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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NKLS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00787

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **178977500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BRIGID'S AT HI-PARK**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/09/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 07/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 07/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/30/2015
(L33)

DETERMINATION APPROVAL

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245355	A. Building B. Wing	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
ID Prefix **F0155** Reg. # **483.10(b)(4)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/29/2015**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/29/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/29/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/29/2015**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **06/29/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	07/23/2015	16022	07/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/20/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245355	01 - MAIN BUILDING 01	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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 06/29/2015	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 06/29/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 07/23/2015	Signature of Surveyor: 25822	Date: 06/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/22/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NKLS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00787

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(L1) **245355**

2.STATE VENDOR OR MEDICAID NO.
(L2) **178977500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BRIGID'S AT HI-PARK**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/20/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE NE II 06/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 06/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/30/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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:

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245355	A. BUILDING _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 155 SS=E	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		6/29/15

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not document accurate code status information in the records for 4 of 8 residents (R10, R30, R40, R90) reviewed for code status. Findings include: R10's electronic record did not contain a current physician's order regarding code status and contained conflicting information regarding code status. Record review on 5/19/15 revealed the electronic face sheet for R10 showing that this resident was admitted from a hospital and discharged on 4/13/15. The electronic face sheet also displayed a prominent red box identifying the resident as a DNR/DNI (do not resuscitate/do not intubate) code status. Progress notes described the events of 4/13/15, which included the discovery of the resident cyanotic (appearance of a blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface having low oxygen saturation) and unresponsive at 5:53 p.m. Cardiopulmonary resuscitation was performed by facility staff. Emergency medical services were called and performed additional resuscitation tasks upon arrival at the facility. R10's pulse returned and the resident was transferred to the hospital where she died within a few hours. The progress note dated 4/13/15, 5:53 p.m. read, "POLST [physician orders for life sustaining treatment] sent from hospital stated full." The	F 155	1. R 10 is no longer in the facility. a. R30, R40, and R90¿s code status has been verified, POLST completed, and Electronic health record updated. 2. All current residents¿ code statuses are audited for accuracy as part of Night nurse¿s routine chart audits. a. Code status¿s for all new admissions are discussed on admission with resident or responsible party by the admission nurse, or clinical managers. i. If there is no established advance directive present on admission and the resident is unable to speak for themselves. The resident is considered a full code until Medical power of attorney is present or resident is seen by the Senior Service team, and written orders are received. b. Code status¿ are reviewed at all care conferences; short stay care conferences, quarterly care conferences for long term clients, or with family at time of significant changes, if the resident can no longer speak for themselves. 3. All licensed staff and Social Services are to review the process regarding code status. 4. Code status audits conducted daily by the Clinical Managers for all new admissions for four weeks and ongoing as determined by Quality Assurance. 5. Audit results are to Quality Assurance per reporting schedule. The Director of Nursing or Designee is responsible for ongoing compliance of this	

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F 155	Continued From page 2 progress note dated 4/13/15, 5:58 p.m. read, "POLST from AL [assisted living] arrived with DNR status posted. Sent that POLST with EMTs to the hospital." Admission physician's orders for code status could not be located in the record, but a nurse practitioner's visit note, dated 4/13/15, but not dictated until 4/15/15 read, "CODE STATUS/ADVANCE DIRECTIVES DISCUSSION: DNR/DNI." The facility's CPR Policy-SNF, dated January 1, 2014, read, "Consistent with the Center for Medicare and Medicaid directive October 2013, 'Prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest [cessation of respirations and/or pulse]...The exceptions needed to NOT DO CPR upon finding someone pulseless, per CMS, are: 1. A valid DNR order is in place;..." The policy went on, "Facility staff needs to be aware of the resuscitation status of each resident. The system used must be updated at any time a resuscitation status changes. This can be communicated through processes such as: Pulling up the MatrixCare [computer software brand] individual resident face sheet..." The facility's director of nursing (DON) and licensed social worker (LSW) were interviewed on 5/19/15 at 2:40 p.m. When asked about an admission code status order for R10, the LSW stated that the resident did not come to this facility with a code status order and on 4/13/15 the facility was waiting for R10's power of attorney to come to the facility after work in order to	F 155	plan.	

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complete some admission documentation, including code status preference, and then a code status order could be requested from the physician. The DON and LSW agreed that until a clear code status order could be obtained for R10, the resident was considered a full code. They were unsure as to who put the DNR/DNI directives on R10's electronic face sheet or why that happened.

R30 was admitted to the facility on 1/22/15 and the electronic medical record contained conflicting code status.

R30's record was reviewed on 5/19/15. Displayed on the top of the current physician orders dated 4/20/15, next to the residents name, in large bold red letters, were the words, DNR/DNI (do not resuscitate/do not intubate). The second order on the physicians order sheet read: 1/22/15 code status: full.

The facility's director of nursing (DON) and licensed social worker (LSW) were interviewed on 5/19/15 at approximately 2:45 p.m. and revealed R30 had signed a POLST (Advance Directive Summary and Medical Orders) when admitted on 1/23/15 which indicated DNR/DNI. That form had not been scanned into the electronic record and was in a binder at the nurses station. The DON and LSW did not know why the physician orders still indicated full code.

R30 was admitted to the facility on 1/22/15 and the electronic medical record contained conflicting code status.

R30's record was reviewed on 5/19/15. Displayed on the top of the current physician orders dated

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4/20/15, next to the residents name, in large bold red letters, were the words, DNR/DNI (do not resuscitate/do not intubate). The second order on the physicians order sheet read: 1/22/15 code status: full.

The facility's director of nursing (DON) and licensed social worker (LSW) were interviewed on 5/19/15 at approximately 2:45 p.m. and revealed R30 had signed a POLST (Advance Directive Summary and Medical Orders) when admitted on 1/23/15 which indicated DNR/DNI. That form had not been scanned into the electronic record and was in a binder at the nurses station. The DON and LSW did not know why the physician orders still indicted full code.

R40's electronic record had conflicting information regarding code status.

R40 was admitted on 1/21/15 with diagnosis including rehabilitation procedures, weakness, muscle-frequent falls, and Parkinsonian. Review of R40's electronic face sheet on 5/20/15 at 9:00 a.m., indicated in a red box, the code status of DNR (Do not resuscitate). Review of physician orders for 4/20/15 - 5/20/15, no order for code status was noted. Interview with the Director of Nursing (DON) at 9:15 a.m., he indicated the nurses assignment sheet was updated to include the residents's code status. He indicated he took the information from the electronic medication administration record. R40 was listed as DNR. Interview with the Director of Nursing on 5/20/15 at 2:00 p.m., indicated R40 had a POLST (Physician Orders for Life -Sustaining Treatment) for full code and do not intubate, which was dated 1/22/15. He did not know why it was not on the current physician orders. Review of electronic

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F 155	Continued From page 5 record at 2:15 p.m., indicated R40 code status was DNI (Do not intubate). Copies were received after the electronic record was updated. R 90's electronic record had conflicting information regarding code status. R 90 was admitted on 5/11/15 with diagnosis including Rehabilitation procedure, cellulitis/abscess foot-L (left), weakness, and kidney disease, chronic stage III, Review of R90's electronic face sheet on 5/20/15 at 9:15 a.m., it indicated in a red box, the code status of 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. Interview with the DON at 2:00 p.m., indicated R90 had completed a POLST on admit, and the code status was DNR/DNI. Review of the R90's electronic record at 2:15 p.m. indicated a code status of DNR/DNI.	F 155		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is	F 156		6/29/15

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entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone

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F 156	Continued From page 7 numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice in a timely manner prior to termination of Medicare skilled services for 2 of 4 residents (R4 and R22) reviewed for liability notice and beneficiary appeal rights. Findings include: R4 did not receive a timely notice of termination of Medicare skilled services.	F 156	1. R 4 and R22 are no longer in the facility. 2. All current residents, whose insurance coverage is ending, will receive their appropriate 48 hour notice. a. The policy for Medicare or Medicaid covered stays is reviewed with all new admissions or responsible party by the admission nurse, or clinical managers. b. Medicare covered services are reviewed at all care conferences for short	

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F 156	Continued From page 8 R4 was admitted to the facility on 1/26/15. R4's therapy and Medicare services were discontinued on 2/6/15. On 2/5/15, the facility provided the Notice of Medicare Non-Coverage to R4, without the required two day notice. On 5/18/15, at 12:05 p.m., registered nurse (RN)-E was interviewed, and verified R4 was not given a timely notice. R22 did not receive a timely notice of termination of Medicare skilled services. R22 was admitted to the facility on 1/2/15. R22's therapy and Medicare services were discontinued on 1/27/15. On 1/27/15, the facility provided the Notice of Medicare Non-Coverage to R22, without the required two day notice. On 5/19/15, at 2:00 p.m., the director of nursing (DON) verified R22 was not given a timely notice. The facility was unable to provide a policy and procedure on Skilled Nursing Facility Advance Beneficiary Notice and notice of Medicare Non-Coverage.	F 156	stay clients with the client, or family at time of a significant change, if the resident can no longer speak for themselves. 3. All licensed staff and social services are to review the process regarding end of Medicare covered stays. 4. Termination of Medicare or Medicaid covered stay audits conducted for all residents receiving covered services for four weeks and ongoing as determined by Quality Assurance. 5. Audit results are to be reviewed by Quality Assurance per reporting schedule. The Director of Nursing, MDS Coordinator, Therapy, Social Services, and Business Office, or Designee are responsible for ongoing compliance of this plan.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		6/29/15

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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; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on 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 Grace Unit (geriatric psych unit) due to behaviors of aggression towards others and elopement. R43 exhibitied 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 medication were changed from the Haldol and	F 279	1. R43¿s care plans have been verified. Care plans completed, and electronic health record updated. 2. All current residents care plans are audited for accuracy. a. Psychotropic meds that could be considered ¿unnecessary meds¿ are reviewed at all care conferences; short stay care conference, quarterly care conference for long term clients, and/or with family at time of significant changes, if the resident can no longer speak for themselves. 3. All licensed staff, Clinical Managers, and Social Services are to review the process regarding use of unnecessary medications. 4. *(Random)* care plan audits conducted weekly by Clinical Managers for four weeks and ongoing as determined by Quality Assurance.	

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F 279	Continued From page 10 Seroquel to Risperidone. R43's behaviors greatly improved and R43 was discharged on 4/3/15 with the diagnoses of dementia with paranoia and behavioral disturbances. R43 had diagnosis of vascular dementia but could not rule out alzheimers. R43's discharge medications included Risperidone .25 ml twice a day (BID) for paranoia, however, the targeted behaviors identified were anxiety, agitation and restlessness. On 5/19/15 a quarterly minimum data set (MDS) was completed and revealed R43 continued to have mild wandering problems. The same behavior had been documented on a significant change MDS, dated 2/16/15. The current plan of care dated 1/14/15 and updated 4/14/15 identified psychotropic drug use for Lexapro and not for the antipsychotic medication, Risperidone. On 5/20/2015 at 2:53 p.m. the director of nursing (DON) was interviewed and acknowledged there was nothing on the plan of care specific to the use of the Risperidone.	F 279	5. Audit results are to be reviewed by Quality Assurance per reporting schedule. The Director of Nursing or Designee is responsible for ongoing compliance of this plan.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		6/29/15

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F 280	Continued From page 11 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan, per facility policy, when 1 of 1 resident (R30) developed an unstageable pressure ulcer. Findings include: R30 was admitted to the facility 1/22/15. The Brief Interview for Mental Status, dated 1/22/15, identified a cognition score of 15, which indicated no cognitive deficits. The Braden scale skin assessment completed 1/22/15 identified a score of 16, which indicated the resident was at risk for the development of pressure ulcers. The assessment identified a plan to place a pressure reducing mattress on the bed and a pressure reducing device in the chair. In addition, R30 would be turned and repositioned every 2 hours. Nurses notes dated 2/7/15 indentified R30 had developed an unstageable pressure ulcer on the right heel. The plan of care developed on 2/11/15, identified R30 as being at risk for the development of	F 280	1. R30¿s care plans has been updated and verified in electronic health record. 2. All current residents care plans were audited for accuracy. a. Skin checks are completed for all new admissions, weekly Braden observations times four, weekly skin checks at time of scheduled bath, and quarterly Braden observations. b. Pressure sores for all new admissions are assessed on admission with resident or responsible party by admission nurse, or clinical managers. 3. All licensed staff and social services are to review the process regarding updating the current working care plan. MDS Nurse counseled about transferring temporary Care plan into Care plan housed in electronic health record. 4. For residents with skin issues: Care plan audits conducted weekly for four weeks and ongoing as determined by Quality Assurance.	

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F 280	Continued From page 12 pressure ulcers, however, the plan of care had not been revised to include the development of the unstageable ulcer. The individualized approaches and treatment, other than turning and repositioning, had not been identified. The 4/22/15 Braden skin assessment scored R30 as a 14, which indicated a moderate risk for the development of a pressure ulcer. The skin assessment identified an unstageable ulcer on the heel due to immobility. The wound was showing steady improvement and was now open. R30 was cooperative in floating heels but refused to wear protective boots. The plan of care, following the skin assessment on 4/22/15, had not been updated to identify approaches needed for healing the heel ulcer. The undated nursing assistant care card directed staff to turn and reposition R30 every 2 hours and to float heels. On 5/20/15 at 3:58 p.m., the DON explained that R30 had developed the unstageable ulcer in the facility and acknowelged that the plan of care was not revised back in February when the unstageable ulcer was identified. DON also communicated that R30 had refused treatment, such as the boots, and acknowledged that the resident's refusals had not been identified on the plan of care. The policy and procedure titled, Pressure Ulcer Risk Assessment, dated 2/2014 indicated after a new skin alteration is noted initiate a pressure/non pressure form related to the type of alteration in the skin. Proceed to care planning and interventions individualized for the resident and their particular risk factors.	F 280	5. Audit results are to Quality Assurance per reporting schedule. The Director of Nursing or Designee is responsible for ongoing compliance of this plan.	

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F 314	Continued From page 13	F 314		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the policy and procedure for hand washing during wound care and failed to revise the care plan, per facility policy, when 1 of 1 resident (R30) developed an unstageable pressure ulcer. Findings include: R30 was admitted to the facility 1/22/15. The Brief Interview for Mental Status, dated 1/22/15, identified a cognition score of 15, which indicated no cognitive deficits. The Braden scale skin assessment completed 1/22/15 identified a score of 16, which indicated the resident was at risk for the development of pressure ulcers. The assessment identified a plan to place a pressure reducing mattress on the bed and a pressure reducing device in the chair. In addition, R30 would be turned and repositioned every 2 hours. Nurses notes dated 2/7/15 indentified R30 had developed an unstageable pressure ulcer on the right heel.	F 314	1. Resident #30 was comprehensively reassessed for pressure ulcer risk using Skin Risk Assessment with Braden Scale, and Tissue Tolerance Observation on April 26, 2015 and it has been determined that care plan is accurate. 2. Each resident will be assessed for pressure ulcer risk upon admission, quarterly and/or with a significant change in condition as determined by the RAI process and per facility policy. A comprehensive analysis and care plan is conducted as part of the process. a. The related policy and procedures including Skin Risk Assessment/Turning and Repositioning, Skin Integrity-Pressure 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, including Na/R care cards and care plans will be	6/29/15

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F 314	Continued From page 14 The plan of care developed on 2/11/15, identified R30 as being at risk for the development of pressure ulcers, however, the plan of care had not been revised to include the development of the unstageable ulcer. The individualized approaches and treatment, other than turning and repositioning, had not been identified. The 4/22/15 Braden skin assessment scored R30 as a 14, which indicated a moderate risk for the development of a pressure ulcer. The skin assessment identified an unstageable ulcer on the heel due to immobility. The wound was showing steady improvement and was now open. R30 was cooperative in floating heels but refused to wear protective boots. The plan of care, following the skin assessment on 4/22/15, had not been updated to identify approaches needed for healing the heel ulcer. The undated nursing assistant care card directed staff to turn and reposition R30 every 2 hours and to float heels. During wound care observations on 5/19/2015 at 9:33 a.m., R30 was observed in bed with a pressure relieving mattress and heels floating off the bed on a pillow. The director or nursing (DON) removed the right heel dressing which contained a small amount of yellowish color drainage. DON explained that the yellowish color drainage was most likely from the treatment being used. DON indicated the area had started as an unstageable wound in February and on 3/26 the physician changed the order so that the wound would open up to promote healing. The area on right heel currently measured .6 x .8 centimeters (cm) with approximately 80% slough and .1 cm. deep. The DON indicated the area	F 314	conducted with all Nursing staff. 4. Audits related to pressure ulcer risk and care plans will be conducted by clinical leadership weekly for all new admissions for 4 weeks and ongoing as determined by Quality Assurance. 5. Audit results are to be reviewed by Quality Assurance per reporting schedule.	

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F 314	Continued From page 15 was healing and the wound was smaller. Skin prep was applied to the pink skin around the wound, Santyl applied in the wound and Primpore dressing applied. Although the DON changed gloves during the procedure four times, hands were no washed before applying new gloves. During interview with the DON, after the procedure on 5/19/15 at 9:40 a.m, DON acknowledged changing gloves but aknowledged hands were not washed. On 5/20/15 at 3:58 p.m., the DON explained that R30 had developed the unstageable ulcer in the facility and acknowelged that the plan of care was not revised back in February when the unstageable ulcer was identified. DON also communicated that R30 had refused treatment, such as the boots, and acknowledged that the resident's refusals had not been identified on the plan of care. The policy and procedure titled, Wound Care, dated October 2010 indicated washing and drying in between all glove changes. The policy and procedure titled, Handwashing/Hand Hygiene, dated 8/2014 indicated the use of gloves does not replace hand washing/hand hygiene and after glove removal hand hygiene needs to be performed. The policy and procedure titled, Pressure Ulcer Risk Assessment, dated 2/2014 indicated after a new skin alteration is noted initiate a pressure/non pressure form related to the type of alteration in the skin. Proceed to care planning and interventions individualized for the resident and their particular risk factors.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		6/29/15

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F 329	Continued From page 16 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not identify specific target behaviors, justification for use, and specific non-pharmacological interventions with outcomes for 2 of 5 residents (R43, R87) reviewed for unnecessary medications. Findings include: R43 received the antipsychotic medication,	F 329	1. R 87 is no longer in the facility. a. As part of R43¿s significant change; care plan have been verified for appropriate target behaviors. Care plans completed, and Electronic health record updated. 2. Further sub-acute resident¿s care plan are updated and audited for accuracy.	

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F 329	Continued From page 17 Risperidone, without identified and documented specific behaviors for the use. 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 Grace Unit (geriatric psych unit) due to behaviors of aggression towards others and elopement. R43 exhibitied 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 medication were changed from the Haldol and Seroquel to Risperidone. R43's behaviors greatly improved and R43 was discharged on 4/3/15 with the diagnoses of dementia with paranoia and behavioral disturbances. R43 had diagnosis of vascular dementia but could not rule out alzheimers. R43's discharge medications included Risperidone .25 ml twice a day (BID) for paranoia, however, the targeted behaviors identified were anxiety, agitation and restlessness. The target behaviors of anxiety, agitation, and restlessness were documented on the treatment administration record (TAR) with follow up documentation in the progress notes. From 4/20/15 through 5/20/15 the documentation revealed four episodes of anxiety, agitation and restlessness. The follow up progress notes revealed on 4/28/15 at 9:55 p.m. that R43 had been out of bed a few times looking for the door. R43 was easily redirected and was pleasant. On 5/2/15 at 4:38 a.m. the progress notes indicated	F 329	a. Specific targeted behaviors or outcomes of interventions for all new admissions are assessed on admission with resident or responsible party but admission nurse, or clinical managers. b. Psychotropic meds that could be considered ¿unnecessary meds¿ are reviewed at all care conferences; short stay care conferences, quarterly care conferences for long term clients, and/or with family at time of significant changes, if the resident can no longer speak for themselves. 3. Licensed staff and social services are to observe clients receiving anti-psychotic meds to verify the client does not have behaviors that would warrant use of antipsychotic meds. If present; document behaviors. If behaviors are not present, notify provider to allow tapper of unnecessary medications. 4. Care plan audits conducted weekly by clinical leadership for four weeks and ongoing as determined by Quality Assurance. 5. Audit results are to be reviewed by Quality Assurance per reporting schedule.	

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F 329	Continued From page 18	F 329		

R43 came out of room three times wanting yogurt and juice. There was no agitation or restlessness. On 5/6/15 the progress notes revealed no behavior issues and that R43 was checked on frequently. There was no corresponding behavioral note for 5/11/15.

On 5/19/15 a quarterly minimum data set (MDS) was completed and revealed R43 continued to have some mild wandering problems.

The current plan of care dated 1/14/15 identified psychotropic drug use, however, listed Lexapro and not the antipsychotic, Risperidone.

On 5/20/15 at 2:53 p.m., the director of nursing (DON) was interviewed and documentation of specific behaviors to warrant the use of the Risperidone was requested, but unable to be provided. The DON agreed there was nothing on the plan of care specific to the use of the Risperidone.

A phone interview with the RNP was suggested, 5/20/15 at 3:40 p.m., however, was unable to be conducted.

The consulting pharmacist (CP) was interviewed, 5/20/2015 at 3:41 p.m., and identified that staff should be documenting what behaviors are occurring to determine whether a dose reduction of the antipsychotic medication is warranted. CP explained that target behaviors should be specific to the medication R43 is taking and explained that on 4/17/15 the targeted behaviors were asked for, regarding the Risperidone that R43 was taking,

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F 329	Continued From page 19 R87 did not have specific, individualized target behaviors identified and non-pharmacological 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 that R87 had received the Seroquel every day since 5/8/15. The treatment administration record showed that R87 had documented target behaviors since 5/18/15, but no outcomes were documented for interventions on the treatment administration record. A progress note, dated 5/18/15, read, "Resident was calling out, confused and yelling at staff, placed an aromatherapy flower with oil in residents [sic] room to help calm resident," but no result was documented. No other progress notes documenting behavior interventions were found in the progress notes. The DON was interviewed on 05/20/2015 at 3:03 p.m. and asked where target behavior interventions and outcomes would be documented. DON replied that the interventions were expected to be found in the progress notes.	F 329		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		6/29/15

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F 356 SS=C	Continued From page 20 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post required staffing information. This practice had the potential to affect all 16 residents residing in the facility as	F 356	1. All current census and staffing numbers are audited for accuracy. a. Staffing sheets are posted by night staff, day nurses, or Clinical Managers.	

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F 356	Continued From page 21 well as staff and visitors. Findings include: During initial tour on 5/17/15, at 1:34 p.m.,the nurse staffing posting was reviewed. The form did not identify the current census in the facility and did not have the correct number of licensed staff currently working. The posting indicated there was a registered nurse (RN) and a licensed practical nurse (LPN) working when in fact there was only a RN and a RN house supervisor. The RN house manager was not working with the residents. During an interview on 05/17/15 at 1:35 p.m., the RN manager (RN)-A verified the current census was not on the posting and it should have been. RN-A also verified that there was not a LPN on the shift and stated that herself (RN-A) is not counted for on the staff posting. On 05/17/15 at 1:38 p.m. the director of nursing was interviewed and agreed the posting was incorrect. A policy was requested, however was not provided.	F 356	b. Staffing sheets are reviewed daily. 2. All licensed staff and social services are to review the process regarding staffing sheets. 3. Staffing sheet audits conducted by random staff assigned by DON or Designee at least three times a week for four weeks and ongoing as determined by Quality Assurance. 4. Audit results are to be reviewed by Quality Assurance per reporting schedule. The Director of Nursing or Designee is responsible for ongoing compliance of this plan.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or	F 412		6/29/15

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F 412	Continued From page 22 damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide dental services to 1 of 1 resident (R30) identified with dental needs. Findings include: During interview and observation on 5/17/15 at 4:36 p.m., R30 communicated that her bottom partial denture did not fit appropriately around her 5 lower remaining teeth. R30 explained that the top denture fit well. When asked if R30 had seen a dentist, R30 stated that she had not seen a dentist, however, staff informed her that she could see one. R30 was admitted 1/22/15 to the facility. An oral cavity assessment was completed at this time, which revealed no dental issues. Another oral cavity assessment was completed on 4/22/15 which identified a loose fitting or broken partial denture. The assessment summary of findings and plan written by the director of nursing (DON) identified, in the last quarter, the resident had complained of difficulty swallowing pills and the continued swallowing difficulties could be due to lower partial not fitting properly. The note identifed that R30 had indicated she would see a dentist sometime in the future. The plan of care dated 2/11/15, under the section "oral care," identified there were no problems with dental or denture issues.	F 412	1. Resident #30 was comprehensively assessed for oral cavity observation on admission by the Clinical Manager and again on 5/19/15 and 6/15/2015 and it has been determined that care plan is accurate, with the resident to see the ¿at home¿ dental provider at their next scheduled visit date to the facility. The release of information was signed by the resident on 5/19/15. 2. Each resident will be assessed for dental needs on admission, quarterly and/or with a significant change in condition as determined by the RAI process and per facility policy. A comprehensive analysis and care plan is conducted as part of the process. 3. Additional mandatory in-services regarding following plan of care, including Na/R care cards and care plans will be conducted with all nursing staff. 4. Audits related to dental services and interventions related to care plans will be conducted twice weekly by clinical leadership for 4 weeks and ongoing as determined by Quality Assurance. Audit results are to be reviewed by Quality Assurance per reporting schedule.	

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F 412	Continued From page 23 Interview on 5/19/2015 at 2:01 p.m., the DON reviewed the care plan and was unable to locate any information on the plan of care that addressed R30's current dental status. DON was unsure why R30 had not seen a dentist earlier, however thought that R30 may have refused. The policy and procedure titled, Dental Examination/Assessment, dated 12/2013, indicated each resident should undergo a dental assessment prior to or within 90 days of admission. It further indicated dental services would be offered as needed and after conducting a dental examination a resident needing dental services will be promptly referred to a dentist.	F 412		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This 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 monitoring for 1 of 5 residents (R43) reviewed for unnecessary medications.	F 428	1. R43¿s care plan has been updated for current behaviors and verified for appropriate target behaviors to monitor. Care plan has been updated and completed, and electronic health record updated.	6/29/15

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F 428	Continued From page 24 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. A phone interview with the RNP was suggested, 5/20/15 at 3:40 p.m., however, was unable to be conducted. The CP was interviewed, 5/20/2015 at 3:41 p.m., and identified that staff should be documenting what behaviors are occurring to determine whether a dose reduction of the antipsychotic medication is warranted. CP explained that target behaviors should be specific to the medication R43 is taking and explained that on 4/17/15 the targeted behaviors were asked for, regarding the Risperidone that R43 was taking,	F 428	2. All current residents care plans are audited for accuracy. a. Specific targeted behaviors or outcomes of interventions for all new admissions are assessed on admission with resident or responsible party by admission nurse, or clinical managers. b. Psychotropic meds that could be considered ¿unnecessary meds¿ are reviewed at all care conferences; short stay care conference, quarterly care conference for long term clients, and/or with family at time of significant changes, if the resident can no longer speak for themselves. 3. Licensed staff and social services are to review the process regarding use of unnecessary medications in regular nursing department meetings. 4. For residents receiving anti-psychotic medications: care plan audits conducted weekly to verify presence of target behaviors for four weeks and ongoing as determined by Quality Assurance. 5. Audit results are to be reviewed by Quality Assurance per reporting schedule.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		6/29/15

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	245355	A. BUILDING _____ B. WING _____	05/20/2015

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F 441	Continued From page 25 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This 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 service.	F 441	1. The facilities infection control program for hand washing during wound care and food delivery has been reviewed and it has been determined that the plan is now accurate. 2. Wound care treatment audits conducted on new admissions, or facility	

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F 441	Continued From page 26 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 titled, Wound Care, revised 10/2010 indicated glove changing and washing and drying hands throughout the procedure. During room tray distribution on 5/18/15 at 11:15 a.m., dietary aide (DA)-B was observed to bring R91's room tray into R88's room. DA-B set the tray down on the chair in R88's room and double checked the name on the tray. When DA-B identified that the wrong tray was brought to R88, DA-B picked up the tray from the chair and brought it into R91's room. When interviewed at 11:20 a.m., DA-B explained that she mixed up R91 and R88's meal trays. Interview with the cook supervisor (C)-A, regarding DA-B mixing up the trays and observation of R91's meal tray being set on R88's room chair and then bringing it to R91's room, C-A stated it was wrong to take a tray into a room and then into another room to serve. Once a tray goes into a room it cannot be used again. At 11:30 a.m. on 5/18/15, the culinary director also stated that the meal tray	F 441	acquired wounds by Clinical Managers on admission, or change in condition, as well as at time of initial or quarterly care conferences. 3. Staff to complete the additional infection control EduCare course assigned by the education/infection control nurse 4. Audits related to food service in the room and wound care will be conducted at least twice weekly for 4 weeks and ongoing as determined by Quality Assurance. 5. Audit results are to be reviewed by Quality Assurance per reporting schedule.	

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F 441	Continued From page 27 should have been exchanged for a new tray. A policy and procedure was requested, however, one was not provided.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This 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: R10's record review, on 5/19/15, revealed the electronic face sheet identified R10 was admitted to the facility 4/13/15. The electronic face sheet displayed a prominent red box identifying the resident as DNR/DNI (do not resuscitate/do not intubate) code status.	F 514	1. R 10 is no longer in the facility. a. R30, R40, and R90¿s code status has been verified, POLST completed, and Electronic health record updated. 2. All current residents¿ code statuses are audited for accuracy by the Clinical Manager or Social Services with-in 24 hours of admission. a. POLST forms and EMR are reviewed nightly by Night staff. b. Code statuses are reviewed at all care conferences; short stay Care Conferences, quarterly CC for Long term clients. Appropriate changes are made at that time on POLST and EMR.	6/29/15

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F 514	Continued From page 28 Progress notes described the events of 4/13/15, which included the discovery of the resident cyanotic (appearance of a blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface having low oxygen saturation) and unresponsive at 5:53 p.m. Cardiopulmonary resuscitation was performed by facility staff. Emergency medical services were called and performed additional resuscitation tasks upon arrival at the facility. R10's pulse returned and the resident was transferred to the hospital where she died within a few hours. The progress note dated 4/13/15, 5:53 p.m. read, "POLST [physician orders for life sustaining treatment] sent from the hospital stated full." The progress note dated 4/13/15, 5:58 p.m. read, "POLST from AL [assisted living] arrived with DNR status posted. Sent that POLST with EMTs to the hospital." Admission physician's orders for code status could not be located in the record, but a nurse practitioner's visit note, dated 4/13/15, but not dictated until 4/15/15 read, "CODE STATUS/ADVANCE DIRECTIVES DISCUSSION: DNR/DNI." The facility's CPR Policy-SNF, dated January 1, 2014, read, "Consistent with the Center for Medicare and Medicaid directive October 2013, 'Prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest [cessation of respirations and/or pulse]...The exceptions needed to NOT DO CPR upon finding someone pulseless, per CMS, are: 1. A valid	F 514	c. Staff are made aware of the code status via the POLST binder, Nurse Report Sheet, and Point of Care Kiosk; that all staff have access to. 3. All staff are to review the process regarding code status¿. 4. Electronic Medical Record audits conducted for all new admissions with-in 24 hours by Clinical leadership for four weeks and ongoing as determined by Quality Assurance. 5. Audit results are to be reviewed by QA per reporting schedule. 6. The Director of Nursing or Designee is responsible for ongoing compliance of this plan.	

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F 514	Continued From page 29	F 514		

DNR order is in place;..." The policy went on, "Facility staff needs to be aware of the resuscitation status of each resident. The system used must be updated at any time a resuscitation status changes. This can be communicated through processes such as: Pulling up the MatrixCare [computer software brand] individual resident face sheet..."

The facility's director of nursing (DON) and licensed social worker (LSW) were interviewed on 5/19/15 at 2:40 p.m. When asked about an admission code status order for R10, the LSW stated that the resident did not come to this facility with a code status order and on 4/13/15 the facility was waiting for R10's power of attorney to come to the facility after work in order to complete some admission documentation, including code status preference, and then a code status order could be requested from the physician. The DON and LSW agreed that until a clear code status order could be obtained for R10, the resident was considered a full code. They were unsure as to who put the DNR/DNI directives on R10's electronic face sheet or why that happened.

R30 was admitted to the facility on 1/22/15 and the electronic medical record contained conflicting code status.

R30's record was reviewed on 5/19/15. Displayed on the top of the current physician orders dated 4/20/15, next to the residents name, in large bold red letters, were the words, DNR/DNI (do not resuscitate/do not intubate). The second order on the physicians order sheet read: 1/22/15 code status: full.

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F 514	Continued From page 30	F 514		

The facility's director of nursing (DON) and licensed social worker (LSW) were interviewed on 5/19/15 at approximately 2:45 p.m. and revealed R30 had signed a POLST (Advance Directive Summary and Medical Orders) when admitted on 1/23/15 which indicated DNR/DNI. That form had not been scanned into the electronic record and was in a binder at the nurses station. The DON and LSW did not know why the physician orders still indicated full code.

R40's electronic record had conflicting information regarding code status.

R40 was admitted on 1/21/15 with diagnosis including rehabilitation procedures, weakness, muscle-frequent falls, and Parkinsonian. Review of R40's electronic face sheet on 5/20/15 at 9:00 a.m., indicated in a red box, the code status of DNR (Do not resuscitate). Review of physician orders for 4/20/15 - 5/20/15, no order for code status was noted. Interview with the Director of Nursing (DON) at 9:15 a.m., he indicated the nurses assignment sheet was updated to include the residents's code status. DON indicated the information was taken from the electronic medication administration record. R40 was listed as DNR. Interview with the Director of Nursing on 5/20/15 at 2:00 p.m., indicated R40 had a POLST (Physician Orders for Life -Sustaining Treatment) for full code and do not intubate, which was dated 1/22/15. He did not know why it was not on the current physician orders. Review of the electronic record at 2:15 p.m., indicated R40's code status was DNI (Do not intubate). Copies were received after the electronic record was updated.

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F 514	Continued From page 31 R 90's electronic record had conflicting information regarding code status. R 90 was admitted on 5/11/15 with diagnosis including Rehabilitation procedure, cellulitis/abscess foot-L (left), weakness, and kidney disease, chronic stage III, Review of R90's electronic face sheet on 5/20/15 at 9:15 a.m., it indicated in a red box, the code status of 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. Interview with the DON at 2:00 p.m., indicated R90 had completed a POLST on admit, and the code status was DNR/DNI. Review of the R90's electronic record at 2:15 p.m. indicated a code status of DNR/DNI.	F 514		

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	245355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/22/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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	K 000	EPOC	

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Brigids at Hi Park is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1977 and was determined to be of Type III(211) construction. In 1986, addition was constructed to the West Wing that was determined to be of Type III(211) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a	K 000		

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K 000	Continued From page 2 census of 15 at the time of the survey.	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Chapters 19.3.4.1, 9.6.1.4, 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 15 residents. Findings include: On facility tour between 7:55 AM and 10:30 AM on 05/22/2015, the review of the annual fire alarm inspection and testing report from Trans Alarm, dated 4/8/15, indicated that the following: 1. The sensitivity for 3/28/14, that (1) smoke and (2) duct smoke detectors were not sensitivity tested; 2. (4) duct smoke detectors were not listed on device count These deficient practices were confirmed by the Facility Maintenance (TS) at the time of discovery.	K 054	Fire Alarm Company has been contacted and will return by June 26, 2015 to inspect the ventilation duct smoke detectors that were missed in initial inspection and to complete sensitivity test on duct smokes. Facility will request a copy of report on completion and review before they depart and will add to our internal TELS system to prompt us to make sure we are in compliance. Plant Operations Director/designee is responsible for ongoing compliance of this plan.	6/29/15
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		6/29/15

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K 062	Continued From page 3 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 15 residents. Findings include: On facility tour between 7:55 AM and 10:30 AM on 05/22/2015, observation revealed that the spare sprinkler head box does not contain 2 of each type of sprinkler head in the facility. This deficient practice was confirmed by the Facility Maintenance (TS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	Olympic Sprinkler returned on June 11, 2015. Provided the facility with the appropriate back-up Sprinkler heads and we are now compliant with the number of spare sprinkler heads needed in the facility. Will be added in the TELS system that will prompt us to make sure we are in compliance. Plant Operations Director/designee is responsible for ongoing compliance of this plan.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00787	A. BUILDING: _____ B. WING _____	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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	2 000	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.	

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On May 17, 18, 19, 20, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		

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2 560	Continued From page 2 This MN 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 10 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 Grace Unit (geriatric psych unit) due to behaviors of aggression towards others and elopement. R43 exhibitied 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 medication were changed from the Haldol and Seroquel to Risperidone. R43's behaviors greatly improved and R43 was discharged on 4/3/15 with the diagnoses of dementia with paranoia and behavioral disturbances. R43 had diagnosis of vascular dementia but could not rule out alzheimers. R43's discharge medications included Risperidone .25 ml twice a day (BID) for paranoia, however, the targeted behaviors identified were anxiety, agitation and restlessness. On 5/19/15 a quarterly minimum data set (MDS) was completed and revealed R43 continued to have mild wandering problems. The same behavior had been documented on a significant	2 560		

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2 560	Continued From page 3 change MDS, dated 2/16/15. The current plan of care dated 1/14/15 and updated 4/14/15 identified psychotropic drug use for Lexapro and not for the antipsychotic medication, Risperidone. On 5/20/2015 at 2:53 p.m. the director of nursing (DON) was interviewed and acknowledged there was nothing on the plan of care specific to the use of the Risperidone. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is complete and accurate. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure the development of the written plan of care for each resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required	2 570		

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2 570	Continued From page 4 by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan, per facility policy, when 1 of 1 resident (R30) developed an unstageable pressure ulcer. Findings include: R30 was admitted to the facility 1/22/15. The Brief Interview for Mental Status, dated 1/22/15, identified a cognition score of 15, which indicated no cognitive deficits. The Braden scale skin assessment completed 1/22/15 identified a score of 16, which indicated the resident was at risk for the development of pressure ulcers. The assessment identified a plan to place a pressure reducing mattress on the bed and a pressure reducing device in the chair. In addition, R30 would be turned and repositioned every 2 hours. Nurses notes dated 2/7/15 indentified R30 had developed an unstageable pressure ulcer on the right heel. The plan of care developed on 2/11/15, identified R30 as being at risk for the development of pressure ulcers, however, the plan of care had not been revised to include the development of the unstageable ulcer. The individualized approaches and treatment, other than turning and repositioning, had not been identified. The 4/22/15 Braden skin assessment scored R30 as a 14, which indicated a moderate risk for the development of a pressure ulcer. The skin assessment identified an unstageable ulcer on the heel due to immobility. The wound was	2 570		

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2 570	Continued From page 5	2 570		

showing steady improvement and was now open. R30 was cooperative in floating heels but refused to wear protective boots. The plan of care, following the skin assessment on 4/22/15, had not been updated to identify approaches needed for healing the heel ulcer. The undated nursing assistant care card directed staff to turn and reposition R30 every 2 hours and to float heels.

On 5/20/15 at 3:58 p.m., the DON explained that R30 had developed the unstageable ulcer in the facility and acknowelged that the plan of care was not revised back in February when the unstageable ulcer was identified. DON also communicated that R30 had refused treatment, such as the boots, and acknowledged that the resident's refusals had not been identified on the plan of care.

The policy and procedure titled, Pressure Ulcer Risk Assessment, dated 2/2014 indicated after a new skin alteration is noted initiate a pressure/non pressure form related to the type of alteration in the skin. Proceed to care planning and interventions individualized for the resident and their particular risk factors.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 570	Continued From page 6 (21) days.	2 570		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals;	2 625		

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2 625	Continued From page 7 M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. 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: R10's record review, on 5/19/15, revealed the electronic face sheet identified R10 was admitted to the facility 4/13/15. The electronic face sheet displayed a prominent red box identifying the resident as DNR/DNI (do not resuscitate/do not intubate) code status. Progress notes described the events of 4/13/15, which included the discovery of the resident cyanotic (appearance of a blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface having low oxygen saturation) and unresponsive at 5:53 p.m. Cardiopulmonary resuscitation was performed by facility staff. Emergency medical services were called and performed additional resuscitation	2 625		

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2 625	Continued From page 8	2 625		

tasks upon arrival at the facility. R10's pulse returned and the resident was transferred to the hospital where she died within a few hours.

The progress note dated 4/13/15, 5:53 p.m. read, "POLST [physician orders for life sustaining treatment] sent from the hospital stated full." The progress note dated 4/13/15, 5:58 p.m. read, "POLST from AL [assisted living] arrived with DNR status posted. Sent that POLST with EMTs to the hospital."

Admission physician's orders for code status could not be located in the record, but a nurse practitioner's visit note, dated 4/13/15, but not dictated until 4/15/15 read, "CODE STATUS/ADVANCE DIRECTIVES DISCUSSION: DNR/DNI."

The facility's CPR Policy-SNF, dated January 1, 2014, read, "Consistent with the Center for Medicare and Medicaid directive October 2013, 'Prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest [cessation of respirations and/or pulse]...The exceptions needed to NOT DO CPR upon finding someone pulseless, per CMS, are: 1. A valid DNR order is in place;..." The policy went on, "Facility staff needs to be aware of the resuscitation status of each resident. The system used must be updated at any time a resuscitation status changes. This can be communicated through processes such as: Pulling up the MatrixCare [computer software brand] individual resident face sheet..."

The facility's director of nursing (DON) and licensed social worker (LSW) were interviewed

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2 625	Continued From page 9 on 5/19/15 at 2:40 p.m. When asked about an admission code status order for R10, the LSW stated that the resident did not come to this facility with a code status order and on 4/13/15 the facility was waiting for R10's power of attorney to come to the facility after work in order to complete some admission documentation, including code status preference, and then a code status order could be requested from the physician. The DON and LSW agreed that until a clear code status order could be obtained for R10, the resident was considered a full code. They were unsure as to who put the DNR/DNI directives on R10's electronic face sheet or why that happened. R30 was admitted to the facility on 1/22/15 and the electronic medical record contained conflicting code status. R30's record was reviewed on 5/19/15. Displayed on the top of the current physician orders dated 4/20/15, next to the residents name, in large bold red letters, were the words, DNR/DNI (do not resuscitate/do not intubate). The second order on the physicians order sheet read: 1/22/15 code status: full. The facility's director of nursing (DON) and licensed social worker (LSW) were interviewed on 5/19/15 at approximately 2:45 p.m. and revealed R30 had signed a POLST (Advance Directive Summary and Medical Orders) when admitted on 1/23/15 which indicated DNR/DNI. That form had not been scanned into the electronic record and was in a binder at the nurses station. The DON and LSW did not know why the physician orders still indicated full code.	2 625		

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2 625	Continued From page 10	2 625		

R40's electronic record had conflicting information regarding code status.

R40 was admitted on 1/21/15 with diagnosis including rehabilitation procedures, weakness, muscle-frequent falls, and Parkinsonian. Review of R40's electronic face sheet on 5/20/15 at 9:00 a.m., indicated in a red box, the code status of DNR (Do not resuscitate). Review of physician orders for 4/20/15 - 5/20/15, no order for code status was noted. Interview with the Director of Nursing (DON) at 9:15 a.m., he indicated the nurses assignment sheet was updated to include the residents's code status. DON indicated the information was taken from the electronic medication administration record. R40 was listed as DNR. Interview with the Director of Nursing on 5/20/15 at 2:00 p.m., indicated R40 had a POLST (Physician Orders for Life -Sustaining Treatment) for full code and do not intubate, which was dated 1/22/15. He did not know why it was not on the current physician orders. Review of the electronic record at 2:15 p.m., indicated R40's code status was DNI (Do not intubate). Copies were received after the electronic record was updated.

R 90's electronic record had conflicting information regarding code status.

R 90 was admitted on 5/11/15 with diagnosis including Rehabilitation procedure, cellulitis/abscess foot-L (left), weakness, and kidney disease, chronic stage III, Review of R90's electronic face sheet on 5/20/15 at 9:15 a.m., it indicated in a red box, the code status of

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2 625	Continued From page 11 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. Interview with the DON at 2:00 p.m., indicated R90 had completed a POLST on admit, and the code status was DNR/DNI. Review of the R90's electronic record at 2:15 p.m. indicated a code status of DNR/DNI. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to documentation of code status for residents and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		

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2 900	Continued From page 12 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the policy and procedure for hand washing during wound care and failed to revise the care plan, per facility policy, when 1 of 1 resident (R30) developed an unstageable pressure ulcer. Findings include: R30 was admitted to the facility 1/22/15. The Brief Interview for Mental Status, dated 1/22/15, identified a cognition score of 15, which indicated no cognitive deficits. The Braden scale skin assessment completed 1/22/15 identified a score of 16, which indicated the resident was at risk for the development of pressure ulcers. The assessment identified a plan to place a pressure reducing mattress on the bed and a pressure reducing device in the chair. In addition, R30 would be turned and repositioned every 2 hours. Nurses notes dated 2/7/15 indentified R30 had developed an unstageable pressure ulcer on the right heel. The plan of care developed on 2/11/15, identified R30 as being at risk for the development of pressure ulcers, however, the plan of care had not been revised to include the development of the unstageable ulcer. The individualized approaches and treatment, other than turning and repositioning, had not been identified.	2 900		

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2 900	Continued From page 13 The 4/22/15 Braden skin assessment scored R30 as a 14, which indicated a moderate risk for the development of a pressure ulcer. The skin assessment identified an unstageable ulcer on the heel due to immobility. The wound was showing steady improvement and was now open. R30 was cooperative in floating heels but refused to wear protective boots. The plan of care, following the skin assessment on 4/22/15, had not been updated to identify approaches needed for healing the heel ulcer. The undated nursing assistant care card directed staff to turn and reposition R30 every 2 hours and to float heels. During wound care observations on 5/19/2015 at 9:33 a.m., R30 was observed in bed with a pressure relieving mattress and heels floating off the bed on a pillow. The director or nursing (DON) removed the right heel dressing which contained a small amount of yellowish color drainage. DON explained that the yellowish color drainage was most likely from the treatment being used. DON indicated the area had started as an unstageable wound in February and on 3/26 the physician changed the order so that the wound would open up to promote healing. The area on right heel currently measured .6 x .8 centimeters (cm) with approximately 80% slough and .1 cm. deep. The DON indicated the area was healing and the wound was smaller. Skin prep was applied to the pink skin around the wound, Santyl applied in the wound and Primpore dressing applied. Although the DON changed gloves during the procedure four times, hands were no washed before applying new gloves. During interview with the DON, after the procedure on 5/19/15 at 9:40 a.m, DON acknowledged changing gloves but aknowledged	2 900		

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2 900	Continued From page 14 hands were not washed. On 5/20/15 at 3:58 p.m., the DON explained that R30 had developed the unstageable ulcer in the facility and acknowelged that the plan of care was not revised back in February when the unstageable ulcer was identified. DON also communicated that R30 had refused treatment, such as the boots, and acknowledged that the resident's refusals had not been identified on the plan of care. The policy and procedure titled, Wound Care, dated October 2010 indicated washing and drying in between all glove changes. The policy and procedure titled, Handwashing/Hand Hygiene, dated 8/2014 indicated the use of gloves does not replace hand washing/hand hygiene and after glove removal hand hygiene needs to be performed. The policy and procedure titled, Pressure Ulcer Risk Assessment, dated 2/2014 indicated after a new skin alteration is noted initiate a pressure/non pressure form related to the type of alteration in the skin. Proceed to care planning and interventions individualized for the resident and their particular risk factors. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.	2 900		

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2 900	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide dental services to 1 of 1 resident (R30) identified with dental needs. Findings include: During interview and observation on 5/17/15 at 4:36 p.m., R30 communicated that her bottom partial denture did not fit appropriately around her 5 lower remaining teeth. R30 explained that the top denture fit well. When asked if R30 had seen a dentist, R30 stated that she had not seen a dentist, however, staff informed her that she could see one. R30 was admitted 1/22/15 to the facility. An oral cavity assessment was completed at this time, which revealed no dental issues. Another oral	21325		

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21325	Continued From page 16 cavity assessment was completed on 4/22/15 which identified a loose fitting or broken partial denture. The assessment summary of findings and plan written by the director of nursing (DON) identified, in the last quarter, the resident had complained of difficulty swallowing pills and the continued swallowing difficulties could be due to lower partial not fitting properly. The note identifed that R30 had indicated she would see a dentist sometime in the future. The plan of care dated 2/11/15, under the section "oral care," identified there were no problems with dental or denture issues. Interview on 5/19/2015 at 2:01 p.m., the DON reviewed the care plan and was unable to locate any information on the plan of care that addressed R30's current dental status. DON was unsure why R30 had not seen a dentist earlier, however thought that R30 may have refused. The policy and procedure titled, Dental Examination/Assessment, dated 12/2013, indicated each resident should undergo a dental assessment prior to or within 90 days of admission. It further indicated dental services would be offered as needed and after conducting a dental examination a resident needing dental services will be promptly referred to a dentist. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to dental care for residents and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided.	21325		

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21325	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21375	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 titled, Wound Care, revised 10/2010 indicated	21375		

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21375	Continued From page 18 glove changing and washing and drying hands throughout the procedure. During room tray distribution on 5/18/15 at 11:15 a.m., dietary aide (DA)-B was observed to bring R91's room tray into R88's room. DA-B set the tray down on the chair in R88's room and double checked the name on the tray. When DA-B identified that the wrong tray was brought to R88, DA-B picked up the tray from the chair and brought it into R91's room. When interviewed at 11:20 a.m., DA-B explained that she mixed up R91 and R88's meal trays. Interview with the cook supervisor (C)-A, regarding DA-B mixing up the trays and observation of R91's meal tray being set on R88's room chair and then bringing it to R91's room, C-A stated it was wrong to take a tray into a room and then into another room to serve. Once a tray goes into a room it cannot be used again. At 11:30 a.m. on 5/18/15, the culinary director also stated that the meal tray should have been exchanged for a new tray. A policy and procedure was requested, however, one was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to tuberculosis infection control and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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21530	Continued From page 19	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		

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21530	Continued From page 20 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 monitoring for 1 of 5 residents (R43) reviewed for unnecessary medications. 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. A phone interview with the RNP was suggested, 5/20/15 at 3:40 p.m., however, was unable to be conducted. The CP was interviewed, 5/20/2015 at 3:41 p.m., and identified that staff should be documenting what behaviors are occurring to determine whether a dose reduction of the antipsychotic medication is warranted. CP explained that target behaviors should be specific to the medication R43 is taking and explained that on 4/17/15 the targeted behaviors were asked for, regarding the Risperidone that R43 was taking, SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review	21530		

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21530	Continued From page 21 and revise policies and procedures related to the consulting pharmacist's review of resident drug regimens and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced	21540		

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21540	Continued From page 22 by: Based on document review and interview, the facility did not identify specific target behaviors, justification for use, and specific non-pharmacological interventions with outcomes for 2 of 5 residents (R43, R87) reviewed for unnecessary medications. Findings include: R43 received the antipsychotic medication, Risperidone, without identified and documented specific behaviors for the use. 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 Grace Unit (geriatric psych unit) due to behaviors of aggression towards others and elopement. R43 exhibitied 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 medication were changed from the Haldol and Seroquel to Risperidone. R43's behaviors greatly improved and R43 was discharged on 4/3/15 with the diagnoses of dementia with paranoia and behavioral disturbances. R43 had diagnosis of vascular dementia but could not rule out alzheimers. R43's discharge medications included Risperidone .25 ml twice a day (BID) for paranoia, however, the targeted behaviors identified were anxiety, agitation and restlessness. The target behaviors of anxiety, agitation, and	21540		

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restlessness were documented on the treatment administration record (TAR) with follow up documentation in the progress notes. From 4/20/15 through 5/20/15 the documentation revealed four episodes of anxiety, agitation and restlessness. The follow up progress notes revealed on 4/28/15 at 9:55 p.m. that R43 had been out of bed a few times looking for the door. R43 was easily redirected and was pleasant. On 5/2/15 at 4:38 a.m. the progress notes indicated R43 came out of room three times wanting yogurt and juice. There was no agitation or restlessness. On 5/6/15 the progress notes revealed no behavior issues and that R43 was checked on frequently. There was no corresponding behavioral note for 5/11/15.

On 5/19/15 a quarterly minimum data set (MDS) was completed and revealed R43 continued to have some mild wandering problems.

The current plan of care dated 1/14/15 identified psychotropic drug use, however, listed Lexapro and not the antipsychotic, Risperidone.

On 5/20/15 at 2:53 p.m., the director of nursing (DON) was interviewed and documentation of specific behaviors to warrant the use of the Risperidone was requested, but unable to be provided. The DON agreed there was nothing on the plan of care specific to the use of the Risperidone.

A phone interview with the RNP was suggested, 5/20/15 at 3:40 p.m., however, was unable to be conducted.

The consulting pharmacist (CP) was interviewed, 5/20/2015 at 3:41 p.m., and identified that staff should be documenting what behaviors are

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occurring to determine whether a dose reduction of the antipsychotic medication is warranted. CP explained that target behaviors should be specific to the medication R43 is taking and explained that on 4/17/15 the targeted behaviors were asked for, regarding the Risperidone that R43 was taking,

R87 did not have specific, individualized target behaviors identified and non-pharmacological 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 that R87 had received the Seroquel every day since 5/8/15. The treatment administration record showed that R87 had documented target behaviors since 5/18/15, but no outcomes were documented for interventions on the treatment administration record.

A progress note, dated 5/18/15, read, "Resident was calling out, confused and yelling at staff, placed an aromatherapy flower with oil in residents [sic] room to help calm resident," but no result was documented. No other progress notes documenting behavior interventions were found in

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21540	Continued From page 25 the progress notes. The DON was interviewed on 05/20/2015 at 3:03 p.m. and asked where target behavior interventions and outcomes would be documented. DON replied that the interventions were expected to be found in the progress notes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to unnecessary medications for residents and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		