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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M6T0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00040

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245599**
2.STATE VENDOR OR MEDICAID NO.
(L2) **356540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE COMMUNITY HOME**
(L4) **700 THIRD AVENUE NORTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

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 **06/09/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(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):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on June 10, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(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 # 245599

June 11, 2014

Ms. Jayna Groebner, Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, Minnesota 56085

Dear Ms. Groebner:

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 May 22, 2014 the above facility is certified for or recommended for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 11, 2014

Ms. Jayna Groebner, Administrator Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

RE: Project Number

Dear Ms. Groebner:

On April 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 17, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 9, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 10, 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 April 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 17, 2014, effective May 22, 2014 and therefore remedies outlined in our letter to you dated April 25, 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.

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

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
245599	A. Building B. Wing	6/9/2014

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **05/22/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/22/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/22/2014**
ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **05/22/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/22/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	06/11/2014	03048	06/09/2014
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
4/17/2014			

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
245599	A. Building 01 - MAIN BUILDING 01 B. Wing	6/10/2014

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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 Reg. # NFPA 101 LSC K0018	Correction Completed 04/18/2014	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	06/11/2014	22373	06/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
4/17/2014

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: M6T0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00040

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245599**

2.STATE VENDOR OR MEDICAID NO.
(L2) **356540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE COMMUNITY HOME**
(L4) **700 THIRD AVENUE NORTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

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 **04/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (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
	58			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 06/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/11/2014 (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
10/01/1991
(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

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

CCN-24-5599

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 25, 2014

Ms. Jayna Groebner, Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, Minnesota 56085

RE: Project Number S5599024

Dear Ms. Groebner:

On April 17, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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>Electronic 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 May 27, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 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 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. 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 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 July 17, 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 October 17, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

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

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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
	245599	A. BUILDING _____ B. WING _____	04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085**

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		5/22/14

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

Electronically Signed | 05/05/2014

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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	245599	A. BUILDING _____ B. WING _____	04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a manner to ensure the privacy of personal medical information for 4 of 4 residents (R23, R60, R59 & R42) who were observed during medication pass. Findings Include: On 4/15/ 14, at 4:30 p.m. during observation of medication pass in the main dining room, trained medication aide (TMA)-A was observed to walk away from the medication cart and leave the computer screen on top of the medication cart open and easily in view of anyone who were present in the hallway. The computer screen had medical information for R23 in view, which included medications, diagnoses and personal information. The information could be easily visualized by other residents, visitors and/or staff who were present in the hallway. On 4/15/14, at 4:45 p.m. TMA-A was again observed to access the computer screen and prepare medications for R60. After TMA-A set up R60's medications, TMA-A was observed to walk away from the medication cart. The computer screen remained open and visible to multiple residents, staff and other persons present in the dining room. Once again, it was noted that the	F 164	The facility will maintain confidentiality of resident information in the electronic medical record. Nursing staff will be reeducated on the EHR (Electronic Health Records) policy and procedure at staff meeting on 5/15/14. Those staff not able to attend the meeting will review policy and sign that they understand. The Policy ECS: HIPPA was updated and revised 4/22/14. When staff walks away from a computer screen, they will be expected to log out of the electronic charting system or utilize the Hide button to protect any information on the resident. The screens will automatically go to a screen saver button after 1 minute of sitting idle. Health Information Services and Charge Nurses will monitor to ensure compliance. They will perform spot checks randomly. Director of Nursing, Health Information Services and Administrator will ensure overall compliance. Any concerns will be addressed with the quality assurance team.	

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F 164	Continued From page 2	F 164		

computer screen contained personal and medical information for R60.

On 4/15/14, at 7:30 p.m. TMA-A was again observed administering medications from the medication cart with the computer located on the medication cart. TMA-A prepared medications for R59. During the observation in the main hall near the nurses station, TMA-A left the screen of the computer open with R59's personal and medical information exposed to view. TMA-A went into R59's room and left the computer screen open and visible in the hall to staff, residents and/or visitors.

On 4/17/14 at 7:25 a.m. licensed practical nurse (LPN)-A was observed to prepare medications for R42 from the medication administration cart. During the observation and after medication preparation, TMA-A was observed to take R42's medications into his room and administer them while leaving the computer screen on top of the medication cart open and visible to anyone in the hallway. The computer screen included medical and personal information for R42 that would be easily visible to anyone in the hallway. R42's medical record was left open and visible for ten minutes while LPN-A was away from the medication cart.

On 04/17/14 at 8:20 a.m. the medication cart was observed to left, unoccupied in the main dining room with the computer screen open. The computer screen was again open to display resident information. At 8:40 a.m. ten minutes later, LPN -A was observed to return to the medication cart.

On 04/17/14, at 10:00 a.m. the director of nursing

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F 164	Continued From page 3 (DON) was interview about the expectation for maintaining confidentiality of resident information on the electronic medical record. The DON verified that information was to be protected by clicking the "hide" button on the computer keyboard when staff left the computer unattended. The DON stated this "hide button" on the computer screen had been implemented so that staff could protect resident's personal and medical information when stepping away from the medication cart. The DON verified the computer screen should be closed and that it was inappropriate for staff to leave the screen open for others to the view. During review of the electronic health records (EHR) policy, revised 3/2011, the following was noted: Health information will be kept confidential within the electronic charting system by utilizing passwords and defined user group privileges; and the computers used to access the electronic record will be for staff only and will not be left unattended without locking or returning to the sign-on screen. Procedure for the policy was identified as follows: 1. when you walk away from the computer screen: a. Click the hide button if you are returning soon. This will lock the computer and prevent others from using it. The only password the system will accept to unlock the computer is the employees password that clicked the hide button.	F 164		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		5/22/14

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F 282	Continued From page 4 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for reporting new skin issues for 1 of 3 (R30) residents reviewed for non-pressure related skin issues and failed to elevate the head of bed during gastrostomy (g) tube feedings for 1 of 1 resident (R42) reviewed who had a g-tube. Findings include: During observation on 4/14/14, at 10:55 a.m. R30 was seated in her wheelchair in her bedroom. R30's left pantleg was not covering all of the lower leg and the bottom half of the lower left leg was exposed. A round scabbed area on the outer aspect of R30's lower left leg measuring approximately 1 centimeter (cm) in diameter with several reddened scratch-like areas in various stages of healing surrounding the scabbed area was observed. Review of R30's medical record revealed an admission date of 5/29/13 with diagnoses including osteoarthrosis, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The plan of care last updated 4/11/14 indicated a problem of potential for tissue integrity impairment/skin changes. The interventions included to inspect skin every shift and report skin changes to the nurse immediately. The record did not identify the scab/scratched areas located on R30's left lower leg.	F 282	On 4/17/14 RN updated R30 plan of care regarding skin integrity. Medical record was immediately corrected on 4/17/14 identifying scab/scratched areas located on R30□s lower leg. All Nursing staff will be reeducated at staff meeting on 5/15/14 regarding Policy: Skin Care Protocol which states, Skin will be inspected with daily cares by NA/Rs and any changes reported to charge nurse for follow-up. Those residents who do not need daily assistance will have their skin inspected at least weekly during their bath. Those staff not able to attend the meeting will review policy and sign that they understand. AM and PM Care Policies were updated to include reporting any skin changes immediately to charge nurse. Changes will be presented at staff meeting on 5/15/14. Those staff not able to attend the meeting will review policy and sign that they understand. Charge nurses will monitor for compliance. Director of Nursing will oversee to ensure overall compliance. Any concerns will be addressed with the quality assurance team. D.O.N. had an employee conference with	

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F 282	Continued From page 5 During interview on 4/17/14, at 9:11 a.m. NA-G stated that upon discovery of a new skin issue the nurse is informed immediately. NA-G further stated that the resident's skin is checked daily with cares and also once a week on bath day; and the nurse will also check the resident's skin on bath day. During interview on 4/17/14, at 9:40 a.m. NA-E stated that when a new skin issue is discovered the nurse is informed immediately. NA-E confirmed she had assisted R30 with dressing "her lower half" that morning. NA-E stated that R30 had many scarred areas on her lower legs that have always been there. During observation of R30's lower legs with NA-E present, it was confirmed there was an area on the outer aspect of the lower left leg that was scabbed and a scrape type area located next to the scab which appeared to be healing. NA-E confirmed the skin area appeared to be a 'new' skin issue and she stated she had not reported it to the nurse as she didn't think it was a big deal. During observation on 4/17/14, at 9:54 a.m. RN-C confirmed the scabbed area located on R30's left lower leg was a new skin area that was healing and the expectation would have been to report it to the nurse for further assessment. RN-C further confirmed R30 had several small reddened areas on the left lower leg that appeared to be scratch marks in various stages of healing. RN-C reviewed R30's record and confirmed the areas were not reported to nursing and they should have been. During interview on 4/17/14, at 10:13 a.m., the director of nursing (DON) confirmed that when a	F 282	LPN-A to review survey findings of deficient practices and updated PEG (Percutaneous Endoscopic Gastrostomy Tube) Management; NG (Nasogastric) Tube Management policy. Expected practice and rationale explained. Nursing staff were informed that R42 head of bed must be elevated at least 30 degrees when tube feeding, medications or water administered as written in plan of care. All nursing staff will be reeducated that any resident receiving enteral feeding or medications will have the head of bed raised at least 30 degrees to decrease the risk of aspiration which may lead to pneumonia or death at staff meeting on 5/15/14. Those staff not able to attend the meeting will review policy and sign that they understand. Nursing assistants and licensed nursing personnel will document each shift to verify that the head of the bed was raised at least 30 degrees. Charge nurses will monitor to ensure compliance. The Director of Nursing will oversee to ensure overall compliance. Any concerns will be addressed with the quality assurance team.	

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new skin issue is discovered by the NA's it was to be reported to the nurse. The DON further confirmed the nursing assistants should be inspecting the resident's skin when providing care as stated in the plan of care.

Review of the policy titled, "Skin Care Protocol" revised 6/09 included: "Skin will be inspected with daily cares by NA/R's and any changes reported to charge nurse for follow-up."

The plan of care for R42, dated 11/26/13, identified that staff should ensure the resident bed is kept with the head of bed (HOB) elevated at all times during tube feedings.
During medication administration observation on 4/17/14, at 7:25 a.m. licensed practical nurse (LPN)-A prepared and administered medications through a G-tube, while R42 was lying flat on his bed. LPN-A was observed to provide care in the following manner: disconnected the continuous feeding of Jevity 1.2 cal at 150 cc/ hour via kangaroo pump, filled a container with 350 cubic centimeters (cc) of water, informed R42 it was time for his Tylenol, turned off the feeding pump, placed a syringe into the port of the g-tube, flushed the tube with water and then administered the medication via the g- tube. R42 remained in bed without the head of the bed elevated as stated in the plan of care.
During interview with the director of nursing (DON) on 4/17/14, at 8:36 a.m. she verified that facility policy dictated the head of the bed to be elevated 30 degrees at all times during the administration of g-tube feedings.
During interview with nursing assistants (NA)-E and NA-F on 4/17/14, at 8:50 a.m. they both stated they were unaware the head of the bed should remain elevated during g-tube feedings,

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F 282	Continued From page 7 whenever R42 was lying in bed. During review of the policy titled: Peg (Percutaneous Endoscopic Gastrostomy Tube) Management NG Tube Management (Nasal Gastric) dated Org: 1/11 and Rev: 3/13, it was stated: 1. Any resident receiving tube feedings must have: a. The head of the bed elevated 30 degrees at all times unless contraindicated.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify, assess, and monitor scratches and an abraded area for 1 of 3 residents (R30) reviewed for non-pressure related skin issues. Findings include: During observation on 4/14/14, at 10:55 a.m. R30 was observed seated in her wheelchair in her bedroom. R30's left pantleg was not covering all of the lower leg and the bottom half of the lower left leg was exposed. A round scabbed area on	F 309	On 4/17/14 nurse completed Incident Report, updated R30 Care Plan, informed physician and reeducated resident on risks of scratching skin. Nursing staff were informed to report any abnormal findings on skin to charge nurse immediately for further assessment. All Nursing staff will be reeducated at staff meeting on 5/15/14 regarding Policy: Skin Care Protocol which states Skin will be inspected with daily cares by NA/R's and	5/22/14

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F 309	Continued From page 8 the outer aspect of R30's lower left leg measuring approximately 1 centimeter (cm) in diameter with several reddened scratch-like areas in various stages of healing surrounding the scabbed area was observed. Review of R30's medical record revealed an admission date of 5/29/13 with diagnoses including osteoarthrosis, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The plan of care last updated 4/11/14 indicated a problem of potential for tissue integrity impairment/skin changes. The interventions included to inspect skin every shift and report skin changes to the nurse immediately. The record did not identify the scab/scratched areas located on R30's left lower leg. During interview on 4/16/1,4 at approximately 11:00 a.m. R30 stated reddened and scabbed areas on her left leg were from running her leg into her wheelchair during transfer. R30 denied reporting the areas to the nurse stating, "It's no big deal". During interview on 4/17/14, at 8:20 a.m. registered nurse (RN)-C stated that upon discovery of a new skin issue, an incident report is completed. RN-C indicated the nurse completing the report will ask the resident if they know what happened and also will do an investigation; if unable to identify the cause of injury, a vulnerable adult report would be filed. The physician and family are notified and the area is monitored daily and measured weekly on the treatment administration record until healed. RN-C further stated that nurses conduct a weekly skin assessment on resident bath day and the	F 309	any changes reported to charge nurse for follow-up. Those residents who do not need daily assistance will have their skin inspected at least weekly during their bath. Those staff not able to attend the meeting will review policy and sign that they understand. AM and PM Care Policies were updated to include reporting any skin changes immediately to charge nurse. Changes will be presented at staff meeting on 5/15/14. Those staff not able to attend the meeting will review policy and sign that they understand. Charge nurses will monitor for compliance. Director of Nursing will oversee to ensure overall compliance. Any concerns will be addressed with the quality assurance team.	

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nursing assistants (NA's) will also inform the nurse when a new skin issue is discovered when doing cares.

During interview on 4/17/14, at 9:11 a.m. NA-G stated that upon discovery of a new skin issue the nurse is informed immediately. NA-G further stated the residents skin is checked daily with cares and also once a week on bath day; and the nurse will also check the residents skin on bath day.

During interview on 4/17/14, at 9:40 a.m. NA-E stated that when a new skin issue is discovered the nurse is informed immediately. NA-E confirmed she had assisted R30 with dressing "her lower half" that morning. NA-E stated that R30 had many scarred areas on her lower legs that have always been there. During observation of R30's lower legs with NA-E present, it was confirmed there was an area on the outer aspect of the lower left leg that was scabbed and a scrape type area located next to the scab which appeared to be healing. NA-E confirmed the skin area appeared to be a 'new' skin issue and she stated she had not reported it to the nurse as she didn't think it was a big deal. NA-E confirmed that when assisting R30 earlier with dressing she had not recognized this as a new area and therefore did not report it to the nurse.

During observation on 4/17/14, at 9:54 a.m. RN-C confirmed the scabbed area located on R30's left lower leg was a new skin area that was healing and the expectation would have been to report this skin issue to the nurse for further assessment and follow-up monitoring. RN-C further confirmed R30 had several small reddened areas on the left lower leg that

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F 309	Continued From page 10 appeared to be scratch marks in various stages of healing. RN-C reviewed R30's record and confirmed the areas were not reported to nursing and they should have been. During interview on 4/17/14, at 10:13 a.m., the director of nursing (DON) confirmed that when a new skin issue is discovered by the NA's it was to be reported to the nurse. The DON further confirmed that the nursing assistants should be inspecting the resident's skin when providing care. Review of the policy titled, "Skin Care Protocol" revised 6/09 included: "Skin will be inspected with daily cares by NA/R's and any changes reported to charge nurse for follow-up."	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		5/22/14

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F 322	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that staff checked for proper tube placement prior to the administration of medication for 1 of 1 resident (R42) who had a gastrostomy tube. Findings include: During medication administration observation on 4/17/14, at 7:25 a.m. licensed practical nurse (LPN)-A prepared and administered medications through a G-tube, while R42 was lying flat on his bed. LPN-A was observed to provide care in the following manner: disconnected the continuous feeding of Jevity 1.2 cal at 150 cc/ hour via kangaroo pump, filled a container with 350 cubic centimeters (cc) of water, informed R42 it was time for his Tylenol, turned off the feeding pump, placed a syringe into the port of the g-tube, flushed the tube with water and then administered the medication via the g- tube. LPN-A did not check for placement of the g-tube prior to the administration of the water and the dissolved medication. When interviewed on 4/17/14, at 7:40 a.m. LPN-A confirmed the placement of the G-tube had not been checked prior to administration of the medications since the Jevity feeding was already running. LPN-A further stated that she would usually check the placement of the tube with auscultation of the abdomen while injecting air into the tube through the port. LPN-A stated she did not have a stethoscope with her at this time to	F 322	D.O.N. had an employee conference with LPN-A to review survey findings of deficient practices and updated PEG (Percutaneous Endoscopic Gastrostomy Tube) Management; NG (Nasogastric) Tube Management policy. Expected practice and rationale explained. Nursing staff were informed that R42 head of bed must be elevated at least 30 degrees when tube feeding, medications, or water administered. All nursing staff will be reeducated that any resident receiving enteral feeding or medications will have the head of bed raised at least 30 degrees to decrease the risk of aspiration which may lead to pneumonia or death at staff meeting on 5/15/14. Those staff not able to attend the meeting will review policy and sign that they understand. Nursing assistants and licensed nursing personnel will document each shift to verify that the head of the bed was raised at least 30 degrees. PEG (Percutaneous Endoscopic Gastrostomy Tube) Management; NG (Nasogastric) Tube Management policy has been revised Nurse may verify proper placement of PEG/Gastric Tube or J	

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	245599	A. BUILDING _____ B. WING _____	04/17/2014

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F 322	Continued From page 12 check for proper placement. During interview with the director of nursing (DON) on 4/17/14, at 8:36 a.m. she verified the placement of G-tube was to be checked with each medication administration and feeding by auscultation and air bolus insertion. The DON also verified that facility policy dictated the head of the bed to be elevated 30 degrees at all times during the administration of g-tube feedings. During review of the policy titled: Peg (Percutaneous Endoscopic Gastrostomy Tube) Management NG Tube Management (Nasal Gastric) dated Org: 1/11 and Rev: 3/13, it was stated: the tube should always be checked for placement prior to administering medications and "The aim of this policy is to ensure that the resident receives a holistic and standardized care. The following guidelines are written so that nurses are aware of the care needed to maintain a PEG tube for resident safety and comfort." B. A resident who is fed by a nasogastric tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal function.'" 1. Any resident receiving tube feedings must have: a. The head of the bed elevated 30 degrees at all times unless contraindicated 4. Verify tube placement: a. Every shift b. Before administering formula c. Before administering medications d. Before flushing	F 322	(jejunum) tube by one of the following ways: 1. Auscultation of insufflated air. 2. Aspirate of gastric contents. Licensed Nursing staff will be reeducated on revised policy at a staff meeting on 5/15/14. Those staff not able to attend will review policy and sign that they understand. Licensed nursing staff will continue to verify placement per policy: every shift, before administering formula/enteral feeding, before administering medications, and before flushing. NG tube placement will always be verified by auscultation of insufflated air unless otherwise directed by physician. Charge nurses will monitor to ensure compliance. The Director of Nursing will oversee to ensure overall compliance. Any concerns will be addressed with the quality assurance team.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/22/14

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F 441	Continued From page 13 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to properly disinfect the glucometer (blood sugar meter) equipment for 1 of 1 resident (R65) observed and had the potential to affect 17 of 17 residents (R5, R7, R10, R16, R19, R21, R24, R29, R31, R35, R39, R40, R43, R54, R61, R65 & R67) who utilized a glucometer; and failed to properly donn gloves during medication administration for 1 of 1 resident (R42) who received medication via a gastrostomy tube (g-tube) and failed to implement proper handwashing and/or failed to transport soiled linens properly after incontinent cares for 2 of 3 residents (R35 & R65) observed during personal cares; . Findings Include: During observation of blood glucose monitoring on 4/16/14, at 11:13 a.m., trained medication assistant (TMA)-B checked the blood sugar (BS) level for R65 after she washed her hands and donned gloves. Upon completion, the test strip was removed from the glucometer and disposed in the trash. TMA-B then removed the soiled gloves, washed her hands and donned new gloves. TMA-B removed a plastic bottle from the tray containing glucometer supplies. The bottle was labeled as a 10 % bleach solution and was dated 8/26/13. TMA-B poured the solution from the labeled bottle, applied it onto a cotton ball, used the saturated cotton ball to wipe the glucometer clean and placed this equipment onto the sink. The TMA-B stated the solution was to be wiped across the glucometer and left to dry for 1-2 minutes. TMA-B further stated she was uncertain when the solution was mixed but	F 441	The outdated bleach solution was disposed on 4/16/14. Nursing staff reconstituted the 1:10 bleach solution immediately on 4/16/14 to ensure adequate disinfection of glucometer between residents. The policy titled Cleaning and Disinfecting of Glucometers was revised 4/16/14 indicating that if an approved 1:10 Bleach wipe was not available to disinfect the glucometer between residents, then the night nurse will prepare a 1:10 concentration Bleach solution each morning. The bleach solution will be remixed on a 24 hours basis to avoid loss of potency. Cold water will be used for dilution as hot water decomposes the active ingredient in bleach and renders it ineffective. The facility will properly disinfect each glucometer between residents requiring blood glucose monitoring in order to prevent any potential cross contamination of pathogens. All nursing staff, including RN, LPN and TMA (trained medication aide) will receive education regarding changes for Cleaning and Disinfecting of Glucometers at a staff meeting on 5/15/14. Those staff not able to attend the meeting will review policy and sign that they understand. Nursing will be educated on the policy upon hire and annually. RN Charge Nurse will monitor on a daily	

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F 441	Continued From page 15 verified the nurses only refilled the 10% bleach solution bottle when it was empty. She indicated they were instructed to label the solution with the date it was prepared (8/26/14- 20 days earlier). During further interview on 4/16/14, at 11:18 a.m. registered nurse (RN)-A entered R65's room and verified the 10% bleach solution bottle was routinely refilled when empty but she was unaware of how frequent the solution was to be mixed for routine disinfection use. During interview with the director of nursing (DON) on 4/16/14, at 11:30 a.m. it was stated the facility mixed their own bleach solution and used a 1:10 water to bleach solution to cleanse the glucometer between each resident use. The DON verified the solution was mixed on as needed basis and she was not aware of bleach solution needing to be remixed on a 24 hour basis to avoid loss of potency. The policy reviewed related to the disinfection of the glucometer, dated 11/2009, was titled, Cleaning and Disinfecting of Glucometer. The policy identified: to disinfect the glucometer (Assure Pro meter), dilute 1 ml of household bleach (5-6% sodium hypochlorite solution) in 9 ml of water. This is a 1:10 dilution. The final concentration is 0.5-0.6% sodium hydrochloride). Solution may be stored in a plastic container labeled appropriately or use approved bleach wipes. The policy failed to identify the solution would dilute in 24 hours and needed to be reconstituted daily to maintain potency. During interview with the DON on 4/17/14, at 8:30 a.m. she stated she had reviewed the standard of practice for the use of the bleach solution and	F 441	basis that the bleach solution has not expired. The Director of Nursing will ensure overall compliance. Any concerns will be addressed with the quality assurance team. AM and PM Cares Policies were updated to ensure that personnel handle, store, process and transport linens so as to prevent the spread of infection. Nursing assistants will be instructed to not put linens on the floor or carry linens up against their scrubs to prevent any spread of potential pathogens. Nursing assistants and licensed nursing personnel will receive reeducation on proper hand washing and the importance of wearing gloves when potential to be in contact with any blood or bodily fluids at staff meeting on 5/15/14. Those staff not able to attend the meeting will review policy and sign that they understand. PEG (Percutaneous Endoscopic Gastrostomy Tube) Management; NG (Nasogastric) Tube Management policy has been revised to instruct licensed nursing staff to use Standard (Universal) Precautions throughout the entire procedure by wearing gloves and proper hand washing. Infection Control education will be provided upon hire and annually thereafter. Staff Development RN will ensure that staff receives education. Charge Nurses will monitor staff during cares on random basis. Charge Nurses	

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F 441	Continued From page 16 confirmed the solution would dilute after 24 hours. The DON stated she had not been aware that the effectiveness of the bleach solution diminished after 24 hours and verified the disinfection of the glucometer equipment had probably not been effective. The DON agreed the bleach solution should have been mixed daily and verified their practice had not met the standard for routine cleaning of the glucometer when used for the residents who required blood glucose monitoring (R5, R7, R10, R16, R19, R21, R24, R29, R31, R35, R39, R40, R43, R54, R61, R65 & R67). During observation of the gastrointestinal tube (g-tube) medication administration for R42 on 4/17/14, at 7:25 a.m. licensed practical nurse (LPN)-A was observed to prepare liquid medication for administration through the G-tube. During this observation, LPN-A entered R42's room, washed her hands and proceeded to administer medication to R42 via the g-tube. The LPN-A failed to donn gloves and with only her bare hands, made contact with the fluid in the g-tube. During observation of evening cares on 4/15/14, at 7:25 p.m. nursing assistant (NA)-B was observed to transfer R35 from her wheelchair onto the toilet in her bathroom. During the observation NA-B removed R35 pants and incontinent brief while R35 was seated on the toilet. NA-B then filled the bathroom sink with warm water, washed R35's face and hands, assisted R35 to a standing position, washed the perineum with disposable wipes and dried this area with the use of a cloth towel. NA-B failed to donn gloves during these cares. Upon completion of cares and after the placement of a clean incontinent brief, NA-B pulled up R25's pants,	F 441	will monitor the administration of medications via enteral tube for correct practice. The Director of Nursing will ensure overall compliance. Any concerns will be addressed with the quality assurance team.	

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F 441	Continued From page 17	F 441		

positioned her in the wheelchair and transported her from the bathroom into the central day room. At 7:44 p.m. NA-B then returned to R35's room, gathered the clothing, towels, and incontinent brief and transported these items to the soiled linen room located in the hallway. NA-B was noted to touch multiple surfaces in R35's room and the soiled utility room. NA-B failed to wash her hands and did not wear gloves throughout this entire process/observation. After sorting the clothing and disposable brief in the soiled utility room, NA-B was observed to use liquid hand sanitizer to cleanse her hands and then proceeded to another resident room.

During interview with the DON on 4/17/14, at 8:45 a.m. it was verified the facility practice/policy had been to wear gloves any time there was a potential for contact with body fluids as referenced in the infection control/standard precautions recommendations.

The handwashing policy revised 3/2010, identified that employees would wash their hands after touching materials soiled with human excrement (feces, urine, etc.) or secretions (from wounds, incisions, etc.) and before providing further care to the resident.

During observation of bedtime cares on 4/15/14, at 7:20 p.m., NA-C placed R65's soiled clothing on the floor next to the garbage can in the bathroom. Upon completion of cares, NA-C washed hands, applied a new pair of gloves, picked up R65's dirty laundry and held it against himself while transporting it through the hallway to the soiled linen room.

During an interview with director of nursing (DON)

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F 441	Continued From page 18 on 4/17/14, at 9:45 a.m. she agreed the nursing assistant had not followed the infection prevention standards for handling soiled linens, which could lead to the spread of infection. DON indicated NA-C should have not have placed the soiled laundry on the floor and then should have used the extra garbage bag in R65's room to transport the soiled linens. Facility policy dated 3/10 titled "Standard Precautions" indicated that soiled linens and resident clothing will be placed in a plastic bag before being deposited in the soiled laundry bin.	F 441		

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2014**

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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 April 17, 2014. At the time of this survey, Divine Providence Community Home 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) Standard 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 Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2014

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.

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K 000	Continued From page 1 By eMail 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 Community Home is a one-story building with no basement. The building was constructed in 1993, and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected throughout. 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. The facility also has automatic smoke detection in all Resident Rooms. The facility has a capacity of 58 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core	K 018		4/18/14

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K 018	Continued From page 2 wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain one or more corridor doors in the means of egress, in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 12 of 58 residents, staff and visitors. FINDINGS INCLUDE: On 04/17/2014 at 1:15 PM, observation revealed the corridor door to the Cart Wash Room did not positively latch into its frame, as the nose of the door leaf was warped at the bottom. This finding was verified with the chief building engineer at the time of discovery.	K 018	Removed and repaired warped material from nose of the door leaf. Door is now able to positively latch. The Maintenance Director will be responsible for monitoring and ensuring continued compliance.	