CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: NKLS

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	ENCY	F	acility ID: 00787
MEDICARE/MEDICAID PROVIDER NO. (L1) 245355 2.STATE VENDOR OR MEDICAID NO. (L2) 178977500	0.	3. NAME AND AD (L3) ST BRIGID'S (L4) 213 PIONEE (L5) RED WING,	S AT HI-PARK R ROAD	ТҮ	(L6)	55066	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUI	PPLIER CATEGOR	Y 09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 07/09/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	65 (L18) 65 (L17)	B. Not in Com	nce With equirements	n	2. Techr 3. 24 He 4. 7-Day 5. Life \$	nical Personnel our RN y RN (Rural SNF)	Following Requirements:	tor
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY ME	EETS		
18 SNF 18/19 SNF 65	19 SNF	ICF	IID		1861 (e) (1) or 1	861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY API	PROVAL	Date:
Susanne Reuss, U	Jnit Supervis	sor	07/09/2015	(L19)	Kate John	nsTon, Pro	ogram Specialis	07/23/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	INGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Part			IPLIANCE WITH C HTS ACT:	CIVIL	2. O		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMI ENDING DAT (L25)		26. TERMINATI VOLUNTARY 01-Merger, Closur 02-Dissatisfaction			L30) 'ARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of	of Admissions:	(L44)		03-Risk of Involun 04-Other Reason fo		OTHER 07-Provider 00-Active	Status Change
	B. Resciliu Sus	pension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (06/30/2015	OF APPROVAL DA	TE				
	(L32)	00/00/2013		(L33)	DETERMINA	TION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245355 July 23, 2015

Mr. Jacob Goering, Administrator St Brigid's at Hi-Park 213 Pioneer Road Red Wing, Minnesota 55066

Dear Mr. Goering:

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 June 29, 2015 the above facility is certified for or recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 23, 2015

Mr. Jacob Goering, Administrator St Brigid's at Hi-Park 213 Pioneer Road Red Wing, Minnesota 55066

RE: Project Number S5355025

Dear Mr. Goering:

On June 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 20, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 30, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 29, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 20, 2015, effective June 29, 2015 and therefore remedies outlined in our letter to you dated June 9, 2015, 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,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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 245355	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/9/2015
Name	of Facility		Street Address, City, State, Zip Code	
ST	BRIGID'S AT HI-PARK		213 PIONEER ROAD	
			RED WING, MN 55066	

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
		Correction				Correction					Correction
ID Drofiv	F0455	Completed 06/29/2015		ID Drofiv	F04F6	Completed 06/29/2015		ID Drofiv	E0070		Completed 06/29/2015
ID Prefix		06/29/2015		ID Prefix		-		ID Prefix			06/29/2015
Reg. # LSC	483.10(b)(4)	_		Reg. # LSC	483.10(b)(5) - (10), 483.10(-		Reg. # LSC	483.20(d), 483.2	(k)(1)	
		_	-			-	-				
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0280	06/29/2015		ID Prefix	F0314	06/29/2015		ID Prefix	F0329		06/29/2015
Reg. #	483.20(d)(3), 483.10(k)(2)	_		Reg.#	483.25(c)	_		•	483.25(I)		
LSC				LSC		-		LSC			
		Correction				Correction					Correction
ID Prefix	F0356	Completed 06/29/2015		ID Prefix	F0412	Completed 06/29/2015		ID Prefix	F0428		Completed 06/29/2015
Rea.#	483.30(e)	_		Rea.#	483.55(b)	_		Rea.#	483.60(c)		
LSC		_		LSC		-					
		Correction				Correction					Correction
ID Drofiv	F0444	Completed 06/29/2015		ID Drofiv	F0F4.4	Completed 06/29/2015		ID Drofiv			Completed
ID Prefix		06/29/2015		ID Prefix							
Reg. # LSC	483.65	_		-	483.75(I)(1)	-		Reg. #			
		_	-			-	-				<u> </u>
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		_		ID Prefix		-		ID Prefix			
Reg. #		_		Reg.#		_		Reg. #	-		
LSC		_		LSC		-		LSC			_
Reviewed By	Reviewed	Bv	Dat	te:	Signature of Surve	wor.				Date:	
-				/23/20		16022	2			Date.	07/09/2015
State Agency Reviewed By	<u> </u>		Dat	to:	Signature of Surve	wor:				Date:	
CMS RO	Reviewed	Бу	Da	. .	Signature of Surve	.yu.				Date.	
	Survey Completed on:				Chook for any	Uncorrected	Doficia	noine Wes	a Summary of		
	5/20/2015		-		-				to the Facility?	YES	NO
	0,20,20.0										110

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 245355	(Y2) Multiple Constru A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 6/30/2015
Name of Facility		Street Address, City, State, Zip Code	
ST BRIGID'S AT HI-PARK		213 PIONEER ROAD RED WING, MN 55066	

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	((5)	Date	(Y4)	Item		(Y5)	Date	(Y	4) Item		(Y5)	Date
		(Correction					Correction					Correction
ID Deefin			Completed		ID Danfin			Completed		ID Deefin			Completed
ID Prefix		—'	06/29/2015					06/29/2015					
ū	NFPA 101 K0054				-	NFPA 101 K0062				Reg. #			
	K0054	_		<u> </u>		K0002			_				<u> </u>
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
			Correction					Correction					Correction
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		_		_					+				
			Correction					Correction					Correction
			Completed					Completed					Completed
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Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
Reviewed By	Reviewe	d B	у	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	, P	S/K	(J	07	7/23/20			2582	2				06/30/2015
Reviewed By	Reviewe	d B	у	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:					Check fo	or any	Uncorrected I	Defi	ciencies. Was	a Summary of	-	
	5/22/2015					Unco	rrecte	d Deficiencies	(C	MS-2567) Sent	to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: NKLS

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	ENCY	F	acility ID: 00787
MEDICARE/MEDICAID PROVIDER N (L1) 245355 2.STATE VENDOR OR MEDICAID NO. (L2) 178977500	0.	3. NAME AND AD (L3) ST BRIGID'S (L4) 213 PIONEE (L5) RED WING,	S AT HI-PARK R ROAD	TY	(L6)	55066	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 05/20, 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	65 (L18) 65 (L17)	X B. Not in Com	nce With	n	2. Tech 3. 24 H 4. 7-Da	nnical Personnel	6. Scope of Servic 7. Medical Direct 8. Patient Room S 9. Beds/Room	or
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 65	19 SNF	ICF	IID		15. FACILITY MI		(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39) S (IF APPLICABLE S	(L42) HOW LTC CANCELI	(L43) LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY API	PROVAL	Date:
Robyn Woolley,	HFE NE II		06/22/2015	(L19)	Kate John	nsTon, Enf	orcement Specia	alist 06/29/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY	icipate		IPLIANCE WITH C HTS ACT:	CIVIL	2. (ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	1513)
2. I definy is not English	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMI ENDING DAT (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	00	INVOLUNT 05-Fail to Me	ARY etet Health/Safety etet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involu	•	OTHER 07-Provider 00-Active	Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	TE	Posted 06	/30/2015 Co.		
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 9, 2015

Mr. Jacob Goering, Administrator St Brigid's At Hi-Park 213 Pioneer Road Red Wing, Minnesota 55066

RE: Project Number S5355025

Dear Mr. Goering:

On May 20, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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

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

St Brigid's At Hi-Park June 9, 2015 Page 2

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:

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793

Fax: 651-215-9697

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 June 29, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 29, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 August 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

St Brigid's At Hi-Park June 9, 2015 Page 5

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 06/30/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245355	B. WING			05/	20/2015
	PROVIDER OR SUPPLIER			213 F	ET ADDRESS, CITY, STATE, ZIP CODE PIONEER ROAD WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000		of correction (POC) will serve	F0	00			
	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.						
F 155 SS=E	on-site revisit of you validate that substate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with TO REFUSE; FORMULATE TIVES	F 1	55			6/29/15
	refuse to participate and to formulate ar	e right to refuse treatment, to e in experimental research, advance directive as aph (8) of this section.					
	specified in subparrelated to maintaini procedures regardi requirements include provide written infoconcerning the right or surgical treatment option, formulate an includes a written described to maintain subparrelation in surgical treatment option, formulate an includes a written described to maintain subparrelation su	Imply with the requirements of 1 of part 489 of this chapter of this chapter of this chapter of part 489 of this chapter of part 489 of this chapter of part 489 of this chapter. These deprovisions to inform and of the provisions to inform and of the accept or refuse medical of the accept or refuse medical of the and, at the individual's of advance directive. This escription of the facility's of the advance directives and of the accept of the accept of the accept of the facility's of the accept of the					
ARORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATI IRE		TITLE		(X6) DATE

Electronically Signed

06/18/2015

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245355	B. WING	·····	05/2	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	Continued From pa	ge 1	F 155			
	by: Based on documer facility did not docu information in the re (R10, R30, R40, R8) Findings include: R10's electronic rec physician's order recontained conflictin status. Record review on 5 face sheet for R10 admitted from a host 4/13/15. The electra prominent red bot DNR/DNI (do not recode status. Progress notes des which included the cyanotic (appearan coloration of the sk to the tissues near oxygen saturation) Cardiopulmonary refacility staff. Emergicalled and performed tasks upon arrival a returned and the rehospital where she The progress note ("POLST" [physician")	nt review and interview, the ment accurate code status ecords for 4 of 8 residents (0) reviewed for code status. cord did not contain a current egarding code status and g information regarding code (19/15) revealed the electronic showing that this resident was spital and discharged on conic face sheet also displayed a identifying the resident as a esuscitate/do not intubate) scribed the events of 4/13/15, discovery of the resident ce of a blue or purple in or mucous membranes due the skin surface having low and unresponsive at 5:53 p.m. esuscitation was performed by gency medical services were ed additional resuscitation at the facility. R10's pulse sident was transferred to the died within a few hours. dated 4/13/15, 5:53 p.m. read, orders for life sustaining in hospital stated full." The		1. R 10 is no longer in the facility. a. R30, R40, and R90¿s code stathas been verified, POLST complete Electronic health record updated. 2. All current residents¿ code statare audited for accuracy as part of nurse¿s routine chart audits. a. Code status¿s for all new admiare discussed on admission with reor responsible party by the admissinurse, or clinical managers. i. If there is no established advardirective present on admission and resident is unable to speak for themselves. The resident is considefull code until Medical power of attopresent or resident is seen by the Service team, and written orders areceived. b. Code status¿ are reviewed at a conferences; short stay care conferquarterly care conferences for long clients, or with family at time of sig changes, if the resident can no long speak for themselves. 3. All licensed staff and Social Seare to review the process regarding status. 4. Code status audits conducted of the Clinical Managers for all new admissions for four weeks and ong determined by Quality Assurance. 5. Audit results are to Quality Assurance. 6. Audit results are to Quality Assurance. 7. Poincetor of Nursing or Designer responsible for ongoing compliance.	ed, and auses Night ssions sident on ace the ered a arrney is Senior re all care rences, term nificant ger rvices a code daily by oing as arrance e is	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245355	B. WING			05/2	20/2015
	PROVIDER OR SUPPLIER			21	FREET ADDRESS, CITY, STATE, ZIP CODE I 3 PIONEER ROAD ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	"POLST from AL [a: DNR status posted to the hospital." Admission physicia could not be located practitioner's visit not dictated until 4/15/1 STATUS/ADVANCE DNR/DNI." The facility's CPR F 2014, read, "Consist Medicare and Medicare in place (cessation of respirate exceptions needed someone pulseless DNR order is in place "Facility staff needs resuscitation status used must be updated status changes. The through processes MatrixCare [compuresident face sheet The facility's direct clicensed social work on 5/19/15 at 2:40 padmission code stated that the resident face sheet stated face sheet stated that the resident face sheet stated that the resident face sheet stated face shee	d 4/13/15, 5:58 p.m. read, sesisted living] arrived with Sesisted living] arrived with Sesisted living] arrived with Sesisted living] arrived with EMTs on the record, but a nurse of the dated 4/13/15, but not 5 read, "CODE EDIRECTIVES DISCUSSION: Policy-SNF, dated January 1, stent with the Center for caid directive October 2013, of emergency medical rising homes must provide including initiation of CPR, to a sences cardiac arrest ations and/or pulse]The to NOT DO CPR upon finding, per CMS, are: 1. A valid ce;" The policy went on, to be aware of the of each resident. The system ted at any time a resuscitation is can be communicated such as: Pulling up the ter software brand] individual	F 1	55	plan.		
		ing for R10's power of attorney ty after work in order to					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING			E SURVEY IPLETED
		245355	B. WING			05/	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 213 PIONEER ROAD RED WING, MN 55066	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROP	BE	(X5) COMPLETION DATE
F 155	complete some adrincluding code status order of physician. The DOI clear code status of R10, the resident with the electronic mediconflicting code status of the electronic mediconflicting code status: full. The facility's director in the physicians order status: full. The facility's director in the physicians order status: full. The facility's director in the physicians order status: full. The facility's director in the physicians order status: full. The facility's director in the physicians order status: full. The facility's director in the physician of the physician of the physician of the electronic record and the electronic mediconflicting code status: full status and the electronic mediconflicting code status: full status and the electronic mediconflicting code status: full status and the electronic mediconflicting code status and the electronic me	mission documentation, as preference, and then a ould be requested from the N and LSW agreed that until a reder could be obtained for ras considered a full code. As to who put the DNR/DNI electronic face sheet or why on the facility on 1/22/15 and cal record contained tus. Eviewed on 5/19/15. Displayed rrent physician orders dated residents name, in large bold etwords, DNR/DNI (do not intubate). The second order on right sheet read: 1/22/15 code or of nursing (DON) and facer (LSW) were interviewed eximately 2:45 p.m. and figned a POLST (Advance and Medical Orders) when so which indicated DNR/DNI. Deen scanned into the find was in a binder at the DON and LSW did not know orders still indicated full code.	F 1	55			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	E SURVEY PLETED
		245355	B. WING		····	05/:	20/2015
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 113 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	red letters, were the resuscitate/do not in the physicians order status: full. The facility's directed licensed social work on 5/19/15 at appropriete appropriete and propriete summary admitted on 1/23/15. That form had not be electronic record an nurses station. The why the physician of R40's electronic regarding representation of R40's electronic a.m., indicated in a DNR (Do not resus orders for 4/20/15 status was noted. Nursing (DON) at 9 nurses assignment the residents's code the information from administration reconnected in the physician Orders for full code and do 1/22/15. He did not 1/22/15. He did not 1/22/15.	residents name, in large bold e words, DNR/DNI (do not ntubate). The second order on er sheet read: 1/22/15 code or of nursing (DON) and ker (LSW) were interviewed eximately 2:45 p.m. and signed a POLST (Advance and Medical Orders) when so which indicated DNR/DNI. Deen scanned into the nd was in a binder at the DON and LSW did not know orders still indicted full code.	F 1	55			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION NG		E SURVEY IPLETED
		245355	B. WING		05/	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156 SS=D	was DNI (Do not intafter the electronic R 90's electronic reinformation regardin R 90 was admitted including Rehabilitacellulitis/abscess fo kidney disease, chr R90's electronic factor a.m., it indicated in full code. Review of 4/20/15 - 5/20/15, ir DNR/DNI. The nurindicated R90 was a DON at 2:00 p.m., if a POLST on admit, DNR/DNI. Review at 2:15 p.m. indicated 483.10(b)(5) - (10), RIGHTS, RULES, Some The facility must information in writing in a launderstands of his regulations governing responsibilities during facility must also protice (if any) of the first stay. Recany amendments to writing.	indicated R40 code status subate). Copies were received record was updated. cord had conflicting and code status. on 5/11/15 with diagnosis	F 1			6/29/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245355	B. WING			05/2	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 213 PIONEER ROAD RED WING, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 156	of admission to the resident becomes a items and services facility services und which the resident rother items and ser and for which the resident resident resident resident resident the amount of charginform each resident the items and servic (i)(A) and (B) of this The facility must infat the time of admist the resident's stay, facility and of chargincluding any chargunder Medicare or I. The facility must fur legal rights which in A description of the funds, under paraginal A description of the for establishing eligithe right to request 1924(c) which deternon-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the down to Medicaid eligitation and the cost of the cost	benefits, in writing, at the time nursing facility or, when the sligible for Medicaid of the that are included in nursing er the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and at when changes are made to be specified in paragraphs (5) is section. The section of the services available in the est for those services, est for services not covered by the facility's per diem rate. This is a written description of cludes: The manner of protecting personal raph (c) of this section; The requirements and procedures ibility for Medicaid, including an assessment under section raines the extent of a couple's ces at the time of and attributes to the community eshare of resources which ed available for payment the institutionalized spouse's or her process of spending	F 1	56			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245355	B. WING		05/20/2015
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLÉTION
F 156	numbers of all pert groups such as the agency, the State li ombudsman progra advocacy network, unit; and a stateme complaint with the agency concerning misappropriation of facility, and non-co directives requirem. The facility must in name, specialty, ar physician responsible. The facility must provide written information applicants for adminformation about he Medicare and Medicare and Medicare states.	inent State client advocacy State survey and certification icensure office, the State am, the protection and and the Medicaid fraud control ent that the resident may file a State survey and certification resident abuse, neglect, and f resident property in the mpliance with the advance	F 156		
	by: Based on interview facility failed to prorights notice in a tir termination of Med residents (R4 and notice and benefici	a timely notice of termination		1. R 4 and R22 are no longer in a facility. 2. All current residents, whose in coverage is ending, will receive the appropriate 48 hour notice. a. The policy for Medicare or Me covered stays is reviewed with all admissions or responsible party by admission nurse, or clinical manages. Medicare covered services are reviewed at all care conferences for	surance eir dicaid new y the gers.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245355	B. WING		05/2	20/2015
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	therapy and Medica on 2/6/15. On 2/5/1 Notice of Medicare the required two da On 5/18/15, at 12:0 (RN)-E was intervising given a timely notice of Medicare skilled R22 was admitted to the the rapy and Medica on 1/27/15. On 1/27 Notice of Medicare the required two dap.m., the director of was not given a time The facility was unaprocedure on Skille Beneficiary Notice of Non-Coverage. 483.20(d), 483.20(b) COMPREHENSIVE A facility must use to develop, review a comprehensive pla. The facility must deplan for each reside objectives and time.	to the facility on 1/26/15. R4's are services were discontinued 5, the facility provided the Non-Coverage to R4, without by notice. 5 p.m., registered nurse ewed, and verified R4 was not e. 6 a timely notice of termination services. 6 to the facility on 1/2/15. R22's are services were discontinued 7/15, the facility provided the Non-Coverage to R22, without by notice. On 5/19/15, at 2:00 f nursing (DON) verified R22 fely notice. 6 able to provide a policy and and Nursing Facility Advance and notice of Medicare 8 (1) DEVELOP E CARE PLANS The results of the assessment and revise the resident's	F 156	stay clients with the client, or family time of a significant change, if the can no longer speak for themselves. 3. All licensed staff and social set are to review the process regarding Medicare covered stays. 4. Termination of Medicare or Me covered stay audits conducted for residents receiving covered service four weeks and ongoing as determ Quality Assurance. 5. Audit results are to be reviewe Quality Assurance per reporting so The Director of Nursing, MDS Coordinator, Therapy, Social Servi and Business Office, or Designee a responsible for ongoing compliance plan.	resident s. rvices g end of dicaid all es for ined by hedule. ces, are e of this	6/29/15

245355 B. WING			A. BOILDIN	IDENTIFICATION NUMBER:		
			B. WING _	245355		
ST BRIGID'S AT HI-PARK 213 PIONEER ROAD RED WING, MN 55066		3 PIONEER RO				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(EACH DEFICIEN	(EACH CO	PREFIX	ST BE PRECEDED BY FULL	REFIX (EACH DEFICIENC)	PRÉFIX
F 279 Continued From page 9 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25 but are not provided due to the resident's exercise of rights under §483.10 (including the right to refuse treatment under §483.10 (including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive plan of care for 1 of 5 residents (R43) reviewed for unnecessary medications. The plan of care for R43 was not developed with specific targeted behaviors and interventions for the use of the antipsychotic, Risperidone. R43 was admitted to the facility 12/30/14 for rehabilitation, chronic obstructive pulmonary disease, generalized pain, depression and dementia. In March, R43 was admitted to the Garace Unit (geritatric psych unit) due to behaviors of aggression towards others and elopement. R43 exhibited behaviors of crawling on floor, yelling out, wandering, and looking for his wife. R43 had been having some falls and the interventions of 1 to 1 did not work. R43 had been receiving Lexapro 10 mg every day for depression, and Haldol and Seroquel (dosages unknown) for behaviors. While in the Grace unit	needs that are ideassessment. The care plan mu to be furnished to highest practicabl psychosocial well-§483.25; and any be required under due to the resider §483.10, including under §483.10(b). This REQUIREMI by: Based on observ review the facility comprehensive pl (R43) reviewed for the plan of care f specific targeted to the use of the anti-R43 was admitted rehabilitation, chrodisease, generalized dementia. In Marc Grace Unit (geriat of aggression to R43 exhibitied bely elling out, wander R43 had been havinterventions of 1 receiving Lexaprodepression, and F	Care plans of health record 2. All curre audited for a a. Psychot considered a reviewed at stay care co conference with family a if the resider themselves. 3. All licens and Social Sprocess regamedications 4. *(Rando conducted with the solutions)	F 27	scribe the services that are nor maintain the resident's vical, mental, and g as required under ices that would otherwise 3.25 but are not provided xercise of rights under right to refuse treatment is not met as evidenced, interview and document d to develop a f care for 1 of 5 residents necessary medications. 43 was not developed with viors and interventions for hotic, Risperidone. The facility 12/30/14 for obstructive pulmonary ain, depression and 43 was admitted to the sych unit) due to behaviors to others and elopement. The sort of crawling on floor, and looking for his wife. Some falls and the did not work. R43 had beeing every day for I and Seroquel (dosages	needs that are ident assessment. The care plan must to be furnished to a highest practicable psychosocial well-begard assessment. The care plan must to be furnished to a highest practicable psychosocial well-begard and and a second assessment. The required under second and and a second and a second and a second assessment assessment. This REQUIREMED by: Based on observative review the facility factor accomprehensive plates (R43) reviewed for a specific targeted between the ause of the antiput the second and a secon	F 279

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245355	B. WING			05/2	20/2015
	PROVIDER OR SUPPLIER			21	FREET ADDRESS, CITY, STATE, ZIP CODE I 3 PIONEER ROAD ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 SS=D	Seroquel to Risperiimproved and R43 the diagnoses of debehavioral disturbativascular demential alzheimers. R43's cincluded Risperidor paranoia, however, identified were anxirestlessness. On 5/19/15 a quarte was completed and have mild wanderin behavior had been change MDS, dated. The current plan of updated 4/14/15 ide for Lexapro and not medication, Risperiimon on 5/20/2015 at 2:5 (DON) was interviewas nothing on the use of the Risperide 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plannichanges in care and A comprehensive continuation of the	done. R43's behaviors greatly was discharged on 4/3/15 with ementia with paranoia and nces. R43 had diagnosis of but could not rule out discharge medications ne .25 ml twice a day (BID) for the targeted behaviors ety, agitation and erly minimum data set (MDS) I revealed R43 continued to g problems. The same documented on a significant di 2/16/15. care dated 1/14/15 and entified psychotropic drug use at for the antipsychotic done. 53 p.m. the director of nursing wed and acknowledged there plan of care specific to the one. 0(k)(2) RIGHT TO NNING CARE-REVISE CP eright, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 2		5. Audit results are to be reviewed Quality Assurance per reporting sol The Director of Nursing or Designe responsible for ongoing compliance plan.	nedule. e is	6/29/15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONST			SURVEY PLETED
		245355	B. WING			05/2	20/2015
	PROVIDER OR SUPPLIER	•		213 PIONE	DDRESS, CITY, STATE, ZIP CODE EER ROAD IG, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	physician, a register for the resident, and disciplines as deter and, to the extent puther resident, the relegal representative and revised by a term assessment. This REQUIREME	age 11 am, that includes the attending pered nurse with responsibility of other appropriate staff in rmined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	30			
	review the facility faper facility policy, we developed an unstance of the per facility policy, we developed an unstance of the per facility policy, we developed an unstance of the per facility policy of the development of the per facility policy of the per facility po	tion, interview and document ailed to revise the care plan, when 1 of 1 resident (R30) ageable pressure ulcer. to the facility 1/22/15. The Brief al Status, dated 1/22/15, on score of 15, which indicated is. The Braden scale skin eted 1/22/15 identified a score ted the resident was at risk for f pressure ulcers. The ied a plan to place a pressure on the bed and a pressure the chair. In addition, R30 and repositioned every 2 hours. In 2/7/15 indentified R30 had ageable pressure ulcer on the eveloped on 2/11/15, identified k for the development of		and versions and versions and versions and versions and versions are as or ressor cling. A are to update MDS temporal house.	and a see and social see a review the process regarding ing the current working care plants are seed on admission with responsible party by admission ing the current working care plant ing the current working care plant in electronic health record.	all new rations me of den nissions sident nurse, rvices plan. ferring n	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
		245355	B. WING		05/2	20/2015
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	, 337	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETION DATE
F 280	not been revised to the unstageable uld approaches and tre repositioning, had respositioning, had respositioning, had respositioning, had respositioning, had respositioning, had respositioned to the heel due to impuse the heel du	wever, the plan of care had include the development of cer. The individualized eatment, other than turning and not been identified. In skin assessment scored R30 cated a moderate risk for the ressure ulcer. The skin ed an unstageable ulcer on nobility. The wound was provement and was now open. We in floating heels but stective boots. The plan of skin assessment on 4/22/15, and to identify approaches the heel ulcer. The undated are card directed staff to turn every 2 hours and to float and the unstageable ulcer in the elged that the plan of care was February when the was identified. DON also R30 had refused treatment, and acknowledged that the had not been identified on the cedure titled, Pressure Ulcer dated 2/2014 indicated after a is noted initiate a sure form related to the type of the proceed to care planning advidualized for the resident	F 280	5. Audit results are to Quality As per reporting schedule. The Director of Nursing or Design responsible for ongoing compliance plan.	ee is	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245355	B. WING		05/20/2015
	PROVIDER OR SUPPLIER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 113 PIONEER ROAD RED WING, MN 55066	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 F 314 SS=D	483.25(c) TREATM PREVENT/HEAL F Based on the compresident, the facility who enters the facility for individual's clinical they were unavoidal pressure sores receives to promote prevent new sores This REQUIREMED by: Based on observative with facility for procedure for hand and failed to revise policy, when 1 of 1 unstageable pressured in the facility for more policy. R30 was admitted and interview for Mental identified a cognition cognitive deficits assessment complined of 16, which indicated	PRESSURE SORES PRESSURE sores	F 314 F 314	, , , , , , , , , , , , , , , , , , ,	g ale, April nat ge is
	assessment identifing reducing mattress reducing device in would be turned an Nurses notes dated	ied a plan to place a pressure on the bed and a pressure the chair. In addition, R30 of repositioned every 2 hours. In 2/7/15 indentified R30 had ageable pressure ulcer on the		Sores, Treatments, Care Planning Process, and Individualized Care Plans and Care Cards were reviewed and revised on May 21, 2015. 3. Additional educational In-Services regarding following plan of care, includ Na/R care cards and care plans will be	ing

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	E SURVEY PLETED
		245355	B. WING			05/2	20/2015
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 113 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	R30 as being at risl pressure ulcers, ho not been revised to the unstageable ulcapproaches and tre repositioning, had r The 4/22/15 Brader as a 14, which indicate development of a passessment identifit the heel due to immishowing steady impigations as a 14, which indicate as a 14, which indic	eveloped on 2/11/15, identified of the development of wever, the plan of care had include the development of the cer. The individualized that turning and	F3	314	conducted with all Nursing staff. 4. Audits related to pressure ulce and care plans will be conducted be clinical leadership weekly for all net admissions for 4 weeks and ongoin determined by Quality Assurance. 5. Audit results are to be reviewed Quality Assurance per reporting sci	y w ng as d by	
	9:33 a.m., R30 was pressure relieving resource relieving	observations on 5/19/2015 at a observed in bed with a nattress and heels floating off. The director or nursing eright heel dressing which amount of yellowish color lained that the yellowish color likely from the treatment indicated the area had started wound in February and on changed the order so that the up to promote healing. The urrently measured .6 x .8 ith approximately 80% slough ne DON indicated the area					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY IPLETED
		245355	B. WING _		05/	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	prep was applied to wound, Santyl appl dressing applied. A gloves during the p were no washed be During interview with procedure on 5/19/acknowledged chain hands were not washed be Constant of the procedure on 5/20/15 at 3:58 R30 had developed facility and acknown not revised back in unstageable ulcer wound communicated that such as the boots, resident's refusals plan of care. The policy and procedure titled, Hadated 8/2014 indicated land wash glove removal hand performed. The policy and procedure titled, Hadated 8/2014 indicated performed. The policy mound in the policy and procedure titled, Hadated 8/2014 indicated Rand wash glove removal hand performed. The policy applied to the policy and procedure titled, Hadated Rand wash glove removal hand performed. The policy applied to t	e wound was smaller. Skin the pink skin around the ied in the wound and Primpore lthough the DON changed rocedure four times, hands fore applying new gloves. th the DON, after the 15 at 9:40 a.m, DON nging gloves but aknowledged	F 31	4		
F 329 SS=D	indicated after a ne initiate a pressure/r the type of alteratio planning and interv resident and their p	w skin alteration is noted non pressure form related to n in the skin. Proceed to care entions individualized for the particular risk factors.	F 32	9		6/29/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245355	B. WING _		05/	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 213 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	unnecessary drugs drug when used in duplicate therapy); without adequate rindications for its unadverse consequents should be reduced combinations of the Based on a compresident, the facilit who have not used given these drugs therapy is necessary as diagnosed and record; and reside drugs receive grad behavioral interver	ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of nces which indicate the dose or discontinued; or any	F 3:	29		
	by: Based on docume facility did not iden justification for use non-pharmacologic for 2 of 5 residents unnecessary medi Findings include:	cal interventions with outcomes (R43, R87) reviewed for		 R 87 is no longer in the faa. As part of R43¿s signification care plan have been verified appropriate target behaviors. completed, and Electronic he updated. Further sub-acute reside plan are updated and audited accuracy. 	ant change; for Care plans ealth record	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245355	B. WING			05/2	20/2015
	PROVIDER OR SUPPLIER			21	TREET ADDRESS, CITY, STATE, ZIP CODE 13 PIONEER ROAD EED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Risperidone, witho specific behaviors R43 was admitted rehabilitation, chrodisease, generalized dementia. In March Grace Unit (geriatr of aggression tow R43 exhibitied behyelling out, wander R43 had been havinterventions of 1 to the receiving Lexapro depression, and Haunknown) for behamedication were of Seroquel to Risper improved and R43 the diagnoses of dibehavioral disturbavascular dementia alzheimers. R43's included Risperido paranoia, however identified were anx restlessness. The target behavior restlessness were administration recodocumentation in the 4/20/15 through 5/2 revealed four episor restlessness. The revealed on 4/28/1 been out of bed at R43 was easily recommendation.	ut identified and documented for the use. to the facility 12/30/14 for nic obstructive pulmonary ed pain, depression and n, R43 was admitted to the ic psych unit) due to behaviors rards others and elopement. aviors of crawling on floor, ing, and looking for his wife. ing some falls and the o 1 did not work. R43 had been 10 mg every day for aldol and Seroquel (dosages viors. While in the Grace unit nanged from the Haldol and idone. R43's behaviors greatly was discharged on 4/3/15 with ementia with paranoia and unces. R43 had diagnosis of but could not rule out discharge medications ne .25 ml twice a day (BID) for , the targeted behaviors	F3	329	a. Specific targeted behaviors or outcomes of interventions for all ne admissions are assessed on admis with resident or responsible party be admission nurse, or clinical manages. Psychotropic meds that could be considered ¿unnecessary meds¿ areviewed at all care conferences; stay care conferences, quarterly care conferences for long term clients, awith family at time of significant chaif the resident can no longer speak themselves. 3. Licensed staff and social service to observe clients receiving anti-psymeds to verify the client does not help behaviors that would warrant use of antipsychotic meds. If present; does behaviors. If behaviors are not presentify provider to allow tapper of unnecessary medications. 4. Care plan audits conducted we clinical leadership for four weeks and ongoing as determined by Quality Assurance. 5. Audit results are to be reviewed Quality Assurance per reporting solutions.	ssion ut ers. be tre hort re and/or anges, for ess are ychotic ave f cument sent, ekly by and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05	/20/2015
NAME OF PROVIDER OR SUPPLIER ST BRIGID'S AT HI-PARK				STREET ADDRESS, CITY, STATE, ZIP (213 PIONEER ROAD RED WING, MN 55066	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 329	R43 came out of ro and juice. There wa On 5/6/15 the progress and frequently. There we behavior issues and frequently. There we behavioral note for On 5/19/15 a quarte was completed and have some mild wa The current plan of psychotropic drug to and not the antipsyon On 5/20/15 at 2:53 (DON) was intervied specific behaviors to Risperidone was reprovided. The DON the plan of care specific behaviors. A phone interview we 5/20/15 at 3:40 p.m. conducted. The consulting phate 5/20/2015 at 3:41 periodoucle should be document of the antipsychotic explained that target to the medication Research that on 4/17/15 the	om three times wanting yogurt as no agitation or restlessness. These notes revealed no did that R43 was checked on as no corresponding 5/11/15. The perly minimum data set (MDS) a revealed R43 continued to	F3	29		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ST BRIGID'S AT HI-PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	behaviors identified target behavior interest not documented. Record review on 5 Order Report show facility on 5/8/15 and dated 5/8/15, for S 12.5 mg. every bed order, dated 5/18/15 for the Seroquel in agitation, and mood target behavior interedirect, 1:1, activity. The medication adrithat R87 had receive since 5/8/15. The trecord showed that behaviors since 5/1 documented for integral administration record.	decific, individualized target and non-pharmacological rventions and outcomes were //20/15 revealed a Physician ing that R87 admitted to the d had a physician's order, eroquel (an antipsychotic) time. There was also an 5, listing the target behaviors the generic terms anxiety, d changes; and listing generic rventions for the Seroquel as y, and offer food/fluids. ministration record showed red the Seroquel every day reatment administration R87 had documented target 8/15, but no outcomes were erventions on the treatment	F3	29		
	placed an aromather residents [sic] room result was document documenting behave the progress notes. The DON was interpreted in the progress of the progress o	viewed on 05/20/2015 at 3:03				
F 356	were expected to be		F 3	56		6/29/15

PRINTED: 06/30/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245355	B. WING		·····	05/20/2015	
NAME OF PROVIDER OR SUPPLIER ST BRIGID'S AT HI-PARK				2	TREET ADDRESS, CITY, STATE, ZIP CODE 13 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 356 SS=C	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sh - Registered nu - Licensed prac vocational nurses (a - Certified nurse o Resident census. The facility must po specified above on of each shift. Data o Clear and readab o In a prominent pla residents and visito The facility must, up make nurse staffing for review at a cost standard. The facility must ma staffing data for a m required by State la This REQUIREMEN by: Based on observat	and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides. stathe nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to rs. con oral or written request, addata available to the public not to exceed the community aintain the posted daily nurse ninimum of 18 months, or as law, whichever is greater. NT is not met as evidenced tion, interview, and document	F3	356	All current census and staffing numbers are audited for accuracy.		
	review, the facility failed to post required staffing information. This practice had the potential to affect all 16 residents residing in the facility as				Staffing sheets are posted by n staff, day nurses, or Clinical Manage		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05/:	20/2015
NAME OF PROVIDER OR SUPPLIER ST BRIGID'S AT HI-PARK			2	TREET ADDRESS, CITY, STATE, ZIP CODE 13 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	well as staff and vising Findings include: During initial tour or nurse staffing postion to identify the currently working. The marking appointment transportation to an interview of the solution of the staff and stated counted for on the staff and stated counted for on the staff and agreed the postion of the staff and staff and agreed the postion of the staff and staff and agreed the postion of the staff and agreed the postion of the staff and staff and agreed the postion of the staff and agreed the postion of the staff and agreed the postion of the staff and staff and agreed the postion of the staff and staff	in 5/17/15, at 1:34 p.m.,the ng was reviewed. The form dident census in the facility and rect number of licensed staff the posting indicated there area (RN) and a licensed N) working when in fact there a RN house supervisor. The was not working with the on 05/17/15 at 1:35 p.m., the A verified the current census ing and it should have been hat there was not a LPN on that herself (RN-A) is not staff posting. On 05/17/15 at or of nursing was interviewed ting was incorrect.	F 356	 b. Staffing sheets are reviewed decomply and social services are to review the process regarding staffing sheets. 3. Staffing sheet audits conducted random staff assigned by DON or Designee at least three times a we four weeks and ongoing as determ Quality Assurance. 4. Audit results are to be reviewed Quality Assurance per reporting soon The Director of Nursing or Designer responsible for ongoing compliance plan. 	d by ek for ined by hedule. ee is e of this	6/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05/2	0/2015
NAME OF PROVIDER OR SUPPLIER ST BRIGID'S AT HI-PARK			2	STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 412	by: Based on observatoreview the facility fato 1 of 1 resident (Fineeds. Findings include: During interview and 4:36 p.m., R30 compartial denture did right top denture fit well. a dentist, R30 state dentist, however, strould see one. R30 was admitted cavity assessment which revealed no cavity assessment which identified a local denture. The assessment and plan written by identified, in the last complained of difficientinued swallowing the same complained of difficientinued swallowing the same compared to the facility of the same complained of difficientinued swallowing the same compared to the facility of the same compared to the facility of the same compared to the sam	_	F 412	,	n on and and it has he ¿at t The by the difference of the differen	
	identified that R30 h dentist sometime in The plan of care da	and indicated she would see a the future. Integrated 2/11/15, under the section and there were no problems with		Assurance per reporting schedule.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245355	B. WING	····	05/	20/2015
NAME OF PROVIDER OR SUPPLIER ST BRIGID'S AT HI-PARK			2	TREET ADDRESS, CITY, STATE, ZIP CODE 13 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	Interview on 5/19/20 reviewed the care pany information on addressed R30's counsure why R30 had however thought the The policy and processindicated each residual each res	D15 at 2:01 p.m., the DON plan and was unable to locate the plan of care that urrent dental status. DON was d not seen a dentist earlier, at R30 may have refused. Deduce titled, Dental sment, dated 12/2013, dent should undergo a dental or or within 90 days of r indicated dental services a needed and after conducting on a resident needing dental mptly referred to a dentist. EGIMEN REVIEW, REPORT	F 412			6/29/15
	by: Based on interview facility failed to act recommendations f	or specific behavior residents (R43) reviewed for		1. R43¿s care plan has been upofor current behaviors and verified frappropriate target behaviors to mo Care plan has been updated and completed, and electronic health reupdated.	or nitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05/:	20/2015
NAME OF PROVIDER OR SUPPLIER ST BRIGID'S AT HI-PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441 SS=D	Findings include: R43's record was re 4/17/15 the consult conducted a drug re requested staff to d behaviors for the m 4/26/15 the consult a potential decreastwice a day to once practitioner (RNP) continued to exhibit A phone interview v 5/20/15 at 3:40 p.m conducted. The CP was interviant and identified that swhat behaviors are whether a dose red medication is warra target behaviors sh medication R43 is t 4/17/15 the targeter regarding the Rispersion SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and conducted and control presafe, sanitary and conducted are consulted as a consulted and control presafe, sanitary and conducted are consulted as a c	eviewed and identified that on ant pharmacist (CP) egimen review for R43. CP ocument and monitor target edication Risperidone. On ant pharmacist recommended in the Risperidone from a day, however, the nurse disagreed, explaining that R43 behaviors. With the RNP was suggested,, however, was unable to be ewed, 5/20/2015 at 3:41 p.m., staff should be documenting occurring to determine uction of the antipsychotic nted. CP explained that ould be specific to the aking and explained that on dependent on the dependent of the explained that on the determine uction of the antipsychotic nted. CP explained that on the aking and explained that on the dependent of the explained that on the explained that are explained to provide a comfortable environment and development and transmission ction.	F 42	 All current residents care plans audited for accuracy. Specific targeted behaviors or outcomes of interventions for all neadmissions are assessed on admi with resident or responsible party admission nurse, or clinical manages. Psychotropic meds that could considered ¿unnecessary meds¿ reviewed at all care conferences; stay care conference, quarterly care conference for long term clients, a with family at time of significant chif the resident can no longer speak themselves. Licensed staff and social servitor review the process regarding usunnecessary medications in regular nursing department meetings. For residents receiving anti-pse medications: care plan audits conceived behaviors for four weeks and ongoing determined by Quality Assurance. Audit results are to be reviewed Quality Assurance per reporting socials. 	ew ssion by gers. be are short re nd/or anges, for ces are se of ar ychotic ducted bing as d by	6/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245355	B. WING			05/20/2015	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 13 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 441	Program under whi (1) Investigates, co in the facility; (2) Decides what poshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility mus communicable disefrom direct contact direct contact will tr (3) The facility mus hands after each dihand washing is incorressional practic (c) Linens Personnel must ha	stablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective affections. The ad of Infection and control Program are ident needs isolation to of infection, the facility must are as or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their arect resident contact for which dicated by accepted	F 4	141			
	by: Based on observative review the facility facontrol program for observed during we	NT is not met as evidenced tion, interview and document ailed to follow the infection of 1 resident (R30) bund care and for 1 of 2 served during food delivery			 The facilities infection control p for hand washing during wound car food delivery has been reviewed ar has been determined that the plan accurate. Wound care treatment audits conducted on new admissions, or f 	re and nd it is now	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05/	20/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 213 PIONEER ROAD RED WING, MN 55066	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 441	dressing change was nursing (DON) was four times, however conducted in-between completing the prowas interviewed ar washed in between The policy and prohandwashing/Handirected staff: The hand washing/handuse along with rour as the best practic associated infection titled, Wound Careglove changing and throughout the proburing room tray intray down on the conducted that the washing that the washing and the probability of the trays and obsever the trays and the	9:33 a.m., R30's wound care ras observed. The director of sobserved to change gloves er, no hand sanitizing was een glove changes. After cedure at 9:40 a.m., the DON and confirmed hands were not an glove changes. cedure titled, died Hygiene revised 8/2014 use of gloves does not replace died hygiene. Integration of glove tine hand hygiene is recognized er for preventing healthcare ins. The policy and procedure er, revised 10/2010 indicated died washing and drying hands	F 4	acquired wounds by admission, or change as at time of initial of conferences. 3. Staff to complete infection control Education control Education control nurse 4. Audits related to room and wound cat least twice weekly for ongoing as determined assurance. 5. Audit results are	te the additional uCare course ucation/infection o food service in the are will be conducted at or 4 weeks and ned by Quality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05/20/2015	
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	A policy and proced one was not provide	exchanged for a new tray. Hure was requested, however,	F 441			
F 514 SS=E	483.75(I)(1) RES RECORDS-COMPI LE	LETE/ACCURATE/ACCESSIB	F 514		6/29/15	
	resident in accorda standards and prac	aintain clinical records on each nce with accepted professional tices that are complete; nted; readily accessible; and nized.				
	information to ident resident's assessm services provided; t	ening conducted by the State;				
	by: Based on documer facility failed to ider code status accura directed staff as to	nt review and interview, the ntify residents preferences for tely on all documents that what a residents code status ents (R10, R30, R40, R90) status.		1. R 10 is no longer in the facility. a. R30, R40, and R90¿s code status has been verified, POLST completed, a Electronic health record updated. 2. All current residents; code statuse are audited for accuracy by the Clinical Manager or Social Services with-in 24 hours of admission.	S	
	electronic face sheeto the facility 4/13/1 displayed a promine	v, on 5/19/15, revealed the et identified R10 was admitted 5. The electronic face sheet ent red box identifying the NI (do not resuscitate/do not us.		 a. POLST forms and EMR are review nightly by Night staff. b. Code statuses are reviewed at all care conferences; short stay Care Conferences, quarterly CC for Long ter clients. Appropriate changes are made that time on POLST and EMR. 	m	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05/2	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	which included the cyanotic (appearar coloration of the sk to the tissues near oxygen saturation) Cardiopulmonary r facility staff. Emer called and perform tasks upon arrival returned and the rehospital where she "POLST [physician treatment] sent fro progress note date "POLST from AL [a DNR status posted to the hospital." Admission physician could not be locate practitioner's visit r dictated until 4/15/STATUS/ADVANC DNR/DNI." The facility's CPR 2014, read, "Consi Medicare and Med 'Prior to the arrival services (EMS), nu basic life support, i resident who experiences resident who experiences resident needed.	scribed the events of 4/13/15, discovery of the resident ace of a blue or purple and or mucous membranes due the skin surface having low and unresponsive at 5:53 p.m. esuscitation was performed by gency medical services were ed additional resuscitation at the facility. R10's pulse esident was transferred to the edied within a few hours. dated 4/13/15, 5:53 p.m. read, orders for life sustaining m the hospital stated full." The ed 4/13/15, 5:58 p.m. read, assisted living] arrived with a Sent that POLST with EMTs an's orders for code status and in the record, but a nurse note, dated 4/13/15, but not	F 514	c. Staff are made aware of the costatus via the POLST binder, Nurse Report Sheet, and Point of Care Kithat all staff have access to. 3. All staff are to review the proce regarding code status. 4. Electronic Medical Record audiconducted for all new admissions via 24 hours by Clinical leadership for weeks and ongoing as determined Quality Assurance. 5. Audit results are to be reviewed per reporting schedule. 6. The Director of Nursing or Desis responsible for ongoing compliant this plan.	ess its vith-in four by d by QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245355	B. WING		05/20/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 514	"Facility staff needs resuscitation status used must be upda status changes. T through processes MatrixCare [compuresident face shee The facility's direct licensed social wor on 5/19/15 at 2:40 admission code stated that the resi facility with a code the facility was wait to come to the faci complete some ad including code status order ophysician. The DO clear code status or R10, the resident with the status of the status or the sta	ace;" The policy went on, is to be aware of the sof each resident. The system ated at any time a resuscitation his can be communicated such as: Pulling up the uter software brand] individual	F 514	4			
		to the facility on 1/22/15 and ical record contained atus.					
	on the top of the cu 4/20/15, next to the red letters, were th resuscitate/do not	reviewed on 5/19/15. Displayed current physician orders dated e residents name, in large bold e words, DNR/DNI (do not intubate). The second order on er sheet read: 1/22/15 code					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG	(X3) DATE SURVEY COMPLETED	
		245355	B. WING		05/	20/2015
	ROVIDER OR SUPPLIER D'S AT HI-PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	licensed social work on 5/19/15 at approrevealed R30 had so Directive Summary admitted on 1/23/15. That form had not be electronic record arnurses station. The why the physician of R40's electronic recording rehabilitation and the electronic regarding R40 was admitted of R40's electronic recording rehabilitation and physician of R40's electronic a.m., indicated in a DNR (Do not resust orders for 4/20/15 status was noted. In Nursing (DON) at 9 nurses assignment the residents's code information was take medication administion as DNR. Interview on 5/20/15 at 2:00 ppolson (Polson	or of nursing (DON) and ker (LSW) were interviewed ximately 2:45 p.m. and igned a POLST (Advance and Medical Orders) when which indicated DNR/DNI. been scanned into the ad was in a binder at the DON and LSW did not know rders still indicated full code.	F 5			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED		
		245355	B. WING			05/2	20/2015
	PROVIDER OR SUPPLIER		•	213	EET ADDRESS, CITY, STATE, ZIP CODE PIONEER ROAD D WING, MN 55066	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 31	F 5	14			
	R 90's electronic re information regarding	cord had conflicting ng code status.					
	including Rehabilita cellulitis/abscess fo kidney disease, chr R90's electronic fac a.m., it indicated in full code. Review of 4/20/15 - 5/20/15, ir DNR/DNI. The nursindicated R90 was a linterview with the DR90 had completed	ot-L (left), weakness, and onic stage III, Review of the sheet on 5/20/15 at 9:15 at red box, the code status of the physician orders for an order for ses assignment sheet					
		2:15 p.m. indicated a code					

T5355024

PRINTED: 06/22/2015 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245355 B. WING 05/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 213 PIONEER ROAD ST BRIGID'S AT HI-PARK RED WING, MN 55066 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Brigids at Hi Park was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 (X6) DATE TITLE

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

Electronically Signed

06/18/2015

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.

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CON ING 01 - M		(X3) DATE SURVEY COMPLETED	
		245355	B, WING		05	05/22/2015	
	PROVIDER OR SUPPLIER			CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE COMP O THE APPROPRIATE	
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of volto correct the deficition. 2. The actual, or properties. 3. The name and/or responsible for correct the deficition. St. Brigids at Hi Parpartial basement. To a different times. The constructed in 1977 Type III(211) constructed to the volto determined to be of Because the original are of the same type existing buildings, to one building. The building is fully fire alarm system we detection and space.	tate.mn.us and n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	KC	000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED
		245355	B. WING _		05/	22/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	All required smoke activating door hold maintained, inspect with the manufacture. This STANDARD Based on docume	detectors, including those dopen devices, are approved, ted and tested in accordance arer's specifications. 9.6.1.3	K 00	Fire Alarm Company has been co		6/29/15
	system in accordar 2000 NFPA 101, C NFPA 72, Section 3 could affect all 15 in Findings include: On facility tour betwon 05/22/2015, the inspection and test	ty failed maintain the fire alarm nee with the requirements of hapters 19.3.4.1, 9.6.1.4, 1999 7-3.2.1. The deficient practice residents. Ween 7:55 AM and 10:30 AM review of the annual fire alarming report from Trans Alarm, eated that the following:		and will return by June 26, 2015 to the ventilation duct smoke detector were missed in initial inspection a complete sensitivity test on duct so Facility will request a copy of report completion and review before the and will add to our internal TELS to prompt us to make sure we are compliance. Plant Operations Director/designer responsible for ongoing compliant plan.	ors that ind to imokes. ort on y depart system e in	
	(2) duct smoke det tested;2. (4) duct smoke device countThese deficient practical practica	or 3/28/14, that (1) smoke and ectors were not sensitivity detectors were not listed on actices were confirmed by the				
K 062 SS=D	discovery.	ce (TS) at the time of	K 06	2		6/29/15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245355	B, WING			05/22/2015	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 13 PIONEER ROAD RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	continuously mainta condition and are in periodically. 19.7 9.7.5 This STANDARD in Based on observation facility failed to main accordance with NFPA 101, Section 1998 NFPA 25,	e sprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, so not met as evidenced by: tion and staff interview, the antain the fire sprinkler system the requirements of 2000 as 19.3.4.1 and 9.6, as well as stion 2-4.1.4. This deficient but all 15 residents. Eveen 7:55 AM and 10:30 AM servation revealed that the aid box does not contain 2 of ler head in the facility. Indeed the side of the time of the side of the	K	062	Olympic Sprinkler returned on Jur 2015. Provided the facility with the appropriate back-up Sprinkler head we are now compliant with the nun spare sprinkler heads needed in the facility. Will be added in the TELS system prompt us to make sure we are in compliance. Plant Operations Director/designer responsible for ongoing compliance plan.	ds and nber of e that will	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted June 9, 2015

Mr. Jacob Goering, Administrator St Brigid's At Hi-Park 213 Pioneer Road Red Wing, Minnesota 55066

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5355025

Dear Mr. Goering:

The above facility was surveyed on May 17, 2015 through May 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

St Brigid's At Hi-Park June 9, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00787	B. WING		05/20/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
ST BRIGIE	O'S AT HI-PARK	213 PIONEI RED WING,					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	****ATTEN	TION*****					
	NH LICENSING CO	ORRECTION ORDER					
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of finithe Minnesota Depart. Determination of whe corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Live-inspection with any result in the assessmit.	ther a violation has been					
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.					
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf icensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwar Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00787	B. WING		05/20/2015
ST BRIGID'S AT HI-PARK			DDRESS, CITY, ST. EER ROAD G, MN 55066 ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	V (X5)
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	
2 000	Department of Health you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elected Minnesota Department On May 17, 18, 19, 20 Department's staff, vithe following correction Please indicate in you correction that you has	orders being submitted to though no plan of correction e Statutes/Rules, please cted" in the box available for edicate in the electronic ass, under the heading date your orders will be ctronically submitting to the ent of Health. O, 2015, surveyors of this sited the above provider and on orders are issued.	2 000	The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule out of compliant listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction order This column also includes the findings which are in violation of the state state after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Correct PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATISTATUTES/RULES.	ce is e "To er. s ute met rors ction. G OF
2 560	Plan of Care; Contents of comprehensive plan of objectives and timetal long- and short-term of and mental and psychidentified in the compassessment. The compust include the individual contents and the contents include the individual contents and contents are contents and contents are contents and contents are contents and contents are contents are contents are contents are contents and contents are contents.	plan of care. The of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident mprehensive plan of care vidual abuse prevention plan a Statutes, section 626.557,	2 560		

Minnesota Department of Health

STATE FORM 6899 NKLS11 If continuation sheet 2 of 26

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		LILD
		00787	B. WING		05/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST BRIGII	D'S AT HI-PARK	213 PIONE				
		RED WING	6, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 560	Continued From page	2	2 560			
2 560	by: Based on observation review the facility fails comprehensive plant (R43) reviewed for un. The plan of care for Fispecific targeted behavioral disease, generalized dementia. In March, Figrace Unit (geriatric pof aggression toward R43 exhibitied behaving interventions of 1 to 1 receiving Lexapro 10 depression, and Hald unknown) for behavior medication were chart Seroquel to Risperido improved and R43 was the diagnoses of dembehavioral disturbance vascular dementia but alzheimers. R43's disincluded Risperidone paranoia, however, the	t is not met as evidenced a, interview and document ed to develop a of care for 1 of 10 residents enecessary medications. A43 was not developed with eviors and interventions for echotic, Risperidone. The facility 12/30/14 for obstructive pulmonary pain, depression and exidence and elopement. For a control of crawling on floor, g, and looking for his wife. Is some falls and the did not work. R43 had been mg every day for ol and Seroquel (dosages fors. While in the Grace unit finged from the Haldol and fine. R43's behaviors greatly fines discharged on 4/3/15 with finentia with paranoia and fines. R43 had diagnosis of t could not rule out charge medications 25 ml twice a day (BID) for fine targeted behaviors	2 560			
	identified were anxiet restlessness.	y, agitation and				
	On 5/19/15 a quarterl was completed and re have mild wandering	y minimum data set (MDS) evealed R43 continued to problems. The same ocumented on a significant				

Minnesota Department of Health

STATE FORM 6899 NKLS11 If continuation sheet 3 of 26

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY
		00787	B. WING		05	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
ST BRIGIE	D'S AT HI-PARK		NEER ROAD NG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 560	Continued From page	3	2 560			
ı	change MDS, dated 2	2/16/15.				
	(DON) was interviewe	p.m. the director of nursing ed and acknowledged there an of care specific to the e.				
	The director of nursin and revise policies ar ensuring the care pla is complete and accu or designee could destaff and develop a management.	OD OF CORRECTION: g or designee could review nd procedures related to n for each individual resident rate. The director of nursing velop a system to educate nonitoring system to ensure ne written plan of care for				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 570	MN Rule 4658.0405 S Plan of Care; Revisio	Subp. 4 Comprehensive n	2 570			
	care must be reviewed interdisciplinary team physician, a registere for the resident, and of disciplines as determ and, to the extent praparticipation of the reguardian or chosen requarterly and within s	that includes the attending d nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, with the sident, the resident's legal				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
				P WING		
		00787	B. WING		05	5/20/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
ST BRIGII	D'S AT HI-PARK		NEER ROAD			
	QUALITY OF		IG, MN 55066	DDOVIDEDIO DI ANI OFI	A CORPORTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 570	Continued From page	e 4	2 570			
	by part 4658.0400, s	ubpart 3, item B.				
	by: Based on observatior review the facility faile	t is not met as evidenced n, interview and document ed to revise the care plan, en 1 of 1 resident (R30) eable pressure ulcer.				
	Findings include:					
	Interview for Mental Sidentified a cognition no cognitive deficits. assessment complete of 16, which indicated the development of plassessment identified reducing mattress on reducing device in the would be turned and Nurses notes dated 2	score of 15, which indicated The Braden scale skin ed 1/22/15 identified a score I the resident was at risk for				
	R30 as being at risk f pressure ulcers, howe not been revised to in the unstageable ulcer	ment, other than turning and				
	as a 14, which indicated development of a preassessment identified	skin assessment scored R30 ted a moderate risk for the ssure ulcer. The skin I an unstageable ulcer on bility. The wound was				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00787	B. WING		05/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
ST BRIGI	D'S AT HI-PARK		EER ROAD G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 570	R30 was cooperative refused to wear prote care, following the ski had not been updated needed for healing th nursing assistant care and reposition R30 exheels. On 5/20/15 at 3:58 p. R30 had developed the facility and acknoweld not revised back in Feunstageable ulcer was communicated that R such as the boots, and resident's refusals haplan of care. The policy and proced Risk Assessment, dain new skin alteration is pressure/non pressural teration in the skin. and interventions indicand their particular rism SUGGESTED METH. The director of nursind develop and implement related to care plan redesignee, could provistaff related to the times.	ovement and was now open. It in floating heels but ctive boots. The plan of in assessment on 4/22/15, it to identify approaches in heel ulcer. The undated is card directed staff to turn overy 2 hours and to float. In the DON explained that the unstageable ulcer in the god that the plan of care was ebruary when the is identified. DON also 30 had refused treatment, it did acknowledged that the did not been identified on the identified on the identified to the type of Proceed to care planning vidualized for the resident is factors. OD OF CORRECTION: If (DON) or designee, could not policies and procedures evisions. The DON or de training for all nursing neliness of care plan assessment and assurance	2 570			
	TIME PERIOD FOR (CORRECTION: Twenty-one				

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wiinnesot	a Department of Health	1			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
71101 2111	or contraction	BERTH 16/11/6/11/10/INBERT	A. BUILDING: _		JONII EETEB
		00787	B. WING		05/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	FE ZIR CODE	
			NEER ROAD	,:	
ST BRIGI	D'S AT HI-PARK		NG, MN 55066		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 570	Continued From page	: 6	2 570		
	(21) days.				
	(21) days.				
2 625	MN Rule 4658.0450 S Contents; In General	Subp. 1 A-P Clinical Record	2 625		
	record, including nurse A. the condition of admission; B. temperature, pressure, according to subpart 2, item I; C. the resident's laccording to part 465 D. the resident's laccording to part 465 D. the resident's laccording to part 465 and attitudes; E. observations, a interventions provided responsible for care of the resconfidential communical religious personners. Significant observation, orientation, nursing home, judy G. date, time, qual method of administration the signature of tipersons who administration.	height and weight, 8.0520, subpart 2, item J; general condition, actions, assessments, and I by all disciplines sident, with the exception of cations with el; ervations on, for example, adjustment to the dgment, or moods; antity of dosage, and ion of all medications, and he nurse or authorized tered the medication; aberculin test within the admission, as described			

dressings;

health care practitioners;

L. visits to clinics or hospitals;

J. dates and times of all treatments and

K. dates and times of visits by all licensed

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		.TED
		00787	B. WING		05/20	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST BRIGII	D'S AT HI-PARK	213 PION	EER ROAD			
		RED WING	G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 625	Continued From page	e 7	2 625			
	M. any orders or comprehensive plan of N. any change in habits or appetite; O. pertinent factor resident's general cor P. results of the ir resident assessment	instructions relative to the of care; the resident's sleeping ors regarding changes in the aditions; and nitial comprehensive				
	This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to identify residents preferences for code status accurately on all documents that directed staff as to what a residents code status was for 4 of 8 residents (R10, R30, R40, R90) reviewed for code status.					
	Findings include:					
	electronic face sheet to the facility 4/13/15. displayed a prominen resident as DNR/DNI intubate) code status.					
	which included the discyanotic (appearance coloration of the skin to the tissues near the oxygen saturation) an Cardiopulmonary rest facility staff. Emerger	ibed the events of 4/13/15, scovery of the resident of a blue or purple or mucous membranes due exist surface having low and unresponsive at 5:53 p.m. suscitation was performed by medical services were additional resuscitation				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED	
		00787	B. WING		05	5/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ST BRIGII	D'S AT HI-PARK	213 PION	IEER ROAD			
		RED WIN	IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	returned and the residence hospital where she did the progress note da "POLST [physician or treatment] sent from the progress note dated 4"POLST from AL [ass DNR status posted. Sto the hospital." Admission physician's could not be located in practitioner's visit not dictated until 4/15/15 STATUS/ADVANCE [DNR/DNI."	the facility. R10's pulse dent was transferred to the ed within a few hours. Ited 4/13/15, 5:53 p.m. read, ders for life sustaining the hospital stated full." The 1/13/15, 5:58 p.m. read, isted living] arrived with Sent that POLST with EMTs orders for code status in the record, but a nurse e, dated 4/13/15, but not read, "CODE DIRECTIVES DISCUSSION:				
	'Prior to the arrival of services (EMS), nursi basic life support, inc resident who experier [cessation of respirati exceptions needed to someone pulseless, pDNR order is in place "Facility staff needs to resuscitation status o used must be update status changes. This through processes su MatrixCare [computer resident face sheet'	id directive October 2013, emergency medical ng homes must provide luding initiation of CPR, to a nees cardiac arrest ons and/or pulse]The NOT DO CPR upon finding per CMS, are: 1. A valid ;" The policy went on, to be aware of the feach resident. The system d at any time a resuscitation can be communicated the as: Pulling up the resoftware brand] individual				

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	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00787	B. WING		05/20/20	015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST BRIGI	D'S AT HI-PARK	213 PIONE RED WING	ER ROAD , MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) OMPLETE DATE
2 625	admission code statu stated that the resider facility with a code statu the facility was waiting to come to the facility complete some admissincluding code status code status order couphysician. The DON a clear code status order R10, the resident was They were unsure as directives on R10's el that happened.	m. When asked about an sorder for R10, the LSW nt did not come to this atus order and on 4/13/15 g for R10's power of attorney after work in order to	2 625			
	the electronic medical conflicting code status: R30's record was revion the top of the curred 4/20/15, next to the result result to the result of the physicians order status: full. The facility's director of licensed social worked on 5/19/15 at approxion revealed R30 had sign Directive Summary and admitted on 1/23/15 with That form had not be electronic record and nurses station. The Directive Status of the physicians order is status: full.	I record contained is. Jewed on 5/19/15. Displayed ent physician orders dated esidents name, in large bold words, DNR/DNI (do not ubate). The second order on sheet read: 1/22/15 code of nursing (DON) and r (LSW) were interviewed mately 2:45 p.m. and ned a POLST (Advance and Medical Orders) when which indicated DNR/DNI.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00787	B. WING		05/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST BRIGI	D'S AT HI-PARK	213 PIONE				
	CLIMMADY CT		, MN 55066	DDOMDEDIC DI AM OF CODDECTIO	NI	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
2 625	Continued From page	2 10	2 625			
	including rehabilitation muscle-frequent falls, of R40's electronic factors., indicated in a red DNR (Do not resuscit orders for 4/20/15 - 5/status was noted. Int Nursing (DON) at 9:11 nurses assignment shather residents's code states information was taken medication administrates as DNR. Interview won 5/20/15 at 2:00 p.r POLST (Physician Or Treatment) for full cod which was dated 1/22 was not on the current of the electronic record R40's code status was copies were received was updated.	1/21/15 with diagnosis in procedures, weakness, and Parkinsonian. Review ce sheet on 5/20/15 at 9:00 id box, the code status of ate). Review of physician (20/15, no order for code erview with the Director of 5 a.m., he indicated the neet was updated to include status. DON indicated the from the electronic ation record. R40 was listed with the Director of Nursing in., indicated R40 had a ders for Life -Sustaining de and do not intubate, 2/15. He did not know why it it physician orders. Review and at 2:15 p.m., indicated s DNI (Do not intubate). I after the electronic record				
	R 90's electronic reco	_				
	including Rehabilitation cellulitis/abscess foot kidney disease, chror R90's electronic face	n 5/11/15 with diagnosis on procedure, -L (left), weakness, and nic stage III, Review of sheet on 5/20/15 at 9:15 red box, the code status of				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
NAME OF D	ROVIDER OR SUPPLIER	00787	RESS, CITY, STA	TE ZID CODE	05/20	0/2015
	D'S AT HI-PARK	213 PIONE		12, 211 0002		
31 BRIGIL	J S AI HI-PARK	RED WING	, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 625	Continued From page	e 11	2 625			
	full code. Review of the physician orders for 4/20/15 - 5/20/15, indicated an order for DNR/DNI. The nurses assignment sheet indicated R90 was full code.					
	R90 had completed a code status was DNR	N at 2:00 p.m., indicated POLST on admit, and the PONI. Review of the R90's 15 p.m. indicated a code				
	The director of nursin and revise policies and documentation of code could provide staff ed policies and procedur	OD OF CORRECTION: g or designee, could review nd procedures related to le status for residents and lucation related to these res. The director of nursing velop an audit tool to ensure lovided.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 900	MN Rule 4658.0525 S Ulcers	Subp. 3 Rehab - Pressure	2 900			
	Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that:	ent assessment, the director ust coordinate the				
	without pressure sore pressure sores unless condition demonstrate	s the individual's clinical				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00787	B. WING		05/20/2015	
	ROVIDER OR SUPPLIER	213 PIONE	RESS, CITY, STA ER ROAD , MN 55066	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 900	receives necessary to promote healing, previous sores from developments from the promote that the promote the promote the pro	has pressure sores reatment and services to rent infection, and prevent	2 900			
	Based on observation review the facility failed procedure for hand w and failed to revise the	i, interview and document ed to follow the policy and ashing during wound care e care plan, per facility sident (R30) developed an e ulcer.				
	R30 was admitted to a Interview for Mental Stidentified a cognition in cognitive deficits. assessment complete of 16, which indicated the development of plassessment identified reducing mattress on reducing device in the would be turned and in Nurses notes dated 2	score of 15, which indicated The Braden scale skin d 1/22/15 identified a score the resident was at risk for				
	R30 as being at risk for pressure ulcers, hower not been revised to in the unstageable ulcer	ment, other than turning and				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00787	B. WING		05/20/2045
			1		05/20/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
ST BRIGI)'S AT HI-PARK		EER ROAD		
			3, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 900	Continued From page	: 13	2 900		
	The 4/22/15 Braden s as a 14, which indicat development of a presassessment identified the heel due to immol showing steady impror R30 was cooperative refused to wear protecare, following the ski had not been updated needed for healing the nursing assistant care	kin assessment scored R30 led a moderate risk for the ssure ulcer. The skin an unstageable ulcer on bility. The wound was evement and was now open.			
	9:33 a.m., R30 was o pressure relieving mathe bed on a pillow. T (DON) removed the ricontained a small amdrainage. DON explaid drainage was most like being used. DON indicated as an unstageable would as an unstageable would would open up area on right heel curcentimeters (cm) with and .1 cm. deep. The was healing and the wound, Santyl applied dressing applied. Alth gloves during the procwere no washed before	ttress and heels floating off he director or nursing ght heel dressing which ount of yellowish color ned that the yellowish color nely from the treatment icated the area had started ound in February and on anged the order so that the to to promote healing. The rently measured .6 x .8 approximately 80% slough DON indicated the area wound was smaller. Skin ne pink skin around the d in the wound and Primpore ough the DON changed cedure four times, hands re applying new gloves.			
	During interview with procedure on 5/19/15 acknowledged changi				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLI	
		00787	B. WING		05/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		213 PIONEI	ER ROAD			
ST BRIGID'S AT HI-PARK RED WING		RED WING	MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 900	Continued From page	: 14	2 900			
	hands were not wash	ed.				
	R30 had developed the facility and acknoweld not revised back in Feunstageable ulcer was communicated that Risuch as the boots, and resident's refusals had plan of care. The policy and proceed dated October 2010 in in between all glove of procedure titled, Hand dated 8/2014 indicated replace hand washing glove removal hand he performed. The policy Pressure Ulcer Risk A indicated after a new initiate a pressure/nor the type of alteration in planning and interven resident and their parts. SUGGESTED METHOM The director of nursing all residents at risk for they are receiving the treatment/services to from developing and the pressure ulcers. The designee, could condidelivery of care; to en	s identified. DON also 30 had refused treatment, d acknowledged that the d not been identified on the dure titled, Wound Care, ndicated washing and drying hanges. The policy and dwashing/Hand Hygiene, d the use of gloves does not g/hand hygiene and after ygiene needs to be y and procedure titled, assessment, dated 2/2014 skin alteration is noted n pressure form related to n the skin. Proceed to care tions individualized for the ticular risk factors. OD OF CORRECTION: g or designee, could review r pressure ulcers to assure necessary prevent pressure ulcers to promote healing of director of nursing or uct random audits of the sure appropriate care and inted; to reduce the risk for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		00787	B. WING		05/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
ST BRIGII	D'S AT HI-PARK		NEER ROAD NG, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
2 900	Continued From page	2 15	2 900		
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one			
21325	MN Rule 4658.0725 S Emergency Oral Heal	Subp. 1 Providing Routine & Ith Ser	21325		
	home must provide, resource, routine den needs of each resider include dental examir fillings and crowns, rooral surgery, bridges orthodontic procedure that are provided for s	dental services. A nursing or obtain from an outside tal services to meet the nt. Routine dental services nations and cleanings, oot canals, periodontal care, and removable dentures, es, and adjunctive services similar dental patients in the is limited by third party es.			
	by: Based on observation review the facility faile	t is not met as evidenced n, interview and document ed to provide dental services 0) identified with dental			
	Findings include:				
	4:36 p.m., R30 comm partial denture did no 5 lower remaining tee top denture fit well. W a dentist, R30 stated	observation on 5/17/15 at nunicated that her bottom t fit appropriately around her with. R30 explained that the When asked if R30 had seen that she had not seen a finformed her that she			
	cavity assessment wa	22/15 to the facility. An oral as completed at this time, ntal issues. Another oral			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00787	B. WING		05/2	0/2015
	ROVIDER OR SUPPLIER D'S AT HI-PARK	213 PIONE	RESS, CITY, STA ER ROAD , MN 55066	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21325	which identified a loos denture. The assessmand plan written by the identified, in the last of complained of difficult continued swallowing lower partial not fitting identifed that R30 had dentist sometime in the The plan of care date "oral care," identified dental or denture issue Interview on 5/19/201 reviewed the care plate any information on the addressed R30's currunsure why R30 had however thought that The policy and proceed Examination/Assessmindicated each reside assessment prior to admission. It further it would be offered as madental examination services will be prompto SUGGESTED METHOTHE The director of nursinand revise policies and dental care for reside education related to the procedures. The director of nursinand revise policies and dental care for reside education related to the procedures. The director of nursinand revise policies and dental care for reside education related to the procedures. The director of nursinand revise policies and dental care for reside education related to the procedures. The director of nursinand revise policies and dental care for reside education related to the procedures. The director of nursinand revise policies and dental care for reside education related to the procedures. The director of nursinand revise policies and dental care for reside education related to the procedures. The director of nursinand revise policies and dental care for reside education related to the procedures.	as completed on 4/22/15 se fitting or broken partial ment summary of findings e director of nursing (DON) quarter, the resident had by swallowing pills and the difficulties could be due to g properly. The note d indicated she would see a me future. d 2/11/15, under the section there were no problems with mes. 5 at 2:01 p.m., the DON n and was unable to locate e plan of care that ent dental status. DON was not seen a dentist earlier, R30 may have refused. dure titled, Dental ment, dated 12/2013, nt should undergo a dental or within 90 days of indicated dental services eeded and after conducting a resident needing dental orly referred to a dentist. OD OF CORRECTION: g or designee, could review ind procedures related to ints and could provide staff	21325			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			SURVEY PLETED
	00787	B. WING		05	/20/2015
ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
D'S AT HI-PARK					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Continued From page	e 17	21325			
TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			
home must establish control program design	and maintain an infection gned to provide a safe and				
by: Based on observation review the facility fails control program for 1 observed during wou	n, interview and document ed to follow the infection of 1 resident (R30) nd care and for 1 of 2				
dressing change was nursing (DON) was o four times, however, conducted in-betwee completing the proce was interviewed and washed in between g The policy and proce Handwashing/Hand H directed staff: The us hand washing/hand h use along with routing as the best practice for	s observed. The director of observed to change gloves no hand sanitizing was n glove changes. After dure at 9:40 a.m., the DON confirmed hands were not glove changes. dure titled, Hygiene revised 8/2014 se of gloves does not replace hygiene. Integration of glove hand hygiene is recognized or preventing healthcare				
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page TIME PERIOD FOR (21) days. MN Rule 4658.0800 Program Subpart 1. Infection home must establish control program desic sanitary environment This MN Requirement by: Based on observation review the facility fail control program for 1 observed during wou residents (R91) obse Findings include: On 05/19/2015 at 9:3 dressing change was nursing (DON) was of four times, however, conducted in-betwee completing the proce was interviewed and washed in between of The policy and proce Handwashing/Hand in directed staff: The us hand washing/hand in use along with routin as the best practice for associated infections	DOTRY ROVIDER OR SUPPLIER STREET A 213 PIOR RED WILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the infection control program for 1 of 1 resident (R30) observed during wound care and for 1 of 2 residents (R91) observed during food delivery.	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE 213 PIONEER ROAD RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the infection control program for 1 of 1 resident (R30) observed during wound care and for 1 of 2 residents (R91) observed during food delivery. Findings include: On 05/19/2015 at 9:33 a.m., R30's wound care dressing change was observed to change gloves four times, however, no hand sanitizing was conducted in-between glove changes. After completing the procedure at 9:40 a.m., the DON was interviewed and confirmed hands were not washed in between glove changes. The policy and procedure titled, Handwashing/Hand Hygiene revised 8/2014 directed staff: The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections. The policy and procedure	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 17 Z1325 TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the infection control program for 1 of 1 resident (R30) observed during wound care and for 1 of 2 residents (R91) observed during food delivery. Findings include: On 05/19/2015 at 9:33 a.m., R30's wound care dressing change was observed. The director of nursing (DON) was observed to change gloves four times, however, no hand sanitizing was conducted in-between glove changes. After completing the procedure at 9:40 a.m., the DON was interviewed and confirmed hands were not washed in between glove changes. The policy and procedure titled, Handwashing/Hand Hygiene revised 8/2014 directed staff. The use of gloves does not replace hand washing/Hand Hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections. The policy and procedure	DEFORMECTION IDENTIFICATION NUMBER A. BUILDING: COME

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	or prejoiencies		(V2) MULTIPLE	CONSTRUCTION	(V2) DATE O	YUDVEV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING: _			
		00787	B. WING		05/2	20/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			ER ROAD			
ST BRIGIE	D'S AT HI-PARK		6, MN 55066			
	OLIMANA DV OT		·	PROVIDERIO DI ANI OF CORRECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
21375	Continued From page	e 18	21375			
	glove changing and w	ashing and drying hands				
	throughout the proced					
	During room tray distr	ribution on 5/18/15 at 11:15				
		x)-B was observed to bring				
		R88's room. DA-B set the				
		r in R88's room and double				
	checked the name on	the tray. When DA-B				
		ng tray was brought to R88,				
	DA-B picked up the tr					
	•	oom. When interviewed at				
	· ·	lained that she mixed up				
		rays. Interview with the				
		x, regarding DA-B mixing up				
	-	om chair and then bringing it				
	_	ated it was wrong to take a				
		hen into another room to				
	•	oes into a room it cannot be				
	used again. At 11:30					
	culinary director also	stated that the meal tray				
	should have been exc	changed for a new tray.				
		e was requested, however,				
	one was not provided					
	SUGGESTED METU	OD OF CORRECTION:				
		g or designee, could review				
		d procedures related to				
		•				
	tuberculosis infection control and could provide staff education related to these policies and					
		ctor of nursing or designee				
	-	it tool to ensure appropriate				
	care is provided.					
	TIME PERIOD FOR (CORRECTION: Twenty-one				
	(21) days.					
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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00787	B. WING		05/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/2	
		213 PIONE				
ST BRIGII	D'S AT HI-PARK	RED WING	, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21530	Continued From page	: 19	21530			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review		21530			
	A. The drug regiment reviewed at least more currently licensed by a This review must be of Appendix N of the State Surveyor Procedures Requirements in Long the Department of He Health Care Financing. This standard is inconvailable through the system. It is not subjuent B. The pharmacisi irregularities to the direct and the attending phymust be acted upon be physician visit, or soon pharmacist. For purpupon means the according report and the signing of nursing services are C. If the attending with the pharmacist's not provide adequate pharmacist believes the being adversely affect refer the matter to the if the medical director physician. If the medical director physician does not change the state of the attending physician justification for the ord physician does not change the state of the assessment and assubly part 4658.0070. If	a of each resident must be athly by a pharmacist the Board of Pharmacy. Jone in accordance with ate Operations Manual, for Pharmaceutical Service garent Care, published by alth and Human Services, gadministration, April 1992. The properties of th				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. Bolebino.			
		00787	B. WING		05/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST BRIGII	D'S AT HI-PARK		ER ROAD			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	5, MN 55066	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
21530	Continued From page	e 20	21530			
	assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to act on the pharmacists					
	recommendations for	specific behavior residents (R43) reviewed for				
	Findings include:					
	R43's record was reviewed and identified that on 4/17/15 the consultant pharmacist (CP) conducted a drug regimen review for R43. CP requested staff to document and monitor target behaviors for the medication Risperidone. On 4/26/15 the consultant pharmacist recommended a potential decrease in the Risperidone from twice a day to once a day, however, the nurse practitioner (RNP) disagreed, explaining that R43 continued to exhibit behaviors.					
		h the RNP was suggested, however, was unable to be				
	and identified that sta what behaviors are of whether a dose reduce medication is warrant target behaviors shou medication R43 is tak 4/17/15 the targeted by regarding the Risperio	ction of the antipsychotic ed. CP explained that				
		g or designee, could review				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BUILDING			
		00787	B. WING		05/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST BRIGII	D'S AT HI-PARK	213 PIONE				
			6, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
21530	Continued From page	21	21530			
	consulting pharmacis regimens and could p related to these polici director of nursing or	od procedures related to the t's review of resident drug rovide staff education es and procedures. The designee could develop an oppropriate care is provided.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21540	MN Rule 4658.1315 S Usage; Monitoring	Subp. 2 Unnecessary Drug	21540			
	monitor each resident unnecessary drug usa home's policies and ppharmacist must reporesident's attending pphysician does not cohome's recommendate adequate justification believes the resident's adversely affected, the matter to the medical medical director is not the medical director of physician does not have order and if the atchange the order, the review to the Quality (QAA) committee require attending physician	age, based on the nursing procedures, and the part any irregularity to the hysician. If the attending procur with the nursing tion, or does not provide				
	This MN Requiremen	t is not met as evidenced				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY PLETED
		00787	B. WING		05	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
ST BRIGI	D'S AT HI-PARK		IEER ROAD IG, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21540	facility did not identify justification for use, a non-pharmacological for 2 of 5 residents (Runnecessary medicat Findings include: R43 received the anti Risperidone, without is specific behaviors for R43 was admitted to rehabilitation, chronic disease, generalized dementia. In March, Finding of aggression toward R43 exhibitied behaving ling out, wandering R43 had been having interventions of 1 to 1 receiving Lexapro 10 depression, and Hald unknown) for behavior medication were charn Seroquel to Risperido improved and R43 was the diagnoses of dem behavioral disturbance vascular dementia but alzheimers. R43's dis included Risperidone paranoia, however, the identified were anxiety restlessness.	eview and interview, the specific target behaviors, and specific interventions with outcomes (43, R87) reviewed for ions. psychotic medication, dentified and documented the use. the facility 12/30/14 for obstructive pulmonary pain, depression and R43 was admitted to the osych unit) due to behaviors dis others and elopement. For sof crawling on floor, g, and looking for his wife. some falls and the did not work. R43 had been mg every day for ol and Seroquel (dosages ers. While in the Grace unit anged from the Haldol and one. R43's behaviors greatly as discharged on 4/3/15 with entia with paranoia and es. R43 had diagnosis of t could not rule out charge medications .25 ml twice a day (BID) for the targeted behaviors	21540			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		00787	B. WING		05/2	0/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST BRIGIE)'S AT HI-PARK	213 PIONE				
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
21540	Continued From page	23	21540			
21540	restlessness were do administration record documentation in the 4/20/15 through 5/20/revealed four episode restlessness. The followerevealed on 4/28/15 at been out of bed a few R43 was easily redire 5/2/15 at 4:38 a.m. th R43 came out of room and juice. There was On 5/6/15 the progress behavior issues and the frequently. There was behavioral note for 5/2/15 at 4:38 a.m. the guently. There was behavioral note for 5/2/15 at 4:38 a.m. the frequently. There was behavioral note for 5/2/2/15 at 3:40 p.m., A phone interview witt 5/20/15 at 3:40 p.m.,	cumented on the treatment (TAR) with follow up progress notes. From 15 the documentation as of anxiety, agitation and ow up progress notes at 9:55 p.m. that R43 had or times looking for the door. Acted and was pleasant. On the progress notes indicated in three times wanting yogurt no agitation or restlessness. The sentence is not corresponding 11/15. The series of the door is no corresponding 11/15. The series of the door is not corresponding 11/15. The series of the door is not corresponding 11/15 identified as the series of the door is no corresponding 11/15 identified as the series of the door is no corresponding 11/15 identified as the series of the door in the director of the door in the door	21540			
	5/20/2015 at 3:41 p.m	nacist (CP) was interviewed, n., and identified that staff				
	should be documenting	ng what behaviors are				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00787	B. WING		05/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
ST BRIGI	D'S AT HI-PARK	213 PIONE RED WING	ER ROAD 5, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21540	of the antipsychotic mexplained that target I to the medication R43 that on 4/17/15 the ta asked for, regarding twas taking, R87 did not have spe behaviors identified a	e whether a dose reduction nedication is warranted. CP behaviors should be specific is taking and explained rgeted behaviors were he Risperidone that R43 cific, individualized target nd non-pharmacological	21540			
	target behavior interventions and outcomes were not documented. Record review on 5/20/15 revealed a Physician Order Report showing that R87 admitted to the facility on 5/8/15 and had a physician's order, dated 5/8/15, for Seroquel (an antipsychotic) 12.5 mg. every bedtime. There was also an order, dated 5/18/15, listing the target behaviors for the Seroquel in the generic terms anxiety, agitation, and mood changes; and listing generic target behavior interventions for the Seroquel as redirect, 1:1, activity, and offer food/fluids. The medication administration record showed					
	since 5/8/15. The tree record showed that R behaviors since 5/18/ documented for interval administration record. A progress note, date was calling out, confurble placed an aromather residents [sic] room to result was documented.	87 had documented target 15, but no outcomes were ventions on the treatment d 5/18/15, read, "Resident used and yelling at staff,				

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	OF DEFICIENCIES DF CORRECTION	` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00787	B. WING		05/	20/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE			
ST BRIGI	D'S AT HI-PARK		EER ROAD 3, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21540	the progress notes. The DON was intervie p.m. and asked where interventions and out documented. DON rewere expected to be for SUGGESTED METH. The director of nursin and revise policies and unnecessary medicat provide staff educatio and procedures. The designee could developpropriate care is provide.	ewed on 05/20/2015 at 3:03 e target behavior comes would be eplied that the interventions found in the progress notes. OD OF CORRECTION: g or designee, could review and procedures related to ions for residents and could n related to these policies director of nursing or op an audit tool to ensure	21540	DEFICIENCY)			

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