baggy of ice cubes which R79 stated was "Not helpful." Interview with the director of nursing (DON) on 7/21/14 at 3:45 pm verified there was no specific plan in place to manage R79's pain. The DON asked, "Isn't it enough that she can ask" for what she needs? The DON further clarified the physician ordered the taper of R79's narcotic pain medications and they were required to do so.	{F 309}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure comprehensive individualized interventions were in place to minimize the risk for falls for 1 of 3 residents (R104) reviewed for falls. Findings include: R104 was admitted to the facility via stretcher on 6/26/14 from an acute care hospital. According to	{F 323}	F 323 Free of Accidents Resident 104 no longer resides in the facility Residents admitted as of 7-21-14 have been reviewed for safety care plans and interventions. Process changes now include completion of the assessment, then completion of the care plan. Care plans will be update as	8/19/14

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{F 323}	Continued From page 10 the admitting orders, R104 had multiple diagnoses contributing to safety issues including anemia, anxiety, depression, muscle weakness, lumbar disc degeneration, severe failure to thrive, and malnutrition. R104 also had medications which could impact her safety including anti-anxiety, narcotic, antidepressant, and antipsychotic medications. A nursing progress note dated 6/30/14 revealed R104 almost fell and was afraid of falling. The note further indicated R104 had been in the hospital for nearly 5 months and was very weak. On 7/1/14 nursing progress notes identified R104 had to be lowered to the floor in the bathroom. R104 was receiving perineal cares following an incontinent stool when she became weak and unable to sit on toilet or wheelchair. She was assisted to the floor by facility staff. Interdisciplinary review of the incident did not occur until 7/6/14. Although weakness was identified as a contributing factor, the review failed to identify how many staff was assisting her in the bathroom or if a transfer belt was used. Review of R104's temporary care plan indicated continence of bowel and bladder. The temporary care plan directed 2 assist with all transfers but ambulated with the stand by assistance of 1 person and a wheeled walker. An undated temporary fall care plan directed staff to keep the call light in reach, use gripper socks, keep room free of clutter and staff assist to bathroom. There was no direction for how much assistance for transfers and toileting was needed with transfers or toileting and no update to reflect bowel incontinence. The facility policy for Falls dated as effective 2/06	{F 323}	assessments are completed, or as new issues are identified; following the nursing process. An Admission Assessment Checklist has been developed to assist with the admission process and shift to shift communication and has been reviewed with nursing. Changes in Condition - Notification Policy, Medication and Treatment Orders Policy, Event Policy, Pain Management Policy, Fall Policy, Interim Care Plan Policy and the NAR Resident Reference Sheet (KARDEX) Policy have been reviewed with nursing. DON or designee will complete audits on any residents with an accident or a negative outcome during the daily IDT meetings, to assure interventions have been developed. The audits will continue consistently until compliance is achieved and then at a level to maintain compliance as determined by the IDT. Compliance will be achieved by 8-19-14	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 11 identified a fall to be any time a resident is "relocated to the floor no matter what the height is." The policy directed staff to document in the progress notes every 4 hours for 24 hours. The policy further identified falls would be reviewed by the interdisciplinary team within 24 hours of occurrence.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING ______ B. WING ______	R 07/21/2014

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{F 000}	INITIAL COMMENTS A post certification resurvey (PCR) was completed on 7/21/14 by surveyors of the Minnesota Department of Health to follow-up on the citations issued for the survey exit 5/20/14. There were one or more deficiencies that were found to be in compliance and these can be found on the CMS2567B. The deficiencies that have not been found to be in compliance at the time of this PCR and these can be found on this CMS2567 form. 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, a second on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment	{F 157}		

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

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

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{F 157}	Continued From page 1	{F 157}		

significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on document review and interview the facility did not ensure physician notification related to discharge and catheter care for 1 of 3 residents (R104) reviewed as new admissions.

Findings include:

R104's physician was not notified when the urinary catheter removed prior to leaving the facility against medical advice (AMA). According to the hospital discharge summary dated 6/26/14, R104 was treated for se[sis from an urinary tract infection (UTI), severe failure to thrive (FTT) and chronic liver failure. R104 was admitted with a foley catheter, according to the discharge summary. The summary indicated staff attempted

the facility failed to notify the physician or the resident's representative of a significant change in condition for 1 of 4 residents (R84) reviewed with death records.
R84 was admitted on 1/24/14, for rehabilitation and aftercare following surgery for three benign neoplasms of the frontal cerebral meninges (brain tumors) as noted on the face sheet.

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{F 157}	Continued From page 2 to remove the catheter but R104 was unable to void and the catheter was reinserted. R104 left the facility AMA on 7/7/14. A nursing progress note dated 7/5/14 identified R104 was admitted for therapy and had a history of leaving AMA. On 7/7/14 at 9:43 am progress notes indicated R104 refused her medications stating she was nauseous. R104 refused anti-nausea medication when it was offered. At 12:42 pm R104 refused therapy stating she wouldn't participate until the catheter was removed. At 3:40 pm resident and family spoke with nursing about ramifications of AMA discharge. At 4:56 pm R104 discharged AMA with family. There was no evidence the physician was notified regarding status of catheter or the resident request for discharge. On 7/22/14 at 10:25 am RN-A stated the nurse practitioner (NP) was at the facility the morning of 7/7/14. They were uncertain if R104 would actually leave as social service and nursing was working with R104 and family to stay in the facility until strong enough for discharge. RN-A stated she sent an email regarding R104's discharge to the NP on 7/7/14; however, the NP did not respond until 7/8/14. At 10:55 am RN-A clarified the AMA discharge form dated as signed by R104, facility staff and the physician on 7/7/14 was actually signed by the physician on 7/9/14. RN-A further stated she received a verbal order from the nurse practitioner to remove the catheter but there was just no time to document it. On 7/21/14 at 4:05 pm the director of nursing was unable to provide any additional information.	{F 157}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	{F 279}		

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{F 279}	Continued From page 3 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not develop comprehensive temporary care plans for 2 of 3 residents (R104, R79) reviewed as new admissions. Findings include: R104 did not have a care plan to address catheter use or safety needs due to weakness. According to the hospital discharge documentation dated 6/26/14 R104 had diagnoses including sepsis with a urinary tract infection (UTI), severe failure to thrive (FTT) and anxiety. The documents also identified R104 was alert and oriented with a foley catheter. Hospital	{F 279}	Based on interview and record review, the facility failed to develop care plan interventions related to care and monitoring related to renal dialysis for 1 of 1 (R85) residents reviewed for dialysis. R85's physician's orders dated 5/1/14, listed diagnoses including chronic kidney disease, acute kidney failure, type I diabetes mellitus and hydronephrosis of the left kidney. Physician's orders dated 1/30/14, directed monitoring for thrill (a vibration felt by placing one's hands on the dialysis shunt) to ensure patency.	

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{F 279}	Continued From page 4 staff attempted to remove the catheter but R104 was unable to void. The notes directed the receiving facility to arrange an appointment with urology. R104 discharged on 7/7/14. R104's admission assessment dated 6/27/14 revealed she was continent of bowel and had a catheter. It further revealed she required limited assistance from one person for toileting. The bowel and bladder assessment dated 6/29/14 revealed R104 was continent of bowel and bladder and required the assistance of 1 to 2 staff "depending on her weakness level." Review of R104's Fall Risk Assessment dated 6/27/14 revealed her to be at risk for falls. A progress note dated 6/29/14 stated R104 required assist of 1-2 staff for toileting depending on her weakness level. A progress note for 6/30/14 revealed R104, "Almost fell and she is very afraid of falling." On 7/1/14 R104 progress notes identified R104 was lowered to the floor in the bathroom while being assisted with perineal cares following bowel incontinence. On 7/5/14 R104 requested assistance to void and was reminded she had a catheter. She was then, "Helped to relax and resident then did let urine pass in tubing." On 7/7/14 R104 refused to participate in therapy unless the catheter was removed. On 7/7/14, R104 discharged against medical advice. R104's temporary care plan indicated continence of bowel and bladder and the area and did not address the foley catheter. The temporary care plan directed 2 assist with all transfers and ambulation with stand by assistance of 1 person and the wheeled walker. An undated temporary fall care plan directed staff to keep the call light	{F 279}		

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{F 279}	Continued From page 5	{F 279}		

in reach, use gripper socks, keep room free of clutter and staff assist to bathroom. The care plan did not address the level of assistance required for transfers, toileting or risk of falls.

On 7/21/14 at 2:00 pm RN-A verified the temporary care plan was current at the time R104's discharge. On 7/21/14 at 3:10 pm the director of nursing (DON) stated R104 did not require specific interventions because the nursing care needs were just "nursing 101." The DON further stated R104 was so weak that she was admitted on a gurney.

The facility policy for Interim (Temporary) Care Plan effective 5/1/09 identified these plans of cares should be developed within 24 hours of admission based on admission information from admitting facility and initial assessment information. The policy further clarified the purpose of the interim plan was to guide the provision of care from the time of admission to ensure staff met resident needs.

R79 was admitted on 7/4/14, following a total left hip arthroplasty. Other diagnoses included chronic inflammatory demyelinating polyneuritis and previous gastric bypass. Social service notes on 7/8/14 revealed R79 to be alert and oriented. R79's pain assessment completed 7/6/14 indicated them most severe pain was rated 8 out of 10. According to resident report medications help to manage the pain as did elevating the left leg, rest and ice. Staff was to observe for verbal and non-verbal signs of pain and report to the nurse. The nurse was to provide pain medications and utilize non-pharmacological interventions. The 7/19/14 pain assessment identified, "Pain ranging from a 6-9 depending on activity level and

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{F 279}	Continued From page 6	{F 279}		

time of day." Assessment otherwise unchanged. Record review revealed R79 had no care plan for managing her pain.

R79's current pain medications included Tylenol 325 mg 2 tablets four times a day; lidocaine 5% patch 1 patch on in am and off at night; and Norco 5-325 mg 1-2 tablets every 4-6 hours as needed for pain. Review of nursing progress notes identified when R79 received pain medications on a routine basis she was better able to care for herself and had more flexibility in addition to a decrease in pain. Physician orders dated 7/17/14, changed routine narcotic pain medications to as needed (PRN) and to taper narcotic pain medications.

R79, interviewed on 7/21/14 at 4:20 p.m., stated, "The pain is still horrible." R79 had long standing issue with pain and had been taking narcotic pain and antianxiety medications on a regular basis at home. R79 stated the scheduled Norco was much more helpful. R79 rated pain at 7-9 most of the time without the routine pain medication. R79 stated physical therapy provided several non-pharmacological interventions which were very effective. When asked if any non-pharmacological interventions were utilized by nursing staff, R79 stated they were not. Review of progress notes and treatment records supported this statement.

Interview with the director of nursing (DON) on 7/21/14, at 3:45 pm verified there was no care plan in place to manage R79's pain. The DON believed the pain management plan for R79 was effective as she could ask for pain interventions when she needed them.

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{F 309} Continued From page 7 {F 309}

{F 309} SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING {F 309}

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility did not ensure a comprehensive pain management program was developed and effectively implemented for 1 of 3 residents reviewed (R79) with pain.

Findings include:

R79 was admitted on 7/4/14, following a total left hip arthroplasty. Other diagnoses included chronic inflammatory demyelinating polyneuritis and previous gastric bypass. Social service notes on 7/8/14 revealed R79 to be alert and oriented. R79's pain assessment completed 7/6/14 revealed the worst pain was rated 8 out of 10 and medications help to manage the pain as did elevating the left leg, rest and ice. Staff was to observe for verbal and non-verbal signs of pain and report to the nurse. The nurse was to provide pain medications and utilize non-pharmacological interventions. The 7/19/14 pain assessment identified pain ranging from a 6-9 depending on activity level and time of day with no additional changes.

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FORM APPROVED
OMB NO. 0938-0391

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{F 309}	Continued From page 8 R79's current pain medications included Tylenol 325 mg 2 tablets four times a day; lidocaine 5% patch 1 patch on in am and off at night; and Norco 5-325 mg 1-2 tablets every 4-6 hours as needed for pain. Review of nursing progress notes from 7/4-22/14 revealed R79 continued to have pain on a daily basis. Progress notes on 7/15/14, indicated scheduled narcotic pain medications were more effective. R79 was, "Having a better time doing adl's [activities of daily living], etc. for herself." Nursing notes on 7/16/14 indicated R79 had "Less pain with the [pain] meds now being scheduled." Physician orders from a 7/17/14, appointment directed narcotic medication tapered and included orders for as needed narcotic pain medications. Progress notes on 7/17/14, indicated R79 was upset over the lack of scheduled narcotic medications. R79 stated she had "Less pain and more flexibility" with routine narcotic pain medications. There was no plan to taper the narcotics while still effectively managing pain. Interview with R79 on 7/21/14 at 4:20 pm revealed ongoing problems with pain management. R79 stated the pain was still horrible. R79 had long standing issues with pain and as a result had utilized "marriage" of morphine, OxyContin and Xanax that she took twice a day for a long time to get moving in the morning and to sleep at night along with Tylenol during the day. R79 stated,"It was the only thing that worked." R79 stated that Norco scheduled was much more helpful but the pain currently, "runs a 7-9 most of the time." R79 stated physical therapy provided several non-pharmacological interventions which were very effective. When	{F 309}		

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{F 309}	Continued From page 9 asked about non-pharmacological interventions provided by nursing staff, there were none. R79 stated she asked for an ice pack one evening and was told they didn't have access to those kinds of things. The nurse then came back with a baggy of ice cubes which R79 stated was "Not helpful." Interview with the director of nursing (DON) on 7/21/14 at 3:45 pm verified there was no specific plan in place to manage R79's pain. The DON asked, "Isn't it enough that she can ask" for what she needs? The DON further clarified the physician ordered the taper of R79's narcotic pain medications and they were required to do so.	{F 309}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure comprehensive individualized interventions were in place to minimize the risk for falls for 1 of 3 residents (R104) reviewed for falls. Findings include: R104 was admitted to the facility via stretcher on 6/26/14 from an acute care hospital. According to	{F 323}	Based on observations, interview, document review, the facility failed to comprehensively assess risk for falls and implement fall interventions for 1 of 3 residents in the sample (R14) who had a history of falls. R14, according to the Minimum Data Set (MDS), diagnoses included vertigo, gait abnormality, osteopathic and generalized weakness, experienced 11 falls from	

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{F 323}	Continued From page 10 the admitting orders, R104 had multiple diagnoses contributing to safety issues including anemia, anxiety, depression, muscle weakness, lumbar disc degeneration, severe failure to thrive, and malnutrition. R104 also had medications which could impact her safety including anti-anxiety, narcotic, antidepressant, and antipsychotic medications. A nursing progress note dated 6/30/14 revealed R104 almost fell and was afraid of falling. The note further indicated R104 had been in the hospital for nearly 5 months and was very weak. On 7/1/14 nursing progress notes identified R104 had to be lowered to the floor in the bathroom. R104 was receiving perineal cares following an incontinent stool when she became weak and unable to sit on toilet or wheelchair. She was assisted to the floor by facility staff. Interdisciplinary review of the incident did not occur until 7/6/14. Although weakness was identified as a contributing factor, the review failed to identify how many staff was assisting her in the bathroom or if a transfer belt was used. Review of R104's temporary care plan indicated continence of bowel and bladder. The temporary care plan directed 2 assist with all transfers but ambulated with the stand by assistance of 1 person and a wheeled walker. An undated temporary fall care plan directed staff to keep the call light in reach, use gripper socks, keep room free of clutter and staff assist to bathroom. There was no direction for how much assistance for transfers and toileting was needed with transfers or toileting and no update to reflect bowel incontinence. The facility policy for Falls dated as effective 2/06	{F 323}	10/6/13 through 3/31/14 without interventions introduced to reduce the risk of subsequent falls.	

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{F 323}	Continued From page 11 identified a fall to be any time a resident is "relocated to the floor no matter what the height is." The policy directed staff to document in the progress notes every 4 hours for 24 hours. The policy further identified falls would be reviewed by the interdisciplinary team within 24 hours of occurrence.	{F 323}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245277	01 - MAIN BUILDING 01	6/25/2014

Name of Facility	Street Address, City, State, Zip Code
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	06/13/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	08/01/2014	03005	06/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/20/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: K89M
Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **05/23/2014** (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 **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Chris Elmgren, HFE NEII
Date : 06/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 07/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(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
Posted 07/03/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3674

June 6, 2014

Mr. David Vandergon, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number S5277023

Dear Mr. Vandergon:

On May 23, 2014, 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. In addition, at the time of the May 23, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number .

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 2, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 23, 2014 (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 23, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

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

Enclosure

cc: Licensing and Certification File 5277s14.rtf

RECEIVED JUN 19 2014 MN Dept of Health Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING ____ B. WING ____	05/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Census: 57	F 000	OK 6/20/14 RLN	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	**F 157** Notification of MD St. Raphael's Health and Rehabilitation Center is not able to correct this deficiency for resident 84 as she no longer resides in the facility. Six additional residents having been recently admitted have been reviewed to assure all orders have been verified by an RN and physician notifications completed as needed and documentation supplied in the medical record. Events occurring May 23 an ongoing have been reviewed for appropriate notification. The Change in Condition/Status Notification Requirements Policy has been reviewed and revised to include responsible party notification. The Neurological Assessment Policy was reviewed and remains appropriate. RNs and LPNs received training on the Change in Condition / Status Notification Requirements Policy and the Neurological Assessment Policy.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David C. Vandenberg	Administrator / CEO	6/19/14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician or the resident's representative of a significant change in condition for 1 of 4 residents (R84) reviewed with death records. Findings include: R84 was admitted on 1/24/14, for rehabilitation and aftercare following surgery for three benign neoplasms of the frontal cerebral meninges (brain tumors) as noted on the face sheet. The hospital discharge summary dated 1/24/14, listed diagnoses of meningioma (brain tumor), hypertension (high blood pressure), and dysphagia (difficulty swallowing). The hospital interagency referral form dated 1/24/14, indicated that, at the time of discharge, R84 was alert and followed commands, speech was clear, and she was oriented to place, and person. R84 had some memory and judgement problems, though was able to express her needs and desires, and she was calm and cooperative. The interagency referral discharge instructions directed physician notification of worsening symptoms of headache,	F 157	Interact III Care Pathway Tools have been bounded as a reference for nursing staff regarding physician notification on each wing and staff received training . Daily stand up meeting agendas currently include review of incidents and changes in condition. These reviews will now include monitoring to assure proper notifications have been completed. This monitoring will be completed not less than weekly on all incidents and changes in condition until compliance has been met and then will be reviewed at a level to assure compliance is maintained as determined by the IDT. The Director of Nursing is responsible for monitoring. Compliance will be achieved by June 27, 2014.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 2 nausea, vomiting, weakness, dizziness, memory or speech difficulty, or numbness or tingling. During an interview on 5/22/14, at 3:01 p.m. the director of nursing (DON) verified this monitoring had not occurred. An informed consent for CPR, was signed by R84's power of attorney (POA) and family representative on 1/24/14. R84 was considered to be a full code (full resuscitation efforts). The admission clinical documentation for observation dated 1/24/14, to 1/25/14, appeared to be an undated late entry and indicated R84 had already expired. The documentation indicated R84 had clear speech, was able to make concrete requests, and responded to simple, direct communication only. The clinical documentation further noted R84's pupils to be equal in size, but the left pupil reacted sluggishly and the right pupil reacted briskly. R84 was unable to describe pain and expressed pain by moaning, vocal complaints of pain, facial expressions and protective body movements. Direct care staff were to monitor for pain and communicate to the licensed nurse if pain was noted. The clinical documentation indicated R84 was alert and able to state she hurt, at the time of the assessment. R84's admission vital signs (temperature, pulse, respirations, and blood pressure) were monitored from 1/24/14 through 1/25/14, and were indicated to be stable. The final set of vital signs recorded in R84's medical record was on 1/25/14, at 4:08 p.m. with blood pressure, pulse, respirations, and temperature documented as stable. There were no documented neurological checks after the physician assessment completed on 1/27/14.	F 157		

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

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F 157	Continued From page 3 The progress notes dated 1/26/14, at 12:45 p.m. indicated R84 had been yelling off and on, but no signs or symptoms of pain were noted. R84 was disrobing, very confused, and was difficult to redirect at that time. Lungs were clear and respirations were even and nonlabored, and the head incision was clean, dry, and scabbed over. The physician's visit referral form dated 1/27/14, indicated a chief complaint of meningioma with a poor quality and incapacitating severity. The physician also documented that R84 was having some back pain as far as could be told, vitals were stable, pupils were equal and reactive to light, and the neurological status for R84 was stable, but poor. The progress notes dated 1/28/14, at 10:07 a.m. indicated R84 was yelling out most of the morning and lying with her head on the table. The nurse attempted to give resident her medications and a pain pill four times, but R84 did not take them. R84 would strike out, lay her head on the table and refuse to open her eyes or mouth. R84 did the same at breakfast. At the time of the documentation, R84 was lying down and sleeping. The progress notes dated 1/28/14, at 1:21 p.m. indicated R84 had refused all other medications during the day and had been quiet since lying down, but would not open eyes or mouth. The documentation indicated staff were unable to tell if earlier yelling was due to pain or anxiety. Head incisions were noted to be clean, dry, and scabbing over. R84 was oriented to self. Lungs were clear; respirations were even and nonlabored, according to documentation.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 4	F 157		

The progress notes dated 1/28/14, at 8:59 p.m. indicated R84 could not be aroused with three unsuccessful attempts to administer medications. R84 was in bed sleeping at the time of the documentation.

The progress notes dated 1/29/14, at 4:07 a.m. indicated R84 was unresponsive, the charge nurse was notified, the ambulance was called and R84's daughter was informed.

The progress notes dated 1/29/14, at 4:25 a.m., indicate the family was informed of R84's death.

The medical record lacked documentation of vital signs, neurological assessments, assessments of change in condition, or notification of the physician or the family regarding R84's deteriorating cognitive status prior to her death on 1/28/14.

During an interview on 5/22/14, at 2:26 p.m., the director of nursing (DON) stated her expectation would be to follow the doctors orders and to be especially detailed in the orders related to the resident's condition. The DON verified neurological assessments and vital signs should have been done for R84, and the physician should have been notified to determine appropriate treatment. The DON verified the family should have also been notified of the change in condition.

The policy and procedure for change in condition dated August 2012, directed the facility to notify the resident's physician, and the resident's legal representative or interested family member of a significant change in the resident's physical,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 5 mental, or psychosocial status, a need to alter treatment significantly, or a decision to transfer or discharge the resident from the facility.	F 157	**F 279 Comprehensive Care Plan**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop care plan interventions related to care and monitoring related to renal dialysis for 1 of 1 (R85) residents reviewed for dialysis. Findings includes: R85's physician's orders dated 5/1/14, listed	F 279	Resident 85's care plan was updated to include a Dialysis care plan and graft monitoring was ordered on May 29. Every resident receiving dialysis has been reviewed for care plan interventions and for monitoring of dialysis access sites. The Arteriovenous Shunts for Dialysis Policy was reviewed and revised and RN and LPNs trained. The Dialysis Care Plan and the Shunt/Graft Monitoring order in Matrix will be utilized for residents receiving dialysis. Monitoring for a dialysis care plan and order to observe access site will be completed upon admission by Health Information and the RN; and will be monitored for by the RAI Manager during initial care plan creation. Monitoring will continue for a period of 3 months and then as determined by the IDT team. The Director of Nursing is responsible for monitoring. Compliance will be achieved by June 27, 2014.	

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	245277	A. BUILDING ____ B. WING ____	05/23/2014

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F 279	Continued From page 6 diagnoses including chronic kidney disease, acute kidney failure, type I diabetes mellitus and hydronephrosis of the left kidney. Physician's orders dated 1/30/14, directed monitoring for thrill (a vibration felt by placing one's hands on the dialysis shunt) to ensure patency. The care plan dated 4/24/14, indicated R85 had renal dialysis three times weekly. The care plan did not identify the location or type of vascular access, frequency of monitoring, signs/symptoms of infection to monitor (redness, swelling, warmth, drainage) or checking bruit/thrill. The care plan did not address dietary or fluid restrictions or monitoring. In addition, there was no direction for where dialysis was provided or contact information for the dialysis unit in case of emergency. There was no direction to avoid blood pressure testing or lab testing on the vascular access limb. R85, interviewed on 5/20/14, at 2:10 p.m. stated he goes to dialysis on Monday, Wednesday and Friday from about 9:30 a.m. until about 3 p.m. depending on when the access site stops bleeding. R85 stated that access site was not checked or monitored by facility staff. Registered nurse (RN)-C, interviewed on 5/20/14, at 2:30 p.m., verified the lack of care planning related to dialysis. On 5/20/14, at 2:45 p.m. the director of nursing (DON) verified the appropriate information was not included on the care plan. The facility's Policy and Procedures for Dialysis Access dated 5/1/10, indicated the arterial venous fistula graft site would checked daily by placing your fingers over the vessel and pressing. (to feel the thrill.) If no pulse was found the	F 279		

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F 279	Continued From page 7 physician would be called. The policy further indicated to check the site daily for redness, hardness, swelling, pain or pus like drainage. The policy indicated staff were to check the site frequently for bleeding.	F 279		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess and treat a significant change of condition resulting in death for 1 of 4 residents (R84) reviewed with death records. Findings include: R84 was admitted on 1/24/14, for rehabilitation and aftercare following surgery for three benign neoplasms of the frontal cerebral meninges (brain tumors) as noted on the face sheet. The progress notes dated 1/24/14, at 8:39 p.m. indicated R84's admission at 7:40 p.m. and noted the primary diagnosis of right and left frontal craniotomy for resection of meningioma (surgery for removal of brain tumors), and indicated the staff was to monitor intake and output, percent of meals eaten, vital signs, incisions daily, pain	F 309	**F 309** St. Raphael's Health and Rehabilitation Center is not able to correct this deficiency for resident 84 as she no longer resides in the facility. Resident Events occurring May 23 and beyond have been reviewed for notification and IDT action. The Change in Condition/Status Notification Requirements Policy has been reviewed and revised to include responsible party notification. RNs and LPNs received training on the Change in Condition / Status Notification Requirements Policy. Interact III Care Pathway Tools have been bounded as a reference for nursing staff regarding physician notification on each wing and staff received training .	

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F 309	Continued From page 8 control and use of pain medications every shift, and lung sounds every shift. The hospital discharge summary dated 1/24/14, also listed discharge diagnoses of meningioma (brain tumor), hypertension (high blood pressure), and dysphagia (difficulty swallowing). The discharge summary indicated R84 underwent the surgery without any complications, continued to have confusion and impulsivity, though controlled with Seroquel (antipsychotic medication), with hypertension controlled with medications, including lopressor, norvasc, and lisinopril. The hospital interagency referral form dated 1/24/14, indicated that, at the time of discharge, R84 was alert and followed commands, speech was clear, and she was oriented to place, and person. The interagency referral form further indicated R84 had some memory and judgement problems, was able to express her needs and desires, and she was calm and cooperative. The interagency referral discharge instructions also directed to contact the physician if R84 developed worsening symptoms of headache, nausea, vomiting, weakness, dizziness, memory or speech difficulty, or numbness or tingling. During an interview on 5/22/14, at 3:01 p.m. the director of nursing (DON) verified this monitoring had not occurred. The admission clinical documentation for observation dated 1/24/14, to 1/25/14, appeared to be an undated late entry and indicated R84 had already expired. The documentation indicated R84 had clear speech, was able to make concrete requests, and responded to simple, direct communication only. The clinical	F 309	Daily stand up meeting agendas currently include review of incidents / events and changes in condition. These reviews will now include auditing to assure proper notifications have been completed and IDT has determined course of action. This auditing will be completed not less than weekly on all incidents and changes in condition until compliance has been met and then will be reviewed at a level to assure compliance is maintained. The Director of Nursing is responsible for monitoring. Compliance will be achieved by June 27, 2014 Per phone c DON on 6/20/14: All licensed nursing staff were provided simulated training and demonstrated competence c response to respiratory arrest and provision of resuscitation on May 6 & 7, 2014. PLN 6/20/14	

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F 309	Continued From page 9	F 309		

documentation further noted R84's pupils to be equal in size, but the left pupil reacted sluggishly and the right pupil reacted briskly. R84 was unable to describe pain and expressed pain by moaning, vocal complaints of pain, facial expressions and protective body movements. Direct care staff were to monitor for pain and communicate to the licensed nurse if pain was noted. The clinical documentation indicated R84 was alert and able to state she hurt at the time of the assessment.

An informed consent for CPR, was signed by R84's power of attorney (POA) and family representative on 1/24/14. R84 was considered to be a full code (full resuscitation efforts).

The undated temporary care plan indicated R84 was alert to self, had a wander guard and audible alarms on bed and wheelchair, and addressed the assistance needed by R84 for activities of daily living, risk for falls, and risk of skin breakdown. The temporary care plan also directed staff to monitor for pain every shift, use analgesics (pain medications) every shift and to monitor incisions daily.

The pain assessment of 1/24/14, at 2:06 p.m. indicated R84 was able to say, "Ow, Ow, Ow" and point to an area, but was unable to rate or describe her pain. The documentation indicated R84 appeared to have left sided abdominal pain when touched in area of a yellowing bruise. R84 also said "Ow" when moving legs, but did not appear in any distress during the pain assessment.

R84's admission vital signs (temperature, pulse, respirations, and blood pressure) were monitored

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F 309	Continued From page 10	F 309		

from 1/24/14 through 1/25/14, and were documented as stable. The final set of vital signs recorded in R84's medical record was on 1/25/14, at 4:08 p.m. with blood pressure, pulse, respirations, and temperature remained stable at that time. There were no documented neurological checks after the physician assessment which occurred on 1/27/14.

The progress notes dated 1/26/14, at 12:45 p.m. indicated R84 had been yelling off and on, but no signs or symptoms of pain were noted. R84 was disrobing, very confused, and was difficult to redirect at that time. Lungs were clear and respirations were even and nonlabored, and the head incision was clean, dry, and scabbed over.

The physician's visit referral form dated 1/27/14, indicated a chief complaint of meningioma with a poor quality and incapacitating severity. The physician also documented that R84 was having some back pain as far as could be told, vitals were stable, pupils were equal and reactive to light, and the neurological status for R84 was stable, but poor.

The progress notes dated 1/28/14, at 10:07 a.m. indicated R84 was yelling out most of the morning and lying with her head on the table. The nurse attempted to give resident her medications and a pain pill four times, but R84 did not take them. R84 would strike out, lay her head on the table and refuse to open her eyes or mouth. R84 did the same at breakfast. At the time of the documentation, R84 was lying down and sleeping.

The progress notes dated 1/28/14, at 1:21 p.m. indicated R84 refused all other medications

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F 309	Continued From page 11 during the day and had been quiet since lying down, but would not open eyes or mouth. The documentation indicated staff were unable to tell if earlier yelling was due to pain or anxiety. Head incisions were noted to be clean, dry, and scabbing over. R84 was oriented to self. Lungs were clear, respirations were even and nonlabored, according to documentation. The progress notes dated 1/28/14, at 8:59 p.m. indicated R84 could not be aroused with three unsuccessful attempts to administer medications. R84 was in bed sleeping at the time of the documentation. The progress notes dated 1/29/14, at 4:07 a.m. indicated, "Staff observe resident [R84] to be unresponsive, went to get charge nurse, call to 911 as [R84] is full code. Presently with [R84] at this time." The progress notes dated 1/29/14, at 4:25 a.m., indicated the family was called, "To inform of [R84] passing away and ambulance staff calling the code." The documentation was unclear as to when the resident stopped breathing, when resuscitation measures were initiated, and by whom (facility or ambulance staff). The progress note on 1/29/14, at 4:34 a.m., indicated, "The ambulance staff called the code at 4:19 a.m., left the facility at 4:25 a.m.." R84's medical record lacked documentation of vital signs, neurological assessments, assessments of change in condition, or notification of the physician on 1/28/14. During an interview on 5/22/14, at 2:06 p.m.,	F 309		

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F 309	Continued From page 12 registered nurse (RN)-B stated that neurological assessments should have been completed at the same time as vital signs upon admission, every hour for four hours, then every fours hours for a total of 24 hours. RN-B verified the lack of documented vital signs on 1/28 or 1/29/14, or neurological status after admission. RN-B stated that assessments should have been provided and the physician/family notified. During an interview on 5/22/14, at 2:26 p.m., the director of nursing (DON) stated she was not working at the facility in January and was not aware of R84's death or circumstances. She was unable to determine if any resuscitation attempts were made before the ambulance arrived. The DON verified neurological assessments and vital signs should have been done for R84, and the physician should have been notified and asked if the physician would have wanted her sent in to the hospital, with the change in condition. The DON verified that monitoring of signs and symptoms of complications, as directed in the interagency referral had not occurred for R84. The policy and procedure for change in condition dated August 2012, directed the facility to notify the resident's physician, and the resident's legal representative or interested family member of a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly, or a decision to transfer or discharge the resident from the facility. A significant change means a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications. The procedure directs licensed nursing staff to assess any changes noted through direct observation or through assigned staff, obtain a	F 309		

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F 309	Continued From page 13 complete set of vital signs at the onset of the change and at 4-hour intervals, or more often as appropriate, obtain any other data necessary for a complete assessment (accucheck, neurocheck, etc.) Notify the physician of the change. Notify family. The facility policy and procedure for neurological assessment dated February 2011, indicated licensed nursing staff will perform, monitor resident neurological functioning and changes in neurological functioning will be reported to the physician immediately. The policy provided the specific procedure in performing the neurological assessment and directs staff to document result of neurological assessment and notify changes immediately to the physician.	F 309	F 323 Safety Resident 14 was placed on a bowel and bladder tracking observation and resident's fall data reviewed for trends and the care plan revised accordingly. Residents having repeat falls in the month of May have had their care plan reviewed and revised if necessary.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview, document review, the facility failed to comprehensively assess risk for falls and implement fall interventions for 1 of 3 residents in the sample (R14) who had a history of falls. Findings include:	F 323	A risk management team has been developed and monthly reviews of safety concerns will be reviewed to determine trends and create additional interventions. Resident Incidents will be reviewed during stand up, and DON or designee will monitor for interventions. Monitoring of incidents and interventions will be completed will be completed M – F to assure compliance for a period of 3 months and then as determined by the risk management team. DON is responsible for monitoring. Compliance will be achieved by June 27, 2014.	

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R14, according to the Minimum Data Set (MDS), diagnoses included vertigo, gait abnormality, osteopathic and generalized weakness, experienced 11 falls from 10/6/13 through 3/31/14 without interventions introduced to reduce the risk of subsequent falls.

Review of interdisciplinary team (IDT) notes established R14 had a fall 10/6/13, while she was attempting to get off the toilet. R14's care plan was updated to ensure staff would assist R14 in the bathroom.

The IDT notes indicated the following:

On 10/24/13, she attempted to sit on a chair, missed and ended up on the floor. No intervention was put in place.

On 11/12/13, R14 was found sitting on the floor by her recliner. No intervention was put in place.

On 12/20/13, while independently ambulating to the toilet and fell. The IDT note stated, "...Staff are to assist to the bathroom for which resident is noncompliant..."

On 12/24/13, R14 fell in the bathroom. The facility's investigation established a possible contributing factor was a medication side effect and changed medication administration times. Documentation indicated R14 refused to ask for assistance for transferring and ambulation, and noted, "... She is persistently noncompliant and does what she wants and knows the risks and benefits of not waiting for help..." A motion sensor was initiated for R14.

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F 323	Continued From page 15 On 1/12/14, R14 fell in room and documentation noted, "... She is persistently noncompliant and does what she wants and knows and understan [sic] the risks and benefits of not waiting for help..." On 1/14/14, R14 had a fall in her bathroom while attempting to use the bathroom independently. A sign was put in R14's bathroom to remind her to call for assistance. Again, the IDT documentation noted, "Res is noncompliant with asking for help and is an assist of 1 for transfers." On 1/18/14, R14 fell in her bathroom. The IDT notes indicated the motion sensor was not activated and the resident was "persistently noncompliant." An intervention was noted as, "will look at shoes." On 2/21/14, R14 fell in the bathroom while attempting to self transfer and walk to the bathroom. The fall resulted in a trip to the emergency department for evaluation of head laceration, back and pelvic pain. No interventions were noted in the IDT notes. On 3/1/14, R14 fell in her room after an independent transfer attempt. Documentation. noted R14 was noncompliant with asking for assistance and was reminded to call for assistance. On 3/31/14, R14 was assisted to the floor after an independent transfer attempt. No intervention was initiated. R14's admission MDS dated 10/10/13, identified R14 at risk for falls and required limited assistance from staff to perform activities of daily	F 323		

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F 323	Continued From page 16 living (ADLs). The Brief Interview for Mental Status (BIMS) indicated R14 had moderate cognitive deficit, where she remained through the quarterly MDS, dated 1/1/14, and significant change MDS, dated 1/9/14. The 1/9/14, MDS also noted R14 declined in her ADLs and required extensive assistance from staff for mobility and transferring. The quarterly MDS, dated 4/4/14, indicated R14 had severe cognitive deficit and continued to need extensive assistance. R14's care plan dated 4/2/14, directed staff to ensure a motion alarm was in place, personal alarm on the recliner, dice (a non-slip surface) was in her wheelchair, ensure the call light was within reach, anticipate needs, and assist to the toilet "ASAP." The director of nursing (DON) stated on 5/22/14, at 12:47 p.m. R14 had a decline in her cognition and reminding her to call for help may not have been an appropriate intervention, and acknowledged other interventions were needed to reduce the risk of subsequent falls.	F 323		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANC E UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANC E. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Raphaels Health & Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-Tags) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, and By email to:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David O. Vandenberg
TITLE: Administrator / CEO
(X6) DATE: 6/19/14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3674

June 6, 2014

Mr. David Vandergon, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, Minnesota 55734

RE: Project Number S5277023

Dear Mr. Vandergon:

On May 23, 2014, 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. In addition, at the time of the May 23, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number .

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - **the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> Plan of Correction - **when a plan of correction will be due and the information to be contained in that document;**
>
> Remedies - **the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

<u>Informal Dispute Resolution</u> - **your right to request an informal reconsideration to dispute the attached deficiencies.**

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 2, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 23, 2014 (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 23, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Enclosure

cc: Licensing and Certification File 5277s14.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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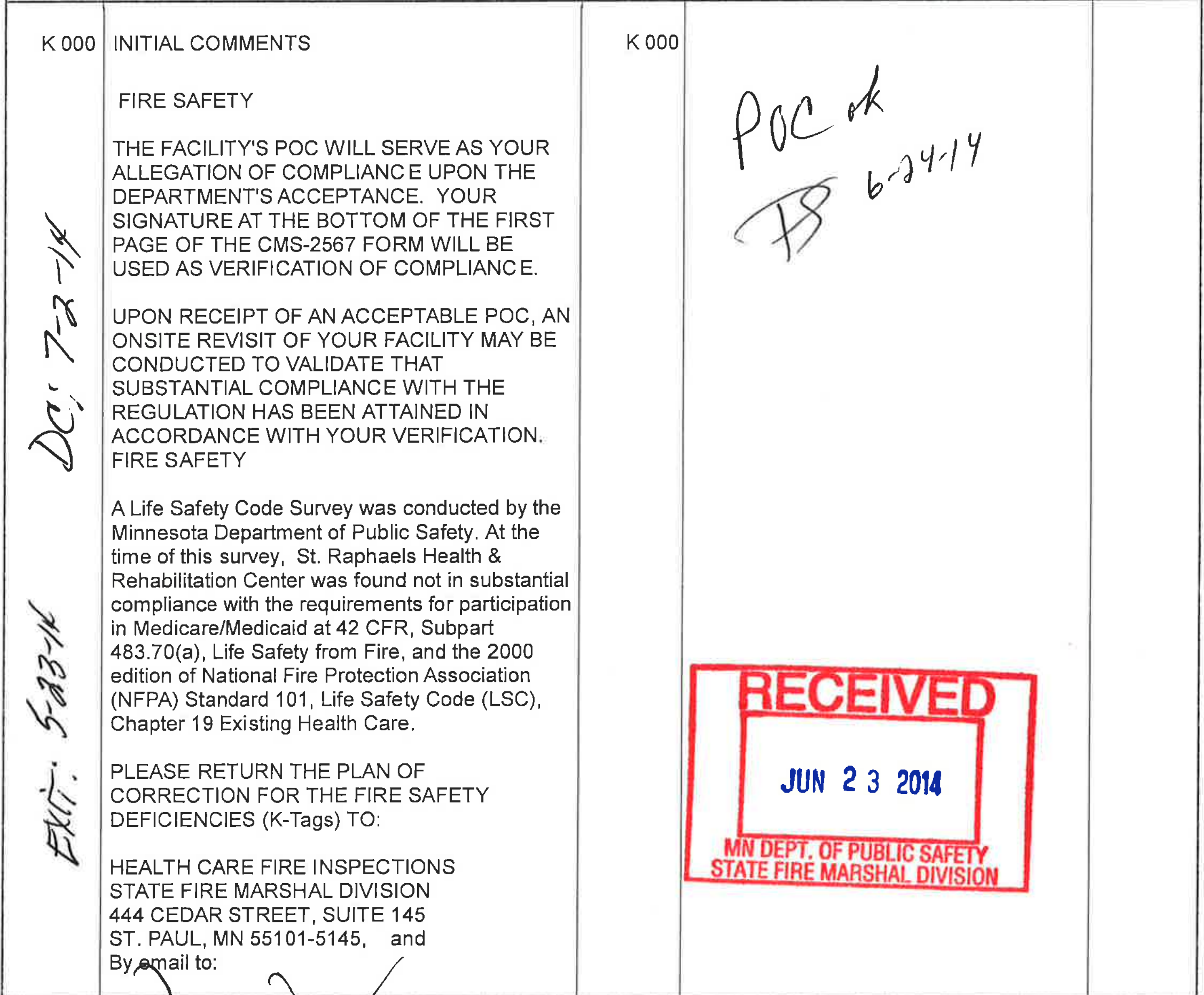
F5277022

PRINTED: 06/05/2014
FORM APPROVED
OMB NO. 0938-0391



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DC: 7-2-14
Exit: 5-23-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David D. Vambler | TITLE: Administrator / CEO | (X6) DATE: 6/19/14

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