DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COM						ID: K89M Facility ID: 00583
1. MEDICARE/MEDICAID PROVIDER N (L1) 245277 2.STATE VENDOR OR MEDICAID NO. (L2) 175197200	iO.	 NAME AND ADI (L3) ST RAPHAE (L4) 601 GRANT (L5) EVELETH, N 	LS HEALTH & 1 AVENUE			(L6) 55734	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	V: <u>7</u> (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PPLIER CATEGOR 05 HHA	Y 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	8. Full Survey After (
6. DATE OF SURVEY 08/26 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	CE	FISCAL YEAR ENDIN 06/30	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 76 (L37) (L38)	19 SNF (L39)	B. Not in Comp Requireme ICF (L42)	ce With quirements Based On: cceptable POC pliance with Program nts and/or Applied IID (L43)	n Waivers:	2. 3. 4. 5. * Code: 15. FACILIT 1861 (e) (1	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code A Y MEETS 1) or 1861 (j) (1):	9. Beds/Room (L12) (L15)	etor I Size
16. STATE SURVEY AGENCY REMARI correction of deficiencies reissu remedies recommended to the 6 17. SURVEYOR SIGNATURE Debra Vincent, HFE NEII		fice will not be in Date :			ust 19, 2014	4, the facility is c SURVEY AGENCY A	ertified for 76 skilled	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible	ζ.	20. COM	D BY HCFA RI				cial Solvency (HCFA-2572) Interest Disclosure Stmt (HC	FA-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/01/1985 (L24)	23. LTC AGREEM BEGINNING I (L41)	DATE	4. LTC AGREEMI ENDING DAT (L25)		<u>VOLUNTAI</u> 01-Merger, 0 02-Dissatisfa		ent 06-Fail to	(L30) <u>WTARY</u> Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)	 ALTERNATIVE A. Suspension of B. Rescind Susp 	of Admissions:	(L44) (L45)		04-Other Rea	ason for Withdrawal	<u>OTHER</u> 07-Provide 00-Active	er Status Change
28. TERMINATION DATE:	29. (L28)	. INTERMEDIARY/C. 03001	ARRIER NO.	(L31)	30. REMAR	RKS		
31. RO RECEIPT OF CMS-1539	32. (L32)	DETERMINATION C 07/03/2014	DF APPROVAL DA	TE (L33)	DETERM	IINATION APPRO	DVAL	



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 Meeth

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.

St Raphaels Health & Rehabilitation Center September 19, 2014 Page 2

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

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

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 245277	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/26/2014
Name	e of Facility		Street Address, City, State, Zip Code	
ST	RAPHAELS HEALTH & REHAB CEN	NTER	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	(Y4) Item	(Y5) Date	(Y4)	ltem		(Y5)	Date
	F0157 483.10(b)(11)	(Correction Completed 08/19/2014	ID Prefix Reg. # LSC	F0279 483.20(d), 483.20(k)(1)	Correction Completed 08/19/2014			F0309 483.25		Correction Completed 08/19/2014
ID Prefix Reg. #		(Correction Completed 08/19/2014	ID Prefix Reg. #		Correction Completed		ID Prefix Reg. #			Correction Completed
Reg. #			Correction Completed	Reg. #				Reg. #			
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC		=		Reg. #			Correction Completed
ID Prefix Reg. # LSC		(Correction Completed	ID Prefix Reg. # LSC				ID Prefix Reg. # LSC	-		Correction Completed
Reviewed B State Agen Reviewed B CMS RO	cy P	iewed ∣ LH/n iewed ∣	nm	Date: 09/17/20 Date:	Signature of Su 14 Signature of Su	296	25			Date: 08/ Date:	/26/2014
Followup t	o Survey Complet 5/23/201				Check for any Unco Uncorrected Defi					YES	NO

DEPARTMENT OF HEAL	FH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: K89M
MEDICARE/MEDICAID PROVID (L1) 245277		3. NAME AND AD (L3) ST RAPHAE	DRESS OF FAC	CILITY	TE SURVEY AGENCY B CENTER	Facility ID: 00583 4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 175197200	NO.	(L4) 601 GRANT (L5) EVELETH ,			(L6) 55734	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	21/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	76 (L18)	Compliance		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
13.Total Certified Beds	76 (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Appli		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 76	7 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REL See Attached Remarks	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Chris Elmgren, HI</u>	FE NEII	0	8/14/2014	(L19)	Enforcement S	pecialist 09/02/2014 (L20)
PA	ART II - TO BE (COMPLETED E	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIB _X_ 1. Facility is Eligible to 2. Facility is not Eligible 	Participate		PLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
, , ,	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN		. LTC AGREEN		26. TERMINATION ACTION	
OF PARTICIPATION 04/01/1985	BEGINNINC	DALE	ENDING DA	ΓE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio	
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	-	n of Admissions: Ispension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)	07/03/2014		(L33)	DETERMINATION APP	ROVAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 addition 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)

St. Raphael's Health & Rehabilitation Center August 1, 2014 Page 2

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

St. Raphael's Health & Rehabilitation Center August 1, 2014 Page 3

> 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

St. Raphael's Health & Rehabilitation Center August 1, 2014 Page 5

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

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

ate Compton

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245277	B. WING		R 07/21/2014
AME OF	PROVIDER OR SUPPLIER	245211		ITREET ADDRESS, CITY, STATE, ZIP CODE	0//21/2014
T RAPI	HAELS HEALTH & RE	HAB CENTER	1	01 GRANT AVENUE EVELETH, MN 55734	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000}	INITIAL COMMEN	rs	{F 000}		
{F 157] SS=D	completed on 7/21/ Minnesota Departm the citations issued There were one or found to be in com found on the CMS2 have not been four time of this PCR ar CMS2567 form. The facility's plan of as your allegation of Department's acce enrolled in ePOC, at the bottom of the form. Your electro be used as verificat Upon receipt of an second on-site rev conducted to valid with the regulation accordance with you 483.10(b)(11) NOT (INJURY/DECLINE A facility must imm consult with the re known, notify the r or an interested fa accident involving injury and has the intervention; a sign physical, mental, of deterioration in he status in either life	TIFY OF CHANGES	{F 157		8/19/14

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.

				FORM A	PPROVED
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPL	SURVEY .ETED
245277	B. WING	i			/2014
HAB CENTER					
MUST BE PRECEDED BY FULL				BE	(X5) COMPLETION DATE
need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in so promptly notify the resident resident's legal representative member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update none number of the resident's e or interested family member. NT is not met as evidenced ent review and interview the ure physician notification e and catheter care for 1 of 3 eviewed as new admissions. vas not notified when the moved prior to leaving the dical advice (AMA). According charge summary dated 6/26/14, for se[sis from an urinary tract vere failure to thrive (FTT) and e. R104 was admitted with a ording to the discharge		57}	facility. Residents with an accident in which results in injury and / or has the pot for requiring physician intervention, significant change in the resident physical, mental, or psychological s a need to alter treatment significant decision to transfer or discharge the resident from the facility, a change room or roommate assignment, or change in resident rights under Fee State law or regulations dating June	n tential s status, tly, a e in a deral or e 26,	
	IDENTIFICATION NUMBER: 245277 HAB CENTER WEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 1 need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in so promptly notify the resident resident's legal representative (member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update none number of the resident's e or interested family member. INT is not met as evidenced ent review and interview the ure physician notification le and catheter care for 1 of 3 eviewed as new admissions. was not notified when the moved prior to leaving the dical advice (AMA). According charge summary dated 6/26/14, for se[sis from an urinary tract vere failure to thrive (FTT) and e. R104 was admitted with a cording to the discharge	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUI A. BUILE 245277 B. WING HAB CENTER ID TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID age 1 (F 1) need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in (F 1) so promptly notify the resident resident's legal representative (member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of (NT is not met as evidenced ent review and interview the ure physician notification le and catheter care for 1 of 3 eviewed as new admissions. WAS not notified when the moved prior to leaving the dical advice (AMA). According charge summary dated 6/26/14, for se[sis from an urinary tract vere failure to thrive (FTT) and e. R104 was admitted with a	& MEDICAID SERVICES (11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ 245277 B. WING	AND HUMAN SERVICES OW & MEDICAID SERVICES OW (X1) PROVDERSUPPLIER/LIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING IN 245277 B. WING IN HAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE EVELETH, MN 55734 FOROMER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) SC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) SG IDENTIFYING INFORMATION IF PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) SG IDENTIFYING INFORMATION IF PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) SG IDENTIFYING INFORMATION IF PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) SG IDENTIFYING INFORMATION IF F157 SG IDENTIFYING INFORMATION IF F157 SG IDENTIFY ING INFORMATION F157 F157 SG IDENTIFY ING INFORMATION F157 Resident 104 no longer resides in t facility. F157 NT IS NOT MET AS evidenced ent review and interview the ire endident for the assignificant change in the residentID phy	8 MEDICAID SERVICES OMB NO. 0 (x1) PROVDERSUPPLIENCUA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DATE: COMPUT 245277 B WING 07/2' HAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE EVELETH, MN 55734 R WILST DE PRECIENCIES KUIST DE PRECIENCIES COMPTORING INFORMATION) ID PREFIX TAG PROVIDERSPIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE cROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) uge 1 need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge ne facility as specified in {F 157} so promptly notify the resident resident's legal representative rommate assignment as 15(e)(2), or a change in er Federal or State law or cified in paragraph (b)(1) of F 157 Notify of Changes Resident 104 no longer resides in the facility. Resident swith an accident in which results in injury and / or has the potential for requiring physician intervention, a significant change in the resident 10 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 normate assignment, or a change in resident rights under Federal or State law or reguinations dating June 26.

Facility ID: 00583

If continuation sheet Page 2 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY LETED
) plan oi	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		R	
		245277	B. WING				1/2014
AME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
T RAPH	AELS HEALTH & RE	HAB CENTER			1 GRANT AVENUE /ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157}	Continued From pa	age 2	{F 15	57}			
	to remove the cathe void and the cathe the facility AMA on note dated 7/5/14 if for therapy and ha On 7/7/14 at 9:43 a R104 refused her nauseous. R104 re when it was offere therapy stating she catheter was remo- family spoke with n AMA discharge. At AMA with family. T physician was noti catheter or the res On 7/22/14 at 10:2 practitioner (NP) w 7/7/14. They were actually leave as s working with R104	heter but R104 was unable to ter was reinserted. R104 left 7/7/14. A nursing progress identified R104 was admitted d a history of leaving AMA. am progress notes indicated medications stating she was efused anti-nausea medication d. At 12:42 pm R104 refused e wouldn't participate until the oved. At 3:40 pm resident and nursing about ramifications of t 4:56 pm R104 discharged There was no evidence the fied regarding status of sident request for discharge. 25 am RN-A stated the nurse was at the facility the morning of uncertain if R104 would social service and nursing was 4 and family to stay in the facility			notification and this continues to be audited during daily IDT meetings. DON or designee will complete aud notifications during the daily IDT meetings. DON or designee will co audits for notification for daily IDT meetings for 4 weeks and then 3 ti week for 4 weeks. And then audits completed weekly. Nursing staff have reviewed the Ch in Condition □ Status Notification F Compliance will be achieved by 8-1	dits for mplete mes a s will be nanges Policy.	
{F 279} SS=D	until strong enoug she sent an email the NP on 7/7/14; respond until 7/8/ ⁻ the AMA discharge R104, facility staff was actually signe RN-A further state from the nurse pra but there was just 7/21/14 at 4:05 pr unable to provide 483.20(d), 483.20	h for discharge. RN-A stated regarding R104's discharge to however, the NP did not 14. At 10:55 am RN-A clarified e form dated as signed by and the physician on 7/7/14 ed by the physician on 7/9/14. ed she received a verbal order actitioner to remove the catheter to time to document it. On in the director of nursing was any additional information. h(k)(1) DEVELOP	{F 2	279}			8/19/14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	08/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED
		245277	B. WING	; 		R 07/2	1/2014
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER			01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 279}	A facility must use to to develop, review a comprehensive pla The facility must de plan for each reside objectives and time medical, nursing, a needs that are ider assessment. The care plan mus to be furnished to a highest practicable psychosocial well-to §483.25; and any s be required under due to the resident §483.10, including under §483.10(b)(4)	the results of the assessment and revise the resident's n of care. evelop a comprehensive care ent that includes measurable etables to meet a resident's ind mental and psychosocial ntified in the comprehensive t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment	{F 2	279}			
	facility did not deve care plans for 2 of reviewed as new a Findings include: R104 did not have catheter use or sa According to the h	a care plan to address fety needs due to weakness.			F 279 Comprehensive Care Plan Resident 104 no longer resides in facility. Resident 79 has had a pain care p developed. Residents currently taking a narco analgesic have been reviewed for care plan. Other residents will hav assessment completed upon new identification of pain and following	lan tic a pain e a pain	
	diagnoses includin infection (UTI), sev anxiety. The docur	ig sepsis with a urinary tract vere failure to thrive (FTT) and ments also identified R104 was with a foley catheter. Hospital			process. Residents admitted on or after 7-2 have been reviewed for a safety p All kardexes have been reviewed	1-14 Ian.	

Event ID: K89M12

Facility ID: 00583

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						R	ł
		245277	B. WING			07/2	1/2014
ME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IAELS HEALTH & RE			60	01 GRANT AVENUE		
INAFI	IALLO TILALITI & RE			E	VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
= 2793	Continued From pa	ane 4	{F 2 ⁻	791			
210]	-	remove the catheter but R104	114	191	accurate.		
		. The notes directed the			Residents with events continue to l	be	
		arrange an appointment with			reviewed at the daily IDT meetings		
	urology. R104 disc	e			Changes in Condition - Notification	Policy,	
		5			Medication and Treatment Orders		
		assessment dated 6/27/14			Event Policy, Pain Management Po		
		continent of bowel and had a			Fall Policy, Interim Care Plan Polic		
		revealed she required limited	:		the NAR Resident Reference Shee		
		he person for toileting. The			(KARDEX) Policy have been review	wea	
		assessment dated 6/29/14	ĺ		with nursing. Temporary care plans are created	from	
		s continent of bowel and ed the assistance of 1 to 2 staff			admission information and are upo		
		weakness level." Review of			daily/or as needed, as assessmen		
		ssessment dated 6/27/14			completed or concerns arise. Proc		
	revealed her to be				changes now include completion c		
					assessment, then completion of th		
		ated 6/29/14 stated R104			plan. All care plans will be update		
		1-2 staff for toileting depending			assessments are completed or as		
		evel. A progress note for			issues are identified; following the	nursing	
		R104, "Almost fell and she is			process.	المطناه	
		g." On 7/1/14 R104 progress			The RAI manager or designee will admission comprehensive care pla		
		04 was lowered to the floor in e being assisted with perineal			assure all triggered areas of conce		
		wel incontinence. On 7/5/14			a care plan decision beginning 8-1		
		ssistance to void and was			following the RAI process. Auditin		
		a catheter. She was then,			continue until compliance is achieved		
		nd resident then did let urine			then will be completed randomly to		
	•	n 7/7/14 R104 refused to			compliance is maintained. The RA	J	
		apy unless the catheter was			manager is part of the IDT mornin		
		14, R104 discharged against			meetings and has good knowledge	e of the	
	medical advice.				residents.		
		eero plan indicated configura-			An Admission Assessment Check	ust nas	
		care plan indicated continence der and the area and did not			been developed to assist with the admission process and shift to shi	ft	
		catheter. The temporary care			communication and has been revi		
		sist with all transfers and			with nursing.	Sweu	
		and by assistance of 1 person			DON or designee will complete au	idits for	
	and the wheeled w	valker. An undated temporary			notifications during the daily IDT		

Facility ID: 00583

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		AND HUMAN SERVICES				FORM	08/14/201 APPROVEI 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		245277	B. WING			F 07/2	र <u>21/2014</u>
	PROVIDER OR SUPPLIER	HAB CENTER	:	60	TREET ADDRESS, CITY, STATE, ZIP CODE 01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
{F 279}	in reach, use grippe clutter and staff ass did not address the for transfers, toiletin On 7/21/14 at 2:00 temporary care pla R104's discharge. director of nursing require specific inte care needs were jut further stated R104 admitted on a gurn The facility policy for Plan effective 5/1/0 cares should be de admission based of admitting facility ar information. The po- purpose of the inte provision of care fr ensure staff met re R79 was admitted hip arthroplasty. Of chronic inflammatic and previous gastr on 7/8/14 revealed R79's pain assess indicated them mo of 10. According to help to manage the leg, rest and ice. S and non-verbal sig nurse. The nurse v and utilize non-pha The 7/19/14 pain a	er socks, keep room free of sist to bathroom. The care plan e level of assistance required ng or risk of falls. pm RN-A verified the n was current at the time On 7/21/14 at 3:10 pm the (DON) stated R104 did not erventions because the nursing ust "nursing 101." The DON 4 was so weak that she was ey. or Interim (Temporary) Care 09 identified these plans of eveloped within 24 hours of on admission information from nd initial assessment olicy further clarified the rim plan was to guide the om the time of admission to		79}	audits for notification for daily IDT meetings for 4 weeks and then 3 tin week for 4 weeks. And then audits completed weekly. Correction date will by 8-19-14		

Facility ID: 00583

If continuation sheet Page 6 of 12

		AND HUMAN SERVICES & MEDICAID SERVICES			C	FORM A MB NO. (08/14/2014 PPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	LETED
		245277	B. WING	;		1	1/2014
	PROVIDER OR SUPPLIER	HAB CENTER	<u> </u>	6	STREET ADDRESS, CITY, STATE, ZIP CODE 501 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
{F 279}	time of day." Assess Record review rever managing her pain R79's current pain 325 mg 2 tablets for patch 1 patch on in Norco 5-325 mg 1- needed for pain. R notes identified wh medications on a r able to care for her addition to a decre dated 7/17/14, cha medications to as a narcotic pain medi R79, interviewed o "The pain is still hor issue with pain and and antianxiety me home. R79 stated much more helpfu the time without th stated physical the non-pharmacologi very effective. Who non-pharmacologi by nursing staff, R Review of progress supported this state Interview with the 7/21/14, at 3:45 pr plan in place to ma believed the pain in	sement otherwise unchanged. ealed R79 had no care plan for medications included Tylenol our times a day; lidocaine 5% am and off at night; and 2 tablets every 4-6 hours as eview of nursing progress en R79 received pain outine basis she was better realf and had more flexibility in ase in pain. Physician orders nged routine narcotic pain needed (PRN) and to taper cations. n 7/21/14 at 4:20 p.m., stated, orrible." R79 had long standing d had been taking narcotic pain edications on a regular basis at the scheduled Norco was l. R79 rated pain at 7-9 most of e routine pain medication. R79 rapy provided several cal interventions which were en asked if any cal interventions were utilized 79 stated they were not. s notes and treatment records tement. director of nursing (DON) on n verified there was no care anage R79's pain. The DON management plan for R79 was ould ask for pain interventions		279}			

Facility ID: 00583

If continuation sheet Page 7 of 12

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		ON	FORM /	08/14/2014 APPROVED 0938-0391 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	• •			`́сомғ F	PLETED
		245277	B. WING				21/2014
	PROVIDER OR SUPPLIER	HAB CENTER		60	REET ADDRESS, CITY, STATE, ZIP CODE 1 GRANT AVENUE /ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309} {F 309} SS=D	HIGHEST WELL B Each resident mus provide the necess or maintain the hig mental, and psycho	CARE/SERVICES FOR	{F 3 {F 3	-			8/19/14
	by: Based on interview facility did not ensu- management prog effectively impleme reviewed (R79) with Findings include: R79 was admitted hip arthroplasty. Of chronic inflammate and previous gastr on 7/8/14 revealed R79's pain assess revealed the worst medications help t elevating the left le observe for verbal and report to the m pain medications. The identified pain rate	NT is not met as evidenced w and document review the ure a comprehensive pain ram was developed and ented for 1 of 3 residents th pain. on 7/4/14, following a total left ther diagnoses included ory demyelinating polyneuritis ric bypass. Social service notes I R79 to be alert and oriented. ment completed 7/6/14 pain was rated 8 out of 10 and o manage the pain as did eg, rest and ice. Staff was to and non-verbal signs of pain nurse. The nurse was to provide and utilize non-pharmacological 7/19/14 pain assessment nging from a 6-9 depending on time of day with no additional			F 309 Provide for highest level of v being Resident 79 has had a pain assess completed, care plan revised on 7/ Residents currently taken a narcoti analgesic have been reviewed for a care plan. The EMAR order for narcotic analg will now include the task for obtain pain scale prior to medication and medication for effectiveness, and t been reviewed with nursing. Process changes now include com of the assessment, then completion care plan. Care plans will be updat assessments are completed, or as issues are identified; following the process. An Admission Assessment CheckI been developed to assist with the admission process and shift to shi communication and has been review with nursing. The RAI manager or designee will	sment 21/14. ic a pain gesics ing a post his has pletion of the te as s new nursing ist has ft ewed	

Facility ID: 00583

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	LETED
		245277	B. WING _			1/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
				601 GRANT AVENUE		
ST RAPH	IAELS HEALTH & RE	HABCENTER		EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 309}	R79's current pain 325 mg 2 tablets for patch 1 patch on ir Norco 5-325 mg 1- needed for pain. Review of nursing revealed R79 cont basis. Progress no scheduled narcotic effective. R79 was adl's [activities of of Nursing notes on 7 "Less pain with the scheduled." Physi appointment direct and included order medications. Prog indicated R79 was scheduled narcotic had "Less pain an narcotic pain med taper the narcotics pain. Interview with R79 revealed ongoing management. R79 horrible. R79 had and as a result hat morphine, OxyCo twice a day for a 1 morning and to st during the day. R79 was much more h "runs a 7-9 most	medications included Tylenol bur times a day; lidocaine 5% n am and off at night; and 2 tablets every 4-6 hours as progress notes from 7/4-22/14 inued to have pain on a daily otes on 7/15/14, indicated c pain medications were more daily living], etc. for herself." 7/16/14 indicated R79 had e [pain] meds now being ician orders from a 7/17/14, ted narcotic medication tapered rs for as needed narcotic pain ress notes on 7/17/14, ted narcotic medication tapered rs for as needed narcotic pain ress notes on 7/17/14, s upset over the lack of c medications. R79 stated she d more flexibility" with routine ications. There was no plan to s while still effectively managing 0 on 7/21/14 at 4:20 pm problems with pain 9 stated the pain was still long standing issues with pain ad utilized "marriage" of ntin and Xanax that she took ong time to get moving in the eep at night along with Tylenol 79 stated, "It was the only thing 9 stated that Norco scheduled helpful but the pain currently, of the time." R79 stated physical several non-pharmacological	{F 30	 admission comprehensivassure all triggered area a care plan decision beg following the RAI process continue until compliance is maintaine manager is part of the II meetings and has good residents. Changes in Condition - Medication and Treatmee Event Policy, Pain Mana Fall Policy, Interim Care the NAR Resident Refe (KARDEX) Policy have with nursing. DON or designee will con notifications during the meetings. DON will com notification for daily IDT weeks and then 3 times weekly. Correction date will by 8 	s of concern have inning 8-11-14 is. Auditing will e is achieved and andomly to assure d. The RAI DT morning knowledge of the Notification Policy, ent Orders Policy, agement Policy, Plan Policy and rence Sheet been reviewed omplete audits for daily IDT nplete audits for meetings for 4 a week for 4 s will be completed	

		AND HUMAN SERVICES & MEDICAID SERVICES		OMB	ORM APPROVE NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	E CONSTRUCTION (X3) DATE SURVEY COMPLETED R
		245277	B. WING		07/21/2014
	ROVIDER OR SUPPLIER	HAB CENTER	61	TREET ADDRESS, CITY, STATE, ZIP CODE 01 GRANT AVENUE VELETH, MN 55734	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
{F 309} {F 323} SS=D	provided by nursing stated she asked f was told they didn't hings. The nurse f ice cubes which R Interview with the of 7/21/14 at 3:45 pm plan in place to ma asked, "Isn't it eno she needs? The D physician ordered medications and th 483.25(h) FREE OF HAZARDS/SUPER The facility must e environment rema as is possible; and	harmacological interventions g staff, there were none. R79 or an ice pack one evening and t have access to those kinds of hen came back with a baggy of 79 stated was "Not helpful." director of nursing (DON) on a verified there was no specific anage R79's pain. The DON ugh that she can ask" for what ON further clarified the the taper of R79's narcotic pain ney were required to do so. OF ACCIDENT RVISION/DEVICES nsure that the resident ins as free of accident hazards a each resident receives ison and assistance devices to			8/19/14
	by: Based on intervie facility did not ens individualized inte minimize the risk (R104) reviewed f Findings include: R104 was admitte	ENT is not met as evidenced w and document review the ure comprehensive rventions were in place to for falls for 1 of 3 residents for falls. ed to the facility via stretcher on cute care hospital. According to		F 323 Free of Accidents Resident 104 no longer resides in the facility Residents admitted as of 7-21-14 ha been reviewed for safety care plans interventions. Process changes now include comp of the assessment, then completion care plan. Care plans will be update	ive and letion of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			TIPLE CONSTRUCTION	(X3) DATE COMI	0938-0391 SURVEY PLETED
NAME OF PROVIDER OR SUPPLIE	R	B. WING			
NAME OF PROVIDER OR SUPPLIE				R 07/21/2014	
	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP 601 GRANT AVENUE EVELETH, MN 55734 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	DRRECTION	(X5) COMPLETION DATE
F 323} Continued From	LSC IDENTIFYING INFORMATION)	TAG {F 32	CROSS-REFERENCED TO THE DEFICIENCY) 23}		
the admitting ord diagnoses contril anemia, anxiety, lumbar disc dege and malnutrition. which could impa anti-anxiety, nard antipsychotic me A nursing progre R104 almost fell note further indic hospital for near On 7/1/14 nursin had to be lowere R104 was receiv incontinent stool unable to sit on t assisted to the fl Interdisciplinary occur until 7/6/14 identified as a co failed to identify in the bathroom Review of R104 continence of bo care plan directe ambulated with person and a wh temporary fall ca call light in reach free of clutter ar was no direction transfers and to or toileting and r incontinence.	ers, R104 had multiple buting to safety issues including depression, muscle weakness, ineration, severe failure to thrive, R104 also had medications lot her safety including otic, antidepressant, and		assessments are complete issues are identified; follow process. An Admission Assessmen been developed to assist v admission process and sh communication and has be with nursing. Changes in Condition - No Medication and Treatment Event Policy, Pain Manage Fall Policy, Interim Care P the NAR Resident Referer (KARDEX) Policy have be with nursing. DON or designee will com any residents with an acci- negative outcome during t meetings, to assure interv been developed. The audi consistently until complian and then at a level to mair as determined by the IDT. Compliance will be achiev	ving the nursing t Checklist has vith the ift to shift een reviewed tification Policy, Orders Policy, ement Policy, lan Policy and nee Sheet en reviewed plete audits on dent or a he daily IDT entions have its will continue nee is achieved ntain compliance	

Event ID: K89M12

Facility ID: 00583

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/14/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY	
		245277	B. WING	;		R 07/21/2014		
NAME OF F	PROVIDER OR SUPPLIER	L			REET ADDRESS, CITY, STATE, ZIP COD			
ST RAPH	IAELS HEALTH & RE	HAB CENTER		i i	GRANT AVENUE ELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
{F 323}	identified a fall to b "relocated to the flo is." The policy direc progress notes eve policy further identi	age 11 e any time a resident is bor no matter what the height cted staff to document in the ery 4 hours for 24 hours. The fied falls would be reviewed by y team within 24 hours of	{F 3	323}	•			
						·		
FORM CMS-2	2567(02-99) Previous Version	s Obsolete Event ID: K89M	12	Faci	lity ID: 00583 If con		Page 12 of 12	

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			PLETED
							R
		245277	B. WING			07/	21/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPHA	AELS HEALTH & REHAB	CENTER			601 GRANT AVENUE		
					EVELETH, MN 55734		
(X4) ID			ID	X		-	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
{F 000}	INITIAL COMMENTS		{F 0	000	}		
	A post certification re	survey (PCR) was					
	completed on 7/21/14	• • •					
		nt of Health to follow-up on					
		or the survey exit 5/20/14.					
		ore deficiencies that were					
		ance and these can be 67B. The deficiencies that					
		to be in compliance at the					
		these can be found on this					
	CMS2567 form.						
	The facility's plan of c	correction (POC) will serve					
	as your allegation of						
		ance. Because you are					
	-	ur signature is not required					
		rst page of the CMS-2567 submission of the POC will					
	be used as verificatio						
	Upon receipt of an ac	ceptable electronic POC, a					
	second on-site revisit						
		that substantial compliance					
	with the regulations h						
	accordance with your		(=)				
{F 157}	483.10(b)(11) NOTIF		F 1	57			
SS=D	(INJURY/DECLINE/R	COM, ETC)					
	A facility must immed	iately inform the resident;					
	-	ent's physician; and if					
		dent's legal representative					
	or an interested famil	y member when there is an					
		e resident which results in					
		tential for requiring physician					
		cant change in the resident's					
		sychosocial status (i.e., a n, mental, or psychosocial					
		reatening conditions or					
); a need to alter treatment					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/01/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245277	B. WING		R 07/21/2014
NAME OF PI	ROVIDER OR SUPPLIER		_ _	STREET ADDRESS, CITY, STATE,	•
				601 GRANT AVENUE	
ST RAPH/	LELS HEALTH & REHAB	CENTER		EVELETH, MN 55734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
{F 157}	treatment); or a decise the resident from the §483.12(a). The facility must also and, if known, the resi- or interested family mi- change in room or roo specified in §483.15(resident rights under regulations as specifi- this section. The facility must reco- the address and phor legal representative of This REQUIREMENT by: Based on document facility did not ensure related to discharge a	eed to discontinue an nent due to adverse commence a new form of ion to transfer or discharge facility as specified in promptly notify the resident ident's legal representative ember when there is a ommate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of rd and periodically update he number of the resident's r interested family member.	{F 1		tify the physician or ntative of a condition for 1 of 4 ved with death 1/24/14, for
	urinary catheter remo facility against medica to the hospital discha R104 was treated for infection (UTI), seven chronic liver failure. F foley catheter, accord	a not notified when the ved prior to leaving the al advice (AMA). According rge summary dated 6/26/14, se[sis from an urinary tract e failure to thrive (FTT) and 104 was admitted with a ing to the discharge ary indicated staff attempted		surgery for three benig frontal cerebral mening as noted on the face s	ges (brain tumors)

Facility ID: 00583

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/01/2014 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION			LETED
		245277	B. WING _			_		२ 21/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
ST RAPHA	AELS HEALTH & REHAB	CENTER			1 GRANT AVENUE			
0(4) 15				E 1	/ELETH, MN 55734	PLAN OF CORRECTION		(15)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 157}	void and the catheter the facility AMA on 7/7 note dated 7/5/14 ide for therapy and had a On 7/7/14 at 9:43 am R104 refused her men nauseous. R104 refus when it was offered. A therapy stating she w catheter was removed family spoke with nurs AMA discharge. At 4: AMA with family. They physician was notified catheter or the reside On 7/22/14 at 10:25 a practitioner (NP) was 7/7/14. They were un actually leave as soci working with R104 an until strong enough for	er but R104 was unable to was reinserted. R104 left 7/14. A nursing progress ntified R104 was admitted history of leaving AMA. progress notes indicated dications stating she was sed anti-nausea medication At 12:42 pm R104 refused ouldn't participate until the d. At 3:40 pm resident and sing about ramifications of 56 pm R104 discharged re was no evidence the d regarding status of nt request for discharge. am RN-A stated the nurse at the facility the morning of certain if R104 would al service and nursing was id family to stay in the facility or discharge. RN-A stated	{F 1	57}				
	the NP on 7/7/14; how respond until 7/8/14. , the AMA discharge fo R104, facility staff and	arding R104's discharge to wever, the NP did not At 10:55 am RN-A clarified rm dated as signed by d the physician on 7/7/14 y the physician on 7/9/14.						
	from the nurse practit but there was just no 7/21/14 at 4:05 pm th	he received a verbal order ioner to remove the catheter time to document it. On e director of nursing was additional information.						
{F 279} SS=D	483.20(d), 483.20(k)(COMPREHENSIVE C		{F 2	79}				

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 08/01/2014 FORM APPROVED //B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				3) DATE SURVEY COMPLETED
		245277	B. WING				R 07/21/2014
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
ST RAPH	AELS HEALTH & REHAE	CENTER			GRANT AVENUE ELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 279}	 {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). 		{F 2	79}			
	by: Based on interview a facility did not develo care plans for 2 of 3 reviewed as new adm Findings include: R104 did not have a catheter use or safety According to the hosy documentation dated diagnoses including s infection (UTI), sever anxiety. The docume	care plan to address / needs due to weakness. pital discharge			Based on interview and record the facility failed to develop care interventions related to care and monitoring related to renal dialy 1 (R85) residents reviewed for o R85's physician's orders dated listed diagnoses including chror disease, acute kidney failure, ty diabetes mellitus and hydronep the left kidney. Physician's orde 1/30/14, directed monitoring for vibration felt by placing one's ha the dialysis shunt) to ensure par	e plan d vsis for 1 o dialysis. 5/1/14, nic kidney vpe l hrosis of ers dated thrill (a ands on	

Facility ID: 00583

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245277	B. WING				R 21/2014
NAME OF P	ROVIDER OR SUPPLIER		-	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ST RAPH	AELS HEALTH & REHAB	CENTER			601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{F 279}	staff attempted to rem was unable to void. T receiving facility to an urology. R104 discha R104's admission ass revealed she was cor catheter. It further rev assistance from one p bowel and bladder as revealed R104 was co bladder and required "depending on her we R104's Fall Risk Asse revealed her to be at A progress note dated required assist of 1-2 on her weakness leve 6/30/14 revealed R100 very afraid of falling." notes identified R104 the bathroom while be cares following bowel R104 requested assis reminded she had a c "Helped to relax and p pass in tubing." On 7/ participate in therapy removed. On 7/7/14, medical advice. R104's temporary car of bowel and bladder address the foley catt plan directed 2 assist ambulation with stand and the wheeled walk	he notes directed the range an appointment with rged on 7/7/14. Sessment dated 6/27/14 htinent of bowel and had a realed she required limited berson for toileting. The sessment dated 6/29/14 ontinent of bowel and the assistance of 1 to 2 staff eakness level." Review of ressment dated 6/27/14 risk for falls. d 6/29/14 stated R104 staff for toileting depending el. A progress note for 14, "Almost fell and she is On 7/1/14 R104 progress was lowered to the floor in eing assisted with perineal incontinence. On 7/5/14 stance to void and was catheter. She was then, resident then did let urine 17/14 R104 refused to unless the catheter was R104 discharged against	{F 2	279}			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245277	B. WING				R 21/2014	
NAME OF P	ROVIDER OR SUPPLIER		.		STREET ADDRESS, CITY, STATE, ZIP CODE	·		
ST RAPH	AELS HEALTH & REHAB	CENTER			601 GRANT AVENUE EVELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 279}	in reach, use gripper clutter and staff assis did not address the le for transfers, toileting On 7/21/14 at 2:00 pr temporary care plan w R104's discharge. On director of nursing (Dr require specific interv care needs were just further stated R104 w admitted on a gurney The facility policy for Plan effective 5/1/09 cares should be deve admission based on a admitting facility and information. The polic purpose of the interim provision of care from ensure staff met resid R79 was admitted on hip arthroplasty. Othe chronic inflammatory and previous gastric to on 7/8/14 revealed R ² R79's pain assessme indicated them most so of 10. According to re help to manage the p leg, rest and ice. Staff and non-verbal signs nurse. The nurse was and utilize non-pharm The 7/19/14 pain asses	socks, keep room free of t to bathroom. The care plan evel of assistance required or risk of falls. m RN-A verified the was current at the time of 7/21/14 at 3:10 pm the ON) stated R104 did not entions because the nursing "nursing 101." The DON vas so weak that she was Interim (Temporary) Care identified these plans of eloped within 24 hours of admission information from initial assessment ey further clarified the n plan was to guide the n the time of admission to lent needs. 7/4/14, following a total left er diagnoses included demyelinating polyneuritis bypass. Social service notes 79 to be alert and oriented.	{F 2	279	}			

Facility ID: 00583

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245277	B. WING				R 21/2014
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	AELS HEALTH & REHAB	CENTER			601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 279}	time of day." Assessin Record review reveal managing her pain. R79's current pain me 325 mg 2 tablets four patch 1 patch on in al Norco 5-325 mg 1-2 t needed for pain. Revi notes identified when medications on a rout able to care for herse addition to a decrease dated 7/17/14, chang medications to as nee narcotic pain medicat R79, interviewed on 7 "The pain is still horrifi issue with pain and he and antianxiety medic home. R79 stated the much more helpful. R the time without the re stated physical therag non-pharmacological very effective. When non-pharmacological by nursing staff, R79 Review of progress n supported this statem Interview with the dire 7/21/14, at 3:45 pm v plan in place to mana believed the pain mar	hent otherwise unchanged. ed R79 had no care plan for edications included Tylenol times a day; lidocaine 5% m and off at night; and ablets every 4-6 hours as ew of nursing progress R79 received pain ine basis she was better If and had more flexibility in e in pain. Physician orders ed routine narcotic pain eded (PRN) and to taper ions. 7/21/14 at 4:20 p.m., stated, ble." R79 had long standing ad been taking narcotic pain cations on a regular basis at e scheduled Norco was 79 rated pain at 7-9 most of putine pain medication. R79 by provided several interventions which were asked if any interventions were utilized stated they were not. otes and treatment records ent. ector of nursing (DON) on erified there was no care ge R79's pain. The DON hagement plan for R79 was a ask for pain interventions	{F 2	279}			

Facility ID: 00583

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 08/01/2014 MAPPROVED). 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245277	B. WING		_	F 07/2	२ 21/2014	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
ST RAPH	AELS HEALTH & REHAB	CENTER	-	01 GRANT AVENUE EVELETH, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 309} {F 309} SS=D	483.25 PROVIDE CA HIGHEST WELL BEIN Each resident must re provide the necessary or maintain the highes mental, and psychoso accordance with the c and plan of care. This REQUIREMENT by: Based on interview a facility did not ensure management program effectively implementer reviewed (R79) with p Findings include: R79 was admitted on hip arthroplasty. Othe chronic inflammatory and previous gastric to on 7/8/14 revealed RT R79's pain assessme revealed the worst pain medications help to m elevating the left leg, observe for verbal and and report to the nurs pain medications. The 7/1 identified pain rangin	RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment is not met as evidenced and document review the a comprehensive pain n was developed and ed for 1 of 3 residents pain. 7/4/14, following a total left r diagnoses included demyelinating polyneuritis pypass. Social service notes 79 to be alert and oriented.	{F 309} {F 309}					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/01/2014 MAPPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ICIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245277	B. WING _				R 21/2014	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CI	ITY, STATE, ZIP CODE	•		
ST RAPH	AELS HEALTH & REHAB	CENTER		601 GRANT AVENUE EVELETH, MN 557				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROV (EACH C	/IDER'S PLAN OF CORRECTIO ORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 309}	325 mg 2 tablets four patch 1 patch on in a Norco 5-325 mg 1-2 f needed for pain. Review of nursing pro- revealed R79 continu- basis. Progress notes scheduled narcotic pa- effective. R79 was, "H adl's [activities of dail Nursing notes on 7/10 "Less pain with the [p scheduled." Physicia appointment directed and included orders f medications. Progress indicated R79 was up scheduled narcotic m had "Less pain and m narcotic pain medicat taper the narcotics wi pain. Interview with R79 or revealed ongoing pro- management. R79 st horrible. R79 had long and as a result had u morphine, OxyContin twice a day for a long morning and to sleep during the day. R79 st was much more help "runs a 7-9 most of the therapy provided sevents.	edications included Tylenol times a day; lidocaine 5% m and off at night; and ablets every 4-6 hours as ogress notes from 7/4-22/14 ted to have pain on a daily s on 7/15/14, indicated ain medications were more Having a better time doing y living], etc. for herself." 6/14 indicated R79 had tain] meds now being in orders from a 7/17/14, narcotic medication tapered or as needed narcotic pain s notes on 7/17/14, best over the lack of redications. R79 stated she nore flexibility" with routine tions. There was no plan to hile still effectively managing	{F 3	09}				

Facility ID: 00583

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/ FORM APP OMB NO. 093	ROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ICIES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	COMPLETED	(X3) DATE SURVEY COMPLETED	
		245277	B. WING		R 07/21/20	14	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ST RAPH	AELS HEALTH & REHAB	3 CENTER		601 GRANT AVENUE EVELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM	(X5) PLETION DATE	
{F 309} {F 323} SS=D			{F 30				
	by: Based on interview a facility did not ensure individualized interve minimize the risk for f (R104) reviewed for f Findings include: R104 was admitted to	ntions were in place to falls for 1 of 3 residents		Based on observations, interv document review, the facility fa comprehensively assess risk f implement fall interventions fo residents in the sample (R14) history of falls. R14, according to the Minimur (MDS), diagnoses included ve abnormality, osteopathic and g weakness, experienced 11 fall	ailed to for falls and r 1 of 3 who had a m Data Set rrtigo, gait generalized		

Event ID: K89M12

Facility ID: 00583

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245277		(X2) MULTIPL	· · ·	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER.	A. BUILDING	A. BUILDING		
		B. WING		07	R 7/ 21/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	AELS HEALTH & REHAB	CENTER		601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
{F 323}	the admitting orders, diagnoses contributin anemia, anxiety, depr lumbar disc degenera and malnutrition. R10 which could impact he anti-anxiety, narcotic, antipsychotic medicat A nursing progress no R104 almost fell and note further indicated hospital for nearly 5 m On 7/1/14 nursing pro had to be lowered to 5 R104 was receiving p incontinent stool whe unable to sit on toilet assisted to the floor b Interdisciplinary revie occur until 7/6/14. Alti identified as a contrib failed to identify how in the bathroom or if a Review of R104's tem continence of bowel a care plan directed 2 a ambulated with the st person and a wheeled temporary fall care pla call light in reach, use free of clutter and star was no direction for h	R104 had multiple g to safety issues including ression, muscle weakness, ation, severe failure to thrive, 4 also had medications er safety including antidepressant, and tions. of the dated 6/30/14 revealed was afraid of falling. The R104 had been in the nonths and was very weak. Ogress notes identified R104 the floor in the bathroom. Derineal cares following an in she became weak and or wheelchair. She was y facility staff. w of the incident did not hough weakness was uting factor, the review many staff was assisting her a transfer belt was used. Apporary care plan indicated and bladder. The temporary assist with all transfers but and by assistance of 1 d walker. An undated an directed staff to keep the e gripper socks, keep room aff assist to bathroom. There ow much assistance for a was needed with transfers	{F 323}	10/6/13 through 3/31/14 without interventions introduced to reduc of subsequent falls.		

If continuation sheet Page 11 of 12

CENTERS FOR MEDICARE & MEI	DICAID SERVICES				FORM APPROVED OMB NO. 0938-0391	
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245277		B. WING		_	R 07/21/2014	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•••=•=•	
ST RAPHAELS HEALTH & REHAB CEI	NTER					
		I	EVELETH, MN 55734		(1/5)	
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		
{F 323} Continued From page 11 identified a fall to be any "relocated to the floor no is." The policy directed st progress notes every 4 he policy further identified fa the interdisciplinary team occurrence.	matter what the height aff to document in the ours for 24 hours. The Ils would be reviewed by	{F 323}		JEFICIENCY)		

Event ID: K89M12

Facility ID: 00583

If continuation sheet Page 12 of 12

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 245277	(Y2) Multiple Constr A. Building B. Wing	BUILDING 01	(Y3) Date of Revisit 6/25/2014
Name of Facility			Street Address, City, State, Zip Code	
ST	RAPHAELS HEALTH & REHAB CENTER	२	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	(Y4)	Item	(Y5)	Date	(Y4)	ltem		Y5)	Date
		Сс	orrection				Correction					Correction
ID Profiv			ompleted 5/13/2014		ID Profix		Completed					Completed
		00	13/2014		Dec. #				Reg. #			
-	NFPA 101 K0050				Reg. # LSC							
									-			
		Сс	orrection				Correction					Correction
			ompleted				Completed					Completed
							-					
Reg. # LSC					Reg. # LSC				Reg. #			
								+-				
		Co	orrection				Correction					Correction
		С	ompleted				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			
Reg. #					Reg. #		-		Reg. #			
LSC					LSC		-		LSC			
		Co	orrection				Correction					Correction
			ompleted				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			
Reg. #					Reg. #		-		Reg. #			
LSC					LSC		-		LSC			
		Co	orrection				Correction					Correction
			ompleted				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			
Reg. #					Reg. #		-		Reg. #			
LSC					LSC				LSC			
Reviewed By	Review	ed By		Da	te:	Signature of Surve	eyor:				Date:	
State Agency	/	PS	/KJ	08	8/01/2014		0300	5			00	5/25/2014
Reviewed By	Review	ed By	·	Da	te:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed on:					Check for any				-		
	5/20/2014					Uncorrecte	d Deficiencies	(CMS	-2567) Sent t	o the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL 'E SURVEY AGENCY		D: K89M Facility ID: 00583
I. MEDICARE/MEDICAID PROVIDER N (L1) 245277 2.STATE VENDOR OR MEDICAID NO. (L2) 175197200	NO.	 NAME AND ADI (L3) ST RAPHAE (L4) 601 GRANT (L5) EVELETH, N 	LS HEALTH & R AVENUE		ENTER (L6) 55734	 TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit 	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Co	
 6. DATE OF SURVEY 05/23 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	3/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF) 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 06/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 76 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	X B. Not in Com Requireme ICF (L42)	ce With quirements Based On: ccceptable POC pliance with Program mts and/or Applied W IID (L43)	/aivers:	And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servio 7. Medical Direct	tor
17. SURVEYOR SIGNATURE	NEII	Date :	06/24/2014	(L19)	18. STATE SURVEY AGENCY AP TOMAL M Enforcement		Date: 07/02/2014
	PART II - TO	BE COMPLETE	D BY HCFA RE		L OFFICE OR SINGLE STAT	TE AGENCY	(L20)
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pa 2. Facility is not Eligible			PLIANCE WITH CI ITS ACT:	VIL	 Statement of Financi Ownership/Control I Both of the Above : 	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(1	L30)
OF PARTICIPATION 04/01/1985	BEGINNING	DATE	ENDING DATE		VOLUNTARY 00 01-Merger, Closure 00		<u>'ARY</u> eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	nt 06-Fail to Me	eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)		04-Other Reason for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	20	. INTERMEDIARY/C	(L45)		30. REMARKS		
20. TERMIN HIGH DITE.	2)	03001	MULLER NO.		50. REMINING		
	(L28)	05001		(L31)	Posted 07/03/202	14 Co.	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	E			
	(L32)			(L33)	DETERMINATION APPRO	VAL	



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:

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

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

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

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST RAPHAELS HEALTH & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION COMI	TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION 1 9 2014	(X3) DATE SURVEY COMPLETED		
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ST RAPHAELS HEALTH & REHAB CENTER EVELETH, MN 65734 CALL STREMENT OF DEFIDIENCIES PROVIDERS PLAN DE CORRECTION REGULATORY OR LSC IDENTFYING INFORMATION) PROVIDERS PLAN DE CORRECTION RECONSTRUCTION CORRECTION RECONSTRUCTION OF DEFIDIENCIES PROVIDERS PLAN DE CORRECTION RECONSTRUCTION OF DEFIDIENCIES PROVIDERS PLAN DE CORRECTION RECONSTRUCTION RECONSTRUCTION RECONSTRUCTION OF DEFIDIENCIES F 000 INITIAL COMMENTS F 000 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-2867 form will be used as verification of compliance. F 000 Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 157 Census: 57 SS=D A facility must immediately inform the resident's physician, motif, the resident's physician, intervention; a significant change in the resident's physician, motif, the resident's physician, intervention; a significant change in the resident's physician, motif, or psychosocial status in either life threatening conditions or clinical compliance); a need to aliser treatment significantly (i.e., a need to aliser treatment ecolecint involving the reaident treatment significanty (i.e., a need to	IAME OF F	PROVIDER OR SUPPLIER						
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 F 000 INTIAL COMMENTS F 000 INTIAL COMMENTS F 000 INTIAL COMMENTS F 000 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 substantia compliance with the regulations has been attained in accordance with your verification. Census: 57 F 157 F 157 F 157 A facility must immediately inform the resident; consult with the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a neet to alter treatment significant of, e., a need to alter treatment significant of treatment due to adverse consequences, or to commence a new form of treatment ue to adverse the resident from the facility as specified in §483.12(a). F 1600 F 167 F 167<td>PREFIX</td><td>(EACH DEFICIENC)</td><td>MUST BE PRECEDED BY FULL</td><td>PREFIX</td><td>(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP</td><td>OULD BE COMPLETI</td>	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	OULD BE COMPLETI		
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 revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Census: 57 483.10(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 intervention; a significant ohange in the resident's physician intervention; a significant change in the resident's physician intervention; a significant ohange in the resident's physicial, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration; a significant due to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to alterse 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). F 157 F 157 Six additional residents having been recently admitted have been reviewed to assure all orders have been verified by an RN and physician; and if known, notify the resident's physician; and if intervention; a significant ohange in the resident's physician intervention; a significant ohange in the resident's negative in ether iffe threatening conditions or or interation in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (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). F 157 		as your allegation of Department's acce bottom of the first p be used as verifica	of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.		St. Raphael's Health and Rel not able to correct this defic	ciency for r esident		
Census: 57F 157483.12(a).F 157F 157483.12(a).F 157F 157A 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 in either life threatening conditions or clinical complications); 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).F 157F 157physician notifications completed as needed and documentation supplied in the medical record. Events occurring May 23 an ongoing have been reviewed for appropriate notification.F 157A facility must immediately inform the resident; consult with the resident from the resident significant change in the resident significant on the facility as specified in §483.12(a).F 157F 157Physician notifications completed as needed and documentation supplied in the medical record. Events occurring May 23 an ongoing have been reviewed for appropriate notification.F 157A facility must immediately inform the resident; physician intervention; a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complexity in 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 di		revisit of your facilit validate that substa regulations has bee	y may be conducted to Intial compliance with the		Six additional residents havi admitted have been review	ing been recently ed to assure all		
 A facility must immediately more 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 (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration); 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). A facility must immediately more thereis and if the resident's physical and it is provided to a specified in \$483.12(a). A tracitity must immediately more thereis and if the resident's physical and the resident from the facility as specified in \$483.12(a). A tracitity must immediately more thereis an accident involving the resident from the facility as specified in \$483.12(a). 		483.10(b)(11) NOT	IFY OF CHANGES :/ROOM, ETC)	F 15	7 physician notifications company and documentation supplie	pleted as needed d in the medical		
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 Change in Condition/Status Notification Requirements Policy has been reviewed and revised to include responsible party notification.Intervention:Intervised to include responsible party notification.Intervention:Intervention:Intervised to include responsible party notification.Intervention:Intervised to include responsible party notification.Intervention:Intervised to include responsible party notification.Intervention:Intervention:Intervention:Intervised to include responsible party notification.Intervention:Intervention:Intervention:Intervention:Intervention:Intervention:Intervention:Intervention:Intervention:I		consult with the res known, notify the re or an interested far	sident's physician; and if asident's legal representative nily member when there is an		have been reviewed for app notification.	propriate		
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 Neurological Assessment Policy was reviewed and remains appropriate. RNs and LPNs received training on the Chan in Condition / Status Notification Requirement		injury and has the p intervention; a sign physical, mental, o deterioration in hea status in either life	botential for requiring physician ificant change in the resident's r psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or		Requirements Policy has be revised to include responsit	en reviewed and		
the resident from the facility as specified in §483.12(a).RNs and LPNs received training on the Chan in Condition / Status Notification Requirement		existing form of tre consequences, or	atment due to adverse to commence a new form of		-			
The facility must also promptly notify the resident [Policy and the Neurological Assessment Policy and the Neurological Assessment Poli		the resident from th §483.12(a).	ne facility as specified in		in Condition / Status Notific	ation Requirements		
and, if known, the resident's legal representative or interested family member when there is a		and, if known, the i or-interested family	resident's legal representative member when there is a			Assessment Policy.		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES				FORM/	06/05/2014 APPROVED 0938-0391
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY
		245277	B. WING			05/2	23/2014
NAME OF	PROVIDER OR SUPPLIER	·····			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPI	HAELS HEALTH & RE	HAB CENTER			01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
F 157	change in room or specified in §483.1 resident rights und regulations as spec this section. The facility must re the address and ph iegal representative This REQUIREME by: Based on interview facility failed to not resident's represer in condition for 1 of with death records	roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update none number of the resident's e or interested family member. NT is not met as evidenced w and document review, the ify the physician or the ntative of a significant change f 4 residents (R84) reviewed	F	157	Interact III Care Pathway Tools had bounded as a reference for nursi regarding physician notification of and staff received training . Daily stand up meeting agendas include review of incidents and of condition. These reviews will no monitoring to assure proper notifi been completed. This monitorin completed not less than weekly of and changes in condition until co been met and then will be review assure compliance is maintained	ng stat on each curren hange w inclu ficatio g will k on all i ompliar ved at	ff h wing tly s in ude ns have be ncidents nce has a level to
	and aftercare follow neoplasms of the f tumors) as noted of The hospital discha- listed diagnoses of hypertension (high dysphagia (difficult interagency referra- that, at the time of followed command was oriented to pla some memory and was able to express she was calm and referral discharge	on 1/24/14, for rehabilitation wing surgery for three benign rontal cerebral meninges (brain in the face sheet. arge summary dated 1/24/14, i meningioma (brain tumor), blood pressure), and y swallowing). The hospital if form dated 1/24/14, indicated discharge, R84 was alert and is, speech was clear, and she ice, and person. R84 had i judgement problems, though is her needs and desires, and cooperative. The interagency instructions directed physician tening symptoms of headache,			by the IDT. The Director of Nursing is respon monitoring. Compliance will be achieved by J		

Facility ID: 00583

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If continuation sheet Page 2 of 17

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

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

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245277	B. WING			05/2	3/2014
	PROVIDER OR SUPPLIER	HAB CENTER		60	TREET ADDRESS, CITY, STATE, ZIP CODE 01 GRANT AVENUE VELETH, MN 55734		
(X4) lD PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	or speech difficulty During an interview director of nursing had not occurred. An informed conse R84's power of attor representative on 1 to be a full code (fu The admission clin observation dated to be an undated la had already expired indicated R84 had make concrete req simple, direct comm documentation furt equal in size, but th and the right pupil unable to describe moaning, vocal cor expressions and pt Direct care staff we communicate to th noted. The clinical was alert and able the assessment. R84's admission vi respirations, and b from 1/24/14 throu to be stable. The f in R84's medical re p.m. with blood pre temperature docum no documented ne	inge 2 veakness, dizziness, memory or numbness or tingling. on 5/22/14, at 3:01 p.m. the (DON) verified this monitoring int for CPR, was signed by orney (POA) and family /24/14. R84 was considered ill resuscitation efforts). ical documentation for 1/24/14, to 1/25/14, appeared the entry and indicated R84 d. The documentation clear speech, was able to uests, and responded to munication only. The clinical her noted R84's pupils to be he left pupil reacted sluggishly reacted briskly. R84 was pain and expressed pain by mplaints of pain, facial totective body movements. are to monitor for pain and e licensed nurse if pain was documentation indicated R84 to state she hurt, at the time of tal signs (temperature, pulse, iood pressure) were monitored gh 1/25/14, and were indicated inal set of vital signs recorded ecord was on 1/25/14, at 4:08 issure, pulse, respirations, and nented as stable. There were urological checks after the ent completed on 1/27/14.		157			

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Facility ID: 00583

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

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

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245277	B. WING			05/2	23/2014
	PROVIDER OR SUPPLIER	HAB CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From particular the progress notes indicated R84 had signs or symptoms disrobing, very comredirect at that time respirations were e head incision was of The physician's vision indicated a chief corpoor quality and incorphysician also docus one back pain as were stable, pupils light, and the neuron stable, but poor. The progress notes indicated R84 was and lying with her hattempted to give respin pill four times, R84 would strike or and refuse to open the same at breakf documentation, R8 sleeping. The progress notes indicated R84 had during the day and down, but would not documentation indi if earlier yelling was incisions were notes cabbing over. R84 would strike of a stable, but poor the same at breakf documentation indi if earlier yelling was incisions were notes cabbing over. R84 would strike of the progress notes indicated R84 had during the day and down, but would not be a stable of the progress notes indicated R84 had during the day and down, but would not be a stable of the progress notes indicated R84 had during the day and down, but would not be a stable of the progress notes indicated R84 had during the day and down, but would not be a stable of the progress notes indicated R84 had during the day and down, but would not be a stable of the progress notes indicated R84 had during the day and down, but would not be a stable of the progress notes indicated R84 had during the day and down, but would not be a stable of the progress notes incluse the progress notes inc				DEFICIENCY)		
		ling to documentation.					Page 4 of 17

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00583

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PRINTED: 06/05/2014 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 245277 B. WING 05/23/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 GRANT AVENUE ST RAPHAELS HEALTH & REHAB CENTER EVELETH, MN 55734 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 157 F 157 Continued From page 4 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,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: K89M11

Facility ID: 00583

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		AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 06/05/20 FORMAPPROVI OMB NO. 0 <u>938-03</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION (X3) DATE SURVEY DING
		245277	B. WING	G05/23/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPH	IAELS HEALTH & RE	HAB CENTER		601 GRANT AVENUE EVELETH, MN 55734
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
F 157	treatment significan discharge the resid	ocial status, a need to alter htly, or a decision to transfer or ent from the facility.		157 F 279 Comprehensive Care Plan
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP			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 wa reviewed and revised and RN and LPNs trained.
	to be furnished to a highest practicable psychosocial well-t	t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise		The Dialysis Care Plan and the Shunt/Graft Monitoring order in Matrix will be utilized for residents receiving dialysis.
	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:			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 wil continue for a period of 3 months and then as determined by the IDT team. The Director of Nursing is responsible for
				monitoring.
		orders dated 5/1/14, listed		Compliance will be achieved by June 27, 2014.
			1	Eacility ID: 00583

Event ID: KB9M11

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Facility ID: 00583

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI			(X3) D/ CC	ATE SURVEY
		245277	B. WING			D	5/23/2014_
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP C	ODE	
ST RAPI	HAELS HEALTH & RE	HAB CENTER			GRANT AVENUE LETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	<	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 279	diagnoses including acute kidney failure hydronephrosis of f orders dated 1/30/1 (a vibration felt by p dialysis shunt) to en The care plan date renal dialysis three did not identify the access, frequency of infection to monid drainage) or check did not address die monitoring. In addi where dialysis was information for the emergency. There blood pressure tes vascular access lin R85, interviewed o he goes to dialysis Friday from about 9 depending on wheil bleeding. R85 stat checked or monito Registered nurse (at 2:30 p.m., verifi related to dialysis. director of nursing information was no The facility's Policy Access dated 5/1/1 venous fistula grafi	g chronic kidney disease, a, type I diabetes mellitus and the left kidney. Physician's 14, directed monitoring for thrill blacing one's hands on the nsure patency. d 4/24/14, indicated R85 had times weekly. The care plan location or type of vascular of monitoring, signs/symptoms itor (redness, swelling, warmth, ing bruit/thrill. The care plan tary or fluid restrictions or tion, there was no direction for provided or contact dialysis unit in case of was no direction to avoid ting or lab testing on the nb. n 5/20/14, at 2:10 p.m. stated on Monday, Wednesday and 0:30 a.m. until about 3 p.m. in the access site stops ed that access site was not	F 2	79			

PRINTED: 06/05/2014

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DA	. 0938-039 TE SURVEY MPLETED
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A, BUILDIN	G	CO	NPLETED
		245277			05/23/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER		601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 279	physician would be indicated to check t hardness, swelling,	called. The policy further the site daily for redness, pain or pus like drainage. The ff were to check the site	F 27	9		
F 309 SS=G	483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on interview facility failed to ass change of condition residents (R84) rev Findings include: R84 was admitted	CARE/SERVICES FOR	F 30	St. Raphael's Health and Reha not able to correct this deficie 84 as she no longer resides in Resident Events occurring Ma have been reviewed for notifi action. The Change in Condition/Stat Requirements Policy has been revised to include responsible notification. RNs and LPNs received trainin in Condition / Status Notification	ency for the facil y 23 and cation a us Notifi n review e party	resident lity. I beyond nd IDT cation ed and
	neoplasms of the fit tumors) as noted o The progress notes indicated R84's add the primary diagno craniotomy for rese for removal of brain staff was to monito	rontal cerebral meninges (brain		Policy. Interact III Care Pathway Too bounded as a reference for n regarding physician notificati and staff received training .	ursing st	aff

Facility ID: 00583

If continuation sheet Page 8 of 17

F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY APLETED
	245277	B. WNG		05/23/2014		
OVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·					
ELS HEALTH & RE	HAB CENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
control and use of j and lung sounds ev The hospital dischar also listed discharg brain tumor), hyp pressure), and dys The discharge sum he surgery without o have confusion a controlled with Sem nedication), with h nedications, includ isinopril. The hospital intera 1/24/14, indicated f R84 was alert and was clear, and she person. The intera ndicated R84 had problems, was able desires, and she w interagency referra directed to contact worsening symptor vorsiting, weaknes speech difficulty, o an interview on 5/2 of nursing (DON) v occurred. The admission clin observation dated o be an undated la nad already expire ndicated R84 had	pain medications every shift, very shift. arge summary dated 1/24/14, ge diagnoses of meningioma ertension (high blood phagia (difficulty swallowing). mary indicated R84 underwent t any complications, continued and impulsivity, though oquel (antipsychotic ypertension controlled with ding lopressor, norvasc, and gency referral form dated that, at the time of discharge, followed commands, speech was oriented to place, and agency referral form further some memory and judgement e to express her needs and ras calm and cooperative. The di discharge instructions also the physician if R84 developed ms of headache, nausea, s, dizziness, memory or r numbness or tingling. During (2/14, at 3:01 p.m. the director rerified this monitoring had not ical documentation for 1/24/14, to 1/25/14, appeared ate entry and indicated R84 d. The documentation clear speech, was able to		309	Daily stand up meeting agendas include review of incidents / ev changes in condition. These rev include auditing to assure prope have been completed and IDT h course of action. This auditing completed not less than weekly and changes in condition until of been met and then will be revie assure compliance is maintaine The Director of Nursing is respon monitoring. Compliance will be achieved by Phe phone DOU All decensed put	ents ar views v er noti: as det will be on all complia wed a d. nsible June 2	nd vill now fications ermined incidents ance has t a level to for 7, 2014 h/ze/14: acf Shap elated
	F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ALLS HEALTH & RE SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR I Continued From pa control and use of and lung sounds er The hospital discharg (brain tumor), hyp pressure), and dys The discharge sum the surgery without to have confusion a controlled with Ser medications, including to have confusion a controlled with Ser medicated R84 had problems, was able desires, and she w interagency referrat directed to contact worsening symptor vomiting, weaknes speech difficulty, o an interview on 5/2 of nursing (DON) v occurred. The admission clin observation dated to be an undated la had already expire indicated R84 had	CORRECTION IDENTIFICATION NUMBER: 245277 COVIDER OR SUPPLIER ALES HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 oressure), 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 isinopril. 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	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245277 B. WING COVIDER OR SUPPLIER 245277 NELS HEALTH & REHAB CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 8 ID Control and use of pain medications every shift, and lung sounds every shift. F3 The hospital discharge summary dated 1/24/14, also listed discharge diagnoses of meningioma (brain tumor), hypertension (high blood pressure), and dysphagia (difficulty swallowing). F3 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 isinopril. 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, yomiting, 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 poccurred.<	PF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ 245277 B. WING	Indicated R84 had some memory and indicated R84 had some memory andindicated R84 had some memory and indicated	F DERIGENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLAN DENTIFICATION NUMBER: 245277 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) CAL CONDERS, CITY, STATE, ZIP CODE 501 GRANT AVENUE EVELETH, MIN 56734 CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 501 GRANT AVENUE EVELETH, MIN 56734 500 FOROMERT AVENUE EVELETH, MIN 56734 SUMMARY STATEMENT OF DEDICIENCIES (EXCLUSTION WUST BE PRECEDED BY FULL REGULTORY OR LSO (DENTIFYING INFORMATION) PREFX TAB PROVIDER/SUPPLIER CACH CORRECTIVE ACTION SINULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 8 (prain tumor), hypertension (high blod corresure), and dysphagia (difficulty swallowing). The discharge summary dated 1/24/14, and lung sounds every shift. F 309 Daily stand up meeting agendas curre Include review of inclidents / events ar changes in condition. These reviews v include auditing to assure proper notif have been completed and IDT has det course of action. This auditing will been met and then will be reviewed a assure complicated n84 underwent the surgery without any complications, continued isinopril. F 309 Daily stand up meeting agendas curre include auditing to assure proper notif have been completed and IDT has det course of action. This auditing will be conspleted not less than weekly on all and changes in condition until complite been met and then will be reviewed a assure compliance is maintained. The bospital interagency referal form dated ifacted to Course har needs and datester, and she was calm and cooperative. The interagency referal discharge instructions also an interview on 5/22/14, at 301 p.m. the director of unrising (CON) verified this monitoring had not occurred. Compleacurel S

	MENT OF HEALTH							FORMA	06/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/		1 ' '			c		SURVEY
		24	5277	B. WNG	i		05/23/20		3/2014
NAME OF F	ROVIDER OR SUPPLIER	L		L	5	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
STRAPL	AELS HEALTH & RE			601 GRANT AVENUE					
UTRAIT						EVELETH, MN 55734			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
F 309	Continued From pa documentation furth equal in size, but th and the right pupil r unable to describe p moaning, vocal con expressions and pro Direct care staff we communicate to the noted. The clinical was alert and able to the assessment. An informed conser R84's power of atto representative on 1 to be a full code (fu The undated tempor was alert to self, ha alarms on bed and the assistance need daily living, risk for f breakdown. The te directed staff to mo analgesics (pain me monitor incisions da The pain assessme indicated R84 was a point to an area, bu describe her pain. R84 appeared to ha when touched in are also said "Ow" whe appear in any distret assessment.	her noted R84 e left pupil rea eacted briskly pain and expri- nplaints of pail otective body re to monitor to e licensed nurs documentation to state she hu int for CPR, wa rney (POA) ar /24/14. R84 v Il resuscitation orary care plan d a wander gu wheelchair, ar ded by R84 for falls, and risk mporary care pail of alls, and risk mporary care pail edications) eva aily. ent of 1/24/14, able to say, "C t was unable for the documen ave left sided a ea of a yellowin n moving legs	acted sluggishly acted sluggishly acted sluggishly acted pain by acted pain by acted pain by acted pain and acted pain was acted pain	F	309				
EORM CMS.05	R84's admission vit respirations, and blo 67(02-99) Previous Versions	ood pressure)		 	Fa	acility ID; 00583	If continuation	sheet P	age 10 of 17

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OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 05/23/2014 245277 B, WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 GRANT AVENUE ST RAPHAELS HEALTH & REHAB CENTER EVELETH, MN 55734 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B, WING 05/23/2014 245277 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 GRANT AVENUE ST RAPHAELS HEALTH & REHAB CENTER EVELETH, MN 55734 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 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.,

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OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 05/23/2014 245277 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 GRANT AVENUE ST RAPHAELS HEALTH & REHAB CENTER EVELETH, MN 55734 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 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

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		· ·	ULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED		
		245277	B. WING		05/23/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER		EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD E	E (X5) COMPLETION	
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			F 323 Safety Resident 14 was placed on a bow	el and bladder		
F 323 SS=D	family. The facility policy a assessment dated licensed nursing sta resident neurologic neurological functio physician immediat specific procedure assessment and di of neurological ass immediately to the 483.25(h) FREE OF HAZARDS/SUPER The facility must er environment remail as is possible; and	nd procedure for neurological February 2011, indicated aff will perform, monitor al functioning and changes in oning will be reported to the rely. The policy provided the in performing the neurological rects staff to document result essment and notify changes physician. F ACCIDENT	F 3.	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. A risk management team has been developed		
by Ba rev as inte	by: Based on observat review, the facility f assess risk for falls	NT is not met as evidenced tions, interview, document ailed to comprehensively and implement fall of 3 residents in the sample story of falls.		Monitoring of incidents and inter- be completed will be completed f compliance for a period of 3 mon as determined by the risk manage DON is responsible for monitoring Compliance will be achieved by Ju	M – F to assure ths and then ement team. g.	

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B WING 05/23/2014 245277 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 GRANT AVENUE ST RAPHAELS HEALTH & REHAB CENTER EVELETH, MN 55734 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 F 323 Continued From page 14 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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		AND HUMAN SERVICES				FORM/ MB NO.	06/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′				SURVEY PLETED
		245277	B. WING			05/2	23/2014
NAME OF F	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER			01 GRANT AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Status (BIMS) indic cognitive deficit, wi quarterly MDS, date also noted R14 dee extensive assistan transferring. The q indicated R14 had continued to need R14's care plan da ensure a motion al alarm on the reclin was in her wheelch within reach, antici toilet "ASAP." The director of nur at 12:47 p.m. R14 and reminding her been an appropria	Brief Interview for Mental cated R14 had moderate here she remained through the ed 1/1/14, and significant d 1/9/14. The 1/9/14, MDS clined in her ADLs and required ce from staff for mobility and uarterly MDS, dated 4/4/14, severe cognitive deficit and extensive assistance. ted 4/2/14, directed staff to arm was in place, personal er, dice (a non-slip surface) hair, ensure the call light was pate needs, and assist to the sing (DON) stated on 5/22/14, had a decline in her cognition to call for help may not have te intervention, and er interventions were needed to		323			

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		AND HUMAN SERVICES			FORM): 06/05/2014 //APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245277	B, WING		05	/20/2014
				STREET ADDRESS, CITY, STAT	E, ZIP CODE	
STRAPP	IAELS HEALTH & RE		, I	EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	κo	000		-
	FIRE SAFETY		1			
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATION HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE S BEEN ATTAINED IN 'ITH YOUR VERIFICATION.				
	Minnesota Departr time of this survey. Rehabilitation Cen compliance with th in Medicare/Medic 483.70(a), Life Saf edition of National	Survey was conducted by the nent of Public Safety. At the , St. Raphaels Health & ter was found not in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.				
	PLEASE RETURN CORRECTION FC DEFICIENCIES (K	R THE FIRE SAFETY				
	HEALTH CARE FI STATE FIRE MAR 444 CEDAR STRE ST. PAUL, MN 551 By email to:	SHAL DIVISION ET, SUITE 145				
LABORATOR	y pirector's or provi	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	Adminisfrator	ICEO 6	(X6) DATE
other safequa	cy statement ending with	an asterisk (*) denotes a deficiency wh otection to the patients. (See instruction r not a plan of correction is provided. I	ns.) Excer	stitution may be excused from cor pt for nursing homes, the findings	stated above are disclo-	sable 90 days

Any othe tollowing 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 10 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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		AND HUMAN SERVICES			FORMA	06/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
		245277	B. WING		05/2	20/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER	1	01 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K 000			
	Marian.Whitney@s	tate.mn.us				
	DEFICIENCY MUS FOLLOWING INFO	RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done				
	to correct the defic 2. The actual, or pi	iency. oposed, completion date.				
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.				
	2-story building wit building was const constructed in 197 II(111) constructior	h & Rehabilitation Center is a h a full basement. The original ructed in 1954 with an addition 4. The 1954 building is of type a and the 1974 building is type h. Therefore, the nursing home one building.				
	facility has a comp smoke detection ir open to the corrido automatic fire dep has a licensed cap	y sprinkler protected. The lete fire alarm system with the corridors and spaces or, that is monitored for artment notification. The facility pacity of 76 beds and had a time of the survey.				
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Facility ID: 00583

If continuation sheet Page 2 of 3

TATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CC	NSTRUCTION	OMB NO	E SURVEY
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		245277	B. WING			05	/20/2014
NAME OF I	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE	HAB CENTER			RANT AVENUE .ETH, MN 55734		
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	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted betweer	at least quarterly on each shift. with procedures and is aware f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are o 9 PM and 6 AM a coded y be used instead of audible		N ii d c V A	Fire drills will be conducted in NFPA 101, Chapter 19, and Se nsure that staff members are o react in the case of a fire e wills will be at unexpected the conditions at least quarterly of When drills are conducted be M, a coded announcement	ection 19 e properl mergenc mes unde on each s tween 9 will be m	.7.1.2 to y trained y. Fire er varying hift. PM and 6 ade
	Based on review o records, it was dete failed to properly cc with NFPA 101 (00) 19.7.1.2 This defi staff react in a fire of	s not met as evidenced by: f available reports and ermined that the facility has onduct fire drills in accordance , Chapter 19, Section cient practice could affect how emergency and could e safety of all building		p ti fo D c	nstead of using the audible a procedure is used during buil he audible alarm will be test ollowing week within the sar ight shift drill occurs. The M pirector shall be responsible onducting fire drills, and sha	ding quit ed during ne montl laintenar for plann ll insure t	e times, g the h that the hce ing and that
	FINDINGS INCLUDE: At the conclusion of the tour, on 5-20-14 at 10:00 AM, during a review of fire drill reports provided by the facility, it was noted that the facility did not conduct fire drills as one per shift per quarter as required. It was further noted that the fire drill forms are not filled out completely, i.e, time of the day, what staff took part in the drill, if the alarm			w ti O Li	omplete records are maintal /hich staff members particip me of day, alarm company c utcomes of the testing, etc. ife Safety Code. ire drill procedures and reco	ated in th ontactec as requir	ne drill, l, ed by the
monitoring company received the alarm, etc. This deficient practice was confirmed by the facility Maintenance Director (DL) and the administrator (DV) at the time of exit.			C	valuated and audited at the ommittee meeting. ate certain: June 13, 2014	monthly	safety	

Event ID: K89M21

Facility ID: 00583

If continuation sheet Page 3 of 3



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:

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

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

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

<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.

St Raphaels Health & Rehab Center June 6, 2014 Page 5 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

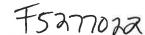
•		AND HUMAN SERVICES				FORM	: 06/05/2014 APPROVEI 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1		LE CONSTRUCTION 01 - Main Building 01		E SURVEY
		245277	B. WING	;		05/	20/2014
NAME OF F	ROVIDER OR SUPPLIER		I	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST RAPH	IAELS HEALTH & RE				01 GRANT AVENUE EVELETH, MN 55734		
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~.,	day, what staff took part in the drill, if the alarm monitoring company received the alarm, etc. This deficient practice was confirmed by the facility Maintenance Director (DL) and the administrator (DV) at the time of exit.				evaluated and audited at the n committee meeting. Date certain: June 13, 2014		

Event ID: K89M21

Facility ID: 00583

If continuation sheet Page 3 of 3

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



CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			1201	10 10	OMB NO	0938-0391
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		245277	B. WING				05	/20/2014
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EXT.	DEFICIENCIES (K- HEALTH CARE FIR STATE FIRE MARS 444 CEDAR STREE ST. PAUL, MN 5510 By email to:	R THE FIRE SAFETY Tags) TO: E INSPECTIONS HAL DIVISION ET, SUITE 145 01-5145, and			MN DEPT. (2 3 2014 DF PUBLIC SAFETY MARSHAL DIVISIO	V	
ABORATORY	DIRECTOR'S OR PROVID	ERISTPHIER REPRESENTATIVE'S SIGN	ATURE	A.	in the	La ICE	5 6	(X6) DATE
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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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245277	B. WING		05/	20/2014
NAME OF PROVIDER OR SUPPLIER ST RAPHAELS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CC 601 GRANT AVENUE EVELETH, MN 55734	DE	
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	Marian.Whitney@s	tate.mn.us				
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:				
	1. A description of v to correct the defici	vhat has been, or will be, done ency.				
	2. The actual, or pr	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency.				
	2-story building with building was constr constructed in 1974 II(111) construction	h & Rehabilitation Center is a n a full basement. The original ucted in 1954 with an addition I. The 1954 building is of type and the 1974 building is type . Therefore, the nursing home ne building.				
	facility has a compl smoke detection in open to the corridor automatic fire depa	sprinkler protected. The ete fire alarm system with the corridors and spaces r, that is monitored for rtment notification. The facility acity of 76 beds and had a time of the survey.				
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ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: K89M2'	F	acility ID: 00583 If	continuation she	et Page 2 of 3

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

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO.	0938-03
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		245277	B. WING		05/	20/2014
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	Based on review records, it was det failed to properly of with NFPA 101 (00 19.7.1.2 This de staff react in a fire adversely affect th occupants. FINDINGS INCLU At the conclusion of AM, during a revie by the facility, it w conduct fire drills a required. It was fu forms are not filled day, what staff too monitoring compa	is not met as evidenced by: of available reports and termined that the facility has conduct fire drills in accordance)), Chapter 19, Section ficient practice could affect how emergency and could be safety of all building DE: of the tour, on 5-20-14 at 10:00 w of fire drill reports provided as noted that the facility did not as one per shift per quarter as inther noted that the fire drill I out completely, i.e, time of the k part in the drill, if the alarm ny received the alarm, etc.		 ANN, a coded announcement instead of using the audib procedure is used during be the audible alarm will be the following week within the night shift drill occurs. The Director shall be responsible conducting fire drills, and second conducting fire drills, and second complete records are main which staff members parting time of day, alarm compare outcomes of the testing, end Life Safety Code. Fire drill procedures and recommittee meeting. 	le alarm. Wh building quite ested during same month Maintenan ole for planni shall insure t ntained show cipated in th by contacted tc. as require ecords will be	nen this times, the that th ce ng and hat ving e drill, ed by the
		e Director (DL) and the		Date certain: June 13, 2014	1	

Facility ID: 00583

If continuation sheet Page 3 of 3