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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LR2S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/12/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 08/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/03/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245327

August 28, 2014

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

Dear Mr. Eeg:

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 4, 2014 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 25 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 28, 2014

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

RE: Project Number S5327024

Amended letter with corrected effective date

Dear Mr. Eeg:

On July 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 4, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 4, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2014, effective August 4, 2014 and therefore remedies outlined in our letter to you dated July 16, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 19, 2014

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

RE: Project Number S5327024

Dear Mr. Eeg:

On July 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 4, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 4, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2014, effective August 2, 2014 and therefore remedies outlined in our letter to you dated July 16, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245327	A. Building B. Wing	8/12/2014

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **08/02/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/02/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/02/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/02/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	08/19/2014	03048	08/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/25/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245327	A. Building B. Wing	8/12/2014

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **08/04/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/04/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/04/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/04/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	08/28/2014	03048	08/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/25/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245327	A. Building 01 - MAIN BUILDING 01 B. Wing	8/4/2014

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0069	07/31/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/KFD	**Date:** 08/19/2014	**Signature of Surveyor:** 19251	**Date:** 08/04/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/24/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LR2S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/25/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 07/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/28/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/28/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5446

July 16, 2014

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

RE: Project Number S5327024

Dear Mr. Eeg:

On June 25, 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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 4, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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 September 25, 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 December 25, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	06/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**F276** The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to F276:	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a decline in urinary continence was comprehensively assessed so that interventions could be implemented to maintain as much urinary continence as possible for 1 of 1 resident (R25) in the closed record sample reviewed for urinary incontinence. Findings include: R25, who was admitted on 1/23/14 had an initial comprehensive assessment (Minimum Data Set-MDS) dated 2/5/14, which identified that R25 had occasional incontinence of bladder with no toileting program. During review of an	F 276	1. Resident R25 was admitted on 1/23/14. The resident was in the hospital during the time of survey. Prior to notification of discharge, resident's care plan was reviewed by DON. Plan was to initiate a 3 day bladder diary upon readmission. Resident was discharged to another facility closer to family. 2. Survey findings reviewed with DON and MDS coordinator. Residents will have 3 day bowel and bladder diaries initiated with quarterly reviews and per facility policy. Individual Resident Care plans reviewed, and staff	

approved KMS 7/28/14

date of completion for all new phone call Charity Hartfiel DNS 10:30am 7/28

(8/4/14)

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

Administrator 7/23/2014

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

RECEIVED
JUL 28 2014
Minnesota Department of Health
Marshall

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F 276	Continued From page 1 assessment dated 2/28/14, it identified that R25 was frequently incontinent of bladder with no toileting program. The quarterly assessment dated 5/2/14 revealed that R25 continued to have frequent urinary incontinence without a toileting program and the record lacked evidence that any further assessments had been conducted to prevent and/or address the decline in urinary incontinence. Review of the medical record did not include a bladder assessment after R25's bladder incontinence had been identified on the MDS. Interview with the director of nursing (DON) on 6/25/14, at 10:30 a.m. confirmed R25 had not been assessed after her urinary incontinence had been identified. The DON also confirmed that an individualized toileting program had not been implemented for R25 to promote and maintain as much urinary continence/control as possible. Review of the facility policy "Urinary Incontinence Assessment and Management" dated 1/27/10, indicates each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. Residents are assessed for urinary incontinence on admission and whenever there is a change in urinary function. The assessment will include identification of individuals with reversible and irreversible causes of incontinence and will be evaluated using the urinary incontinence assessment tool found in Matrix. A 3 day voiding diary and summary will be completed as part of the urinary incontinence assessment. The type of urinary incontinence will be determined using these tools and interventions will be implemented to address the residents incontinence.	F 276	interviews conducted to identify if there are any changes in residents toileting patterns with dates that are not in a quarterly review period. 3 day bowel and bladder diaries initiated for residents with changes to toileting patterns not in a review period, and care plans will be updated following completion of the bladder diary. 3. A policy Review was conducted on7/23/2014, On 7/23/2014, MDS coordinator was provided education on plan of correction and assigned to initiate 3 day Bowel and Bladder monitoring tool for upcoming quarterly assessments. Education was provided to the charge Nurses on 7/25/14 about the Survey Deficiency. Policy for Urinary Incontinence Assessment and Management and Bladder Diary Procedure reviewed with the Charge nurses. C.N.A. staff were provided education between 7/23/2014, and 08/04/2014, on policy for managing resident incontinence, how to complete the 3 day Bowel and Bladder forms and	

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F 276	Continued From page 2 Individualized toileting schedules will be developed for residents based on their urinary incontinence assessment.	F 276	purpose for completing forms, and expectations for completion of forms. MDS Coordinator will be educated on policy/procedure on 7/30/2014.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the appropriate services were provided for 1 of 1 resident (R25) whose closed record was reviewed and who experienced had a decline in urinary continence. Findings include: R25 was admitted on 1/23/14 with diagnoses identified on the diagnosis report form that included: dementia, weakness and kidney disease and was hospitalized on 6/22/14. R25, who was admitted on 1/23/14 had an initial comprehensive assessment (Minimum Data Set-MDS) dated 2/5/14, which identified that R25 had occasional incontinence of bladder with no toileting program. During review of an	F 315	4. Charge Nurse is to review the MDS schedule nightly, and communicate through report to staff on taped report and on the written communication document every shift which residents are being monitored for toileting patterns. Charge nurse is responsible to review completion of the 3 day bladder diary form at the end of each shift to ensure completion. MDS coordinator will monitor completion of Bowel and Bladder forms each week, and complete assessment tool for completion, and the DON will review completion the weekly monitoring tool at IDT to ensure the completion of the of Bowel and Bladder forms and ensure updating of the individual resident care plans at weekly IDT meetings. DON will audit for a period of six months and until it has been determined by QA to discontinue. Data will be	

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F 315	Continued From page 3 assessment dated 2/28/14, it identified that R25 was frequently incontinent of bladder with no toileting program. The quarterly assessment dated 5/2/14 revealed that R25 continued to have frequent urinary incontinence without a toileting program and the record lacked evidence that any further assessments had been conducted to prevent and/or address the decline in urinary incontinence. Review of the medical record did not include a bladder assessment after R25's bladder incontinence had been identified on the MDS. Interview with nursing assistant (NA)-A on 6/24/14, at 2:00 p.m. confirmed R25 was frequently incontinent of bladder. NA-A indicated the nursing staff would toilet R25 every 2 hours during the day, but urinary incontinence continued frequently. NA-A also confirmed R25 would be incontinent before she asked to be toileted. Interview with the director of nursing (DON) on 6/25/14, at 10:30 a.m. confirmed R25 had not been assessed after her urinary incontinence had been identified. The DON also confirmed that an individualized toileting program had not been implemented for R25 to promote and maintain as much urinary continence/control as possible. Review of the facility policy "Urinary Incontinence Assessment and Management" dated 1/27/10, indicates each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. Residents are assessed for urinary incontinence on admission and whenever there is a change in urinary function. The assessment will include identification of individuals with reversible	F 315	collected and will be presented to the committee at the next QA meeting in September. 5. Completion date will be ~~August 8~~, 2014. Aug 4, 2014 per DON **F 315** 1. Resident R25 was admitted on 1/23/14. The resident was in the hospital during the time of survey. Prior to notification of discharge, resident's care plan was reviewed by DON. Plan was to initiate a 3 day bladder diary upon readmission. Resident was discharged to another facility closer to family. 2. Survey findings reviewed with DON and MDS coordinator. Residents will have 3 day bowel and bladder diaries initiated with quarterly reviews and per facility policy. Individual Resident Care plans reviewed, and staff interviews conducted to identify if there are any changes in residents toileting patterns with dates that are not in a quarterly review period. 3 day bowel and bladder diaries initiated for residents with changes to toileting patterns not in a	

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F 315	Continued From page 4 and irreversible causes of incontinence and will be evaluated using the urinary incontinence assessment tool found in Matrix. A 3 day voiding diary and summary will be completed as part of the urinary incontinence assessment. The type of urinary incontinence will be determined using these tools and interventions will be implemented to address the residents incontinence. Individualized toileting schedules will be developed for residents based on their urinary incontinence assessment.	F 315	review period, and care plans will be updated following completion of the bladder diary. 3. A policy Review was conducted on7/23/2014, On 7/23/2014, MDS coordinator was provided education on plan of correction and assigned to initiate 3 day Bowel and Bladder monitoring tool for upcoming quarterly assessments. Education was provided to the charge Nurses on 7/25/14 about the Survey Deficiency. Policy for Urinary Incontinence Assessment and Management and Bladder Diary Procedure reviewed with the Charge nurses. C.N.A. staff were provided education between 7/23/2014, and 08/04/2014, on policy for managing resident incontinence, how to complete the 3 day Bowel and Bladder forms and purpose for completing forms, and expectations for completion of forms. MDS Coordinator will be educated on policy/procedure on 7/30/2014.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure parameters for use of medications were identified for 2 of 5 residents (R3 & R11) reviewed for use of as needed (PRN) analgesics, anti-psychotics, anti-anxiety and stool softener medications. The facility also failed to assess and justify the continued use of an antidepressant and proton pump inhibitor for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: Review of R3's current physician orders dated 6/24/14, included the following PRN medication orders: (1) Roxanol (morphine) 20 mg/ml (give 0.5-2.0 ml PRN for severe pain and dyspnea). (2) Senokot 8.6 mg (give 1-8 tablets daily PRN for constipation). (3) Haldol 2 mg/ml (give 0.5 mg-3.0 mg PRN for anxiety). (4) Ativan 0.5 mg (give 1-2 tablets PRN for anxiety). (5) Lidoderm patch 5% (give 1-3 patches every 12 hrs PRN for neck pain). There were no parameters ordered for the above medications found in the medical record. Review of the current physician orders dated 6/24/14, included the following scheduled medications: (1) Sertraline HCL 50 mg daily for depression ordered on 7/11/11, with no dose reduction or	F 329	4. Charge Nurse is to review the MDS schedule nightly, and communicate through report to staff on taped report and on the written communication document every shift which residents are being monitored for toileting patterns. Charge nurse is responsible to review completion of the 3 day bladder diary form at the end of each shift to ensure completion. MDS coordinator will monitor completion of Bowel and Bladder forms each week, and complete assessment tool for completion, and the DON will review completion the weekly monitoring tool at IDT to ensure the completion of the of Bowel and Bladder forms and ensure updating of the individual resident care plans at weekly IDT meetings. DON will audit for a period of six months and until it has been determined by QA to discontinue. Data will be collected and will be presented to the committee at the next QA meeting in September. 5. Completion date will be ~~August 8, 2014.~~ Aug 4 per DON	

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F 329	Continued From page 6 justification noted for continued use in the medical record; and (2) Omeprazole (Prilosec) 20 mg daily was ordered on 2/14/12 with no dose reduction or justification for continued use evident in the medical record. Documentation was lacking to indicate the effectiveness of the medication. Review of the facility pharmacy consultant recommendations dated 2/26/14, included the use of the Sertraline for R3. The report indicated the pharmacist recommended a dose reduction. Review of the pharmacist recommendations for the use of Prilosec dated 3/26/14, indicated the need to re-evaluate the continued use and effectiveness of medication. Further review of the pharmacy consultant reports since these recommendations were made, did not include follow up recommendations when there had been no response from the physician. Review of R11's current physician orders dated 6/24/14, included the following PRN medication orders: (1) Haldol 2 mg/ml (give 0.5 mg-3.0 mg PRN for anxiety). (2) Ativan 0.5 mg (give 1-2 tablets PRN for anxiety). There were no parameters ordered for the above medications found in the medical record. Interview with licensed practical nurse (LPN)-A on 6/24/14, at 2:30 p.m. indicated the above PRN medications for R3 and R11 were given very rarely and there had been no defined parameters for the dosage to be given. LPN-A further confirmed she had given the above PRN medications, but would only give the lowest dose	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to **F329** 1. On 7/14/2014 Review of R3s current physician orders and prn medications reviewed for need and recent use. Physician was contacted, to address dose reduction, and stop orders initiated to reduce PRN medications, and to request parameters for range order medications. Resident's Mood assessments reviewed with physician, and orders written to continue medication as ordered for R3s antidepressant medication. Reviewed R11's medications on 06/16/2014 with physician. Medication review conducted by pharmacy on 06/26/2014.	

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F 329	Continued From page 7 ordered regardless of the resident's symptoms. Interview with the director of nursing (DON) on 6/24/14, at 3:00 p.m. confirmed the above PRN medications for R3 and R11 had not included parameters for the appropriate dosage to be administered. The DON also confirmed there had been no dose reductions or justification for the continued use of the medications, Sertraline and Prilosec for R3 in the past year, and no follow up recommendations from the facility pharmacist had been evident. Interview with the facility pharmacist on 6/25/14, at 10:00 a.m. confirmed the physician had not responded to the recommendations related to R3's use of Sertraline and Prilosec. She verified she had not followed up on these recommendations when there had been no response from the physician. The pharmacist further indicated there were no parameters found in the medical record for the use of the PRN medications for R3 and R11. The pharmacist also indicated she had assumed the nursing staff had defined criteria for the dosage of the medication to be administered.	F 329	Hospice nurse contacted to address clarification of medication orders from hospice to be more specific. Plan is for hospice nurse to address with hospice medical director, and to clarify parameters for R11s medications with the physician. Hospice nurse will report updates by August 4, 2014. 2. Review of resident medications conducted with pharmacy review that focused on identifying dose reductions. Pharmacist identified need for dose reductions and updated DON. DON of residents needing dose reductions addressed. Physician contacted and given data to determine whether or not a dose reduction is to be ordered at this time.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	3. Policy review of psychotropic medications and prn medications reviewed by DON. Education provided to MDS coordinator to address dose reductions with quarterly reviews and communicate times for dose reductions during weekly IDT meetings. Dose reduction flow sheet was	

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F 428	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility pharmacist failed to ensure parameters for use of medications were identified for 2 of 5 residents (R3 & R11) reviewed for use of as needed (PRN) analgesics, anti-psychotics, anti-anxiety and stool softener medications. The pharmacist also failed to ensure recommendations for the continued use of an antidepressant and proton pump inhibitor for 1 of 5 residents (R3) had been reviewed by the physican. Findings include: Review of R3's current physician orders dated 6/24/14, included the following PRN medication orders: (1) Roxanol (morphine) 20 mg/ml (give 0.5-2.0 ml PRN for severe pain and dyspnea). (2) Senokot 8.6 mg (give 1-8 tablets daily PRN for constipation). (3) Haldol 2 mg/ml (give 0.5 mg-3.0 mg PRN for anxiety). (4) Ativan 0.5 mg (give 1-2 tablets PRN for anxiety). (5) Lidoderm patch 5% (give 1-3 patches every 12 hrs PRN for neck pain). There were no parameters ordered for the above medications found in the medical record. Review of the current physician orders dated 6/24/14, included the following scheduled medications:	F 428	implemented on 7/24/2014 to monitor when dose reductions are addressed or attempted, and education on policies and implementation of monitoring will be provided to MDS coordinator on 7/30/2014. MDS coordinator and pharmacist will monitor times for dose reductions and communicate with the Charge Nurse and DON need to address dose reductions. Charge nurses were provided education for when to clarify orders pertaining to orders that are without parameters and orders that have ranges. 4. Monitoring of medication orders will be done by the charge nurse daily as orders are written, and a double check will occur on the night shift. Charge nurse will contact physicians for clarification on orders that have no parameters or ranges. Night charge nurse will monitor physician orders nightly before filing them and verify that physicians are contacted to clarify orders that have no parameters. 5. DON and pharmacist will	

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F 428	Continued From page 9 (1) Sertraline HCL 50 mg daily for depression ordered on 7/11/11, with no dose reduction or justification noted for continued use in the medical record; and (2) Omeprazole (Prilosec) 20 mg daily was ordered on 2/14/12 with no dose reduction or justification for continued use evident in the medical record. Documentation was lacking to indicate the effectiveness of the medication. Review of the facility pharmacy consultant recommendations dated 2/26/14, included the use of the Sertraline for R3. The report indicated the pharmacist recommended a dose reduction. Review of the pharmacist recommendations for the use of Prilosec dated 3/26/14, indicated the need to re-evaluate the continued use and effectiveness of medication. Further review of the pharmacy consultant reports since these recommendations were made, did not include follow up recommendations when there had been no response from the physician. Review of R11's current physician orders dated 6/24/14, included the following PRN medication orders: (1) Haldol 2 mg/ml (give 0.5 mg-3.0 mg PRN for anxiety). (2) Ativan 0.5 mg (give 1-2 tablets PRN for anxiety). There were no parameters ordered for the above medications found in the medical record. Interview with licensed practical nurse (LPN)-A on 6/24/14, at 2:30 p.m. indicated the above PRN medications for R3 and R11 were given very rarely and there had been no defined parameters for the dosage to be given. LPN-A further	F 428	monitor medications for presence of parameters for medications and monitor for clarification of medications with ranges during the monthly pharmacy review. 6. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed and discussed at the next quaterly Quality Assurance meeting in September. At this time, the QA comitte will make the decision and or recommendation regarding any necessary follow-up studies Completion date August 4, 2014. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	06/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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F 428	Continued From page 10 confirmed she had given the above PRN medications, but would only give the lowest dose ordered regardless of the resident's symptoms. Interview with the director of nursing (DON) on 6/24/14, at 3:00 p.m. confirmed the above PRN medications for R3 and R11 had not included parameters for the appropriate dosage to be administered. The DON also confirmed there had been no dose reductions or justification for the continued use of the medications, Sertraline and Prilosec for R3 in the past year, and no follow up recommendations from the facility pharmacist had been evident. Interview with the facility pharmacist on 6/25/14, at 10:00 a.m. confirmed the physician had not responded to the recommendations related to R3's use of Sertraline and Prilosec. She verified she had not followed up on these recommendations when there had been no response from the physician. The pharmacist further indicated there were no parameters found in the medical record for the use of the PRN medications for R3 and R11. The pharmacist also indicated she had assumed the nursing staff had defined criteria for the dosage of the medication to be administered.	F 428	**F428** 1. On 7/14/2014 Review of R3s current physician orders and prn medications reviewed for need and recent use. Physician was contacted, to address dose reduction, and stop orders initiated to reduce PRN medications, and to request parameters for range order medications. Resident's Mood assessments reviewed with physician, and orders written to continue medication as ordered for R3s antidepressant medication. Reviewed R11's medications on 06/16/2014 with physician. Medication review conducted by pharmacy on 06/26/2014. Hospice nurse contacted to address clarification of medication orders from hospice to be more specific. Plan is for hospice nurse to address with hospice medical director, and to clarify parameters for R11s medications with the physician. Hospice nurse will report updates by August 4, 2014.	

2. Review of resident medications conducted with pharmacy review that focused on identifying dose reductions. Pharmacist identified need for dose reductions and updated Don. DON of residents needing dose reductions addressed. Physician contacted and given data to determine whether or not a dose reduction is to be ordered at this time.

3. Policy review of psychotropic medications and prn medications reviewed by DON. Education provided to MDS coordinator to address dose reductions with quarterly reviews and communicate times for dose reductions during weekly IDT meetings. Dose reduction flow sheet was implemented on 7/24/2014 to monitor when dose reductions are addressed or attempted, and education on policies and implementation of monitoring will be provided to MDS coordinator on 7/30/2014. MDS coordinator and pharmacist will monitor times for dose reductions and communicate with the Charge Nurse and DON need to address dose reductions. Charge nurses were provided education for when to clarify orders pertaining to orders that are without parameters and orders that have ranges.

4. Monitoring of medication orders will be done by the charge nurse daily as orders are written, and a double check will occur on the night shift. Charge nurse will contact physicians for clarification on orders that have no parameters or ranges. Night charge nurse will monitor physician orders nightly before filing them and verify that physicians are contacted to clarify orders that have no parameters.

5. DON and pharmacist will monitor medications for presence of parameters for medications and monitor for clarification of medications with ranges during the monthly pharmacy review.

6. The data collected will be presented to the QA committee by the Director of Nursing. The data will be reviewed and discussed at the next quaterly Quality Assurance meeting in September. At this time, the QA comitte will make the decision and or recommendation regarding any necessary follow-up studies

Completion date August 4, 2014.

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

F5327022

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 24, 2014. At the time of this survey, Divine Providence Health Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	Pock B 1-25-14 RECEIVED JUL 24 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 8-4-14
Exit: 6-25-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	7/18/2014

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Divine Providence Health Center is a one-story building, constructed in 1967. It has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an outpatient medical clinic and an assisted living facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching 90-minute fire-rated door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with battery-operated smoke alarms. The facility has a capacity of 25 beds and had a census of 23 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 069 K 069 SS=D	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's commercial kitchen hood mesh filter system is not in accordance with NFPA 101 (2000) Section 9.2.3. This deficient practice could adversely affect 9 of 25 residents or staff.. FINDINGS INCLUDE: During the facility tour between 9:30 AM and 12:30 PM on 6/24/2014, it was observed that the kitchen hood had the mesh type filiters and not the stainless steel baffled filters in accordance with NFPA LSC(00) edition section 9.2.3. This deficient practice was confirmed with the Maintenance Supervisor.	K 069 K 069	K 069 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to K069: 1. On 6/27/2014, the facility plant manager initiated contact with Classic Acoustic Clean to replace the outdated kitchen hood filters. Classic Acoustic Clean was onsite to measure the filters that are to be replaced on 6/30/2014. 2. The Plant Manager will ensure that all required kitchen hood filters are replaced by 7/31/2014. 3. The Administrator will audit the completion of this corrective action on 8/1/2014. Completion date: August 1, 2014	