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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O7JC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00593

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245483**

2.STATE VENDOR OR MEDICAID NO.
(L2) **940220900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ELIGIUS HEALTH CENTER**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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 **05/20/2014** (L34)
06/10/2014

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 **77** (L18)

13.Total Certified Beds **77** (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
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Patricia Halverson, Unit Supervisor — 06/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 07/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(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
06/10/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5483

July 24, 2014

Ms. Melody Krattenmaker, Administrator
St Eligius Health Center
7700 Grand Avenue
Duluth, Minnesota 55807

Dear Ms. Krattenmaker:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective May 16, 2014 the above facility is certified for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 10, 2014

Ms. Melody Krattenmaker, Administrator
St Eligius Health Center
7700 Grand Avenue
Duluth, Minnesota 55807

RE: Project Number S5483023

Dear Ms. Krattenmaker:

On April 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 2014 that included an investigation of complaint number . 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 May 20, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 10, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective May 16, 2014 and therefore remedies outlined in our letter to you dated April 15, 2014, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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
245483	A. Building B. Wing	5/20/2014

Name of Facility	Street Address, City, State, Zip Code
ST ELIGIUS HEALTH CENTER	7700 GRAND AVENUE DULUTH, MN 55807

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 **F0242** Reg. # **483.15(b)** LSC	Correction Completed **05/16/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/16/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/16/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **05/16/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/16/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/03/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/16/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **05/16/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	06/10/2014	12835	05/20/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/3/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245483	A. Building B. Wing **01 - MAIN BUILDING 01**	6/10/2014

Name of Facility	Street Address, City, State, Zip Code
ST ELIGIUS HEALTH CENTER	7700 GRAND AVENUE DULUTH, MN 55807

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 K0052	Correction Completed **04/03/2014**	ID Prefix Reg. # **NFPA 101** LSC K0062	Correction Completed **04/08/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/PS	Date: 06/10/2014	Signature of Surveyor: 03005	Date: 06/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/1/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O7JC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00593

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245483**
2.STATE VENDOR OR MEDICAID NO.
(L2) **940220900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ELIGIUS HEALTH CENTER**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (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
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Afcpwj H, Hmflqml* FDC LCGG 06/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
K_pi Kc_rf*Cldmpackclr Qncag_jgqr 06/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5483

On April 3, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. In addition, at the time of the standard survey, investigation of complaint numbers, H5483026 and H5483027 were conducted and found to be unsubstantiated. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2304 1349

April 15, 2014

Ms. Melody Krattenmaker, Administrator
St Eligius Health Center
7700 Grand Avenue
Duluth, MN 55807

RE: Project Number S5483023, H5483026, H5483027

Dear Ms. Krattenmaker:

On April 3, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the April 3, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5483026 and H5483027.

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. In addition, at the time of the April 3, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5483026, H5483027 that was found to be unsubstantiated.

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

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

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

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

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:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 13, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 13, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 3, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 3, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5483s14.rtf

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

RECEIVED
APR 28 2014
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIGIUS HEALTH CENTER	7700 GRAND AVENUE DULUTH, MN 55807

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS: 64 A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey. Investigation of complaints H5483026, and H5483027, were completed. The complaints related to H5483026, and H5483027, were not substantiated.	F 000 05/05/14 PHL/mpm	F242 It is the policy of St. Eligius Health Center to ensure residents have the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. The facility will continue to provide R135 with choices per the regulation. All residents will continue to be encouraged to make the above decisions as is current practice demonstrated by policy and procedure. Audits will be conducted with residents (staff will speak directly with random residents) to assess and ensure that they are being offered choices and those choices are being honored. These audits will be conducted on 5% of the resident population monthly by Activity Director X 6 months.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by:	F 242		

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

CED Admin 4/27/14

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

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	245483	A. BUILDING _____ B. WING _____	04/03/2014

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F 242	Continued From page 1 Based on interview and document review, the facility failed to honor bathing preferences for 1 of 3 residents (R135) who were reviewed for choices. Findings include: R135, interviewed on 3/31/14, at 4:24 p.m., stated he could not choose whether to take a shower, tub, or bed bath. R135 would like to soak in the tub but did not think there was a tub in the building. The admission MDS dated 2/22/14, indicated R135 was cognitively intact and required extensive assist for transfers and physical assist of one staff with dressing. The MDS noted R135 had balance problems. The MDS question on how important was to choose between a tub bath, shower or sponge bath, R135's answer was, "Very important". The Care Plan dated 6/3/14, indicated R135 required physical assistance with bathing, but did not indicate the preference for a tub bath. Registered nurse (RN)-E, interviewed on 4/3/14, at 10:05 a.m., stated she didn't think there was a bath tub. The occupational therapist (OT)-H stated there might be a bathtub at the other end of the hall. Interview on 4/3/14, at 10:15 a.m. with NA-F indicated there was a whirl pool tub that could be used if someone wanted to. RN-D was interviewed on 4/4/14, at 10:30 a.m. and stated that residents were suppose to get the type of bath they wanted. Residents were asked about preferences at the admission care conference. R135's care conference records	F 242	Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-16-14	

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F 242	Continued From page 2 dated 3/21/14, and 3/26/14, did not address bathing preferences.	F 242		
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 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 care plan to address Coumadin use and the potential for bleeding for 2 of 5 residents (R107, R31) reviewed for unnecessary medications. Findings include: R107's physician order dated 3/24/14, directed	F 279	F279 It is the policy of St. Eligius Health Center to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental, and psychosocial needs that are identified in the comprehensive assessment. R107's and R31's care plans have been modified to include monitoring for side effects of Coumadin therapy. This monitoring has also been added as a task to the MAR for nursing staff to observe and indicate completion via electronic signature. A report of all residents on anticoagulant therapy has been generated. All residents on such therapy have been audited to ensure care plans and MARs have observation for side effects and documentation of completion included. Nursing staff will be educated on the above by 5-16-14.	

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F 279	Continued From page 3 Coumadin 6 milligrams (mg) every evening for a diagnosis of pulmonary embolism/infarction (a blockage of the artery in the lungs, that can be caused by a blood clot). The care plan dated 12/19/14, directed the use of Coumadin, but did not identify potential side effects and monitoring. On 4/3/14, at 9:36 a.m. registered nurse (RN)-A was interviewed and verified monitoring for indications of bleeding as a side effect of Coumadin should be on the care plan. The facility policy and procedure on comprehensive care plans dated 10/10, directs an individual comprehensive care plan be developed that includes measurable objectives and timetables to meet the resident's medical needs. R31's physician order dated 3/20/14, directed Coumadin 1.5 milligrams (mg) daily on Sundays ,Tuesday, Thursday and Saturdays and 2 mg on Monday, Wednesday and Friday. R31's care plan dated 5/8/13, identified diagnoses to include atrial fibrillation, cerebral vascular accident and history of a subarachnoid hemorrhage. The care plan lacked indications for monitoring potential side effects On 4/3/14, at 12:00 p.m. registered nurse (RN)-A was interviewed and verified a care plan did not identify potential adverse response or monitoring for us of Coumadin.	F 279	DON or designee will conduct a full house audit (record review) of residents on anticoagulant therapy monthly X 3 months, with random audits of residents on anticoagulation therapy monthly for 3 months. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-16-14	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 4 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositinoing as directed by the plan of care for 1 of 3 residents (R14) reviewed for pressure ulcers; or to monitor the vascular access site for 1 of 1 residents (R40) reviewed for dialysis. Findings include: R14 was not provided every one hour repositioning for a Stage II (partial thickness loss of dermis presenting as shallow open ulcer) coccyx pressure ulcer as directed by the care plan. R14's care plan dated 10/24/13, indicated a Stage II pressure ulcer on the coccyx with hourly repositioning. R14 was not provided repositioning during continuous observation on 4/2/14, from 5:06 a.m. until 6:46 a.m. At that time, the administrator and licensed practical nurse (LPN)-B, transferred R14 to the toilet, then back into bed to do a dressing change to R14's pressure ulcer. On 4/3/14, at 2:44 p.m. register nurse (RN)-A stated staff were expected to reposition R14 every hour as directed by the care plan. The facility policy and procedure on pressure		F282 It is the policy of St. Eligius Health Center to ensure resident care plans are followed. R14 has been re-evaluated by OT for w/c positioning, potential change to her advanced pressure relieving cushion, or change to advanced pressure reduction mattress. Current interventions including: dietary assessments, hourly repositioning attempts with encouragement, and use of pressure reduction devices will be continued. All residents requiring every 1 - 2 hour repositioning will continue to have quarterly and prn assessments to review interventions. Interventions to allow for pressure reduction will remain in effect. All nursing staff members will be re-educated regarding the above by 5-16-14. DON or designee will conduct repositioning audits (visually) for all residents requiring every 1 - 2 hour intervention on a weekly basis X 4; then biweekly X 4. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency.	

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F 282	Continued From page 5 ulcers/skin breakdown dated 10/104/11, directed once risk factors have been identified, care planning and interventions are individualized for the resident and their particular risk factors. R40's hemodialysis access site was not monitored for infection, infiltration (blood leaking into the tissues), bleeding, and patency (un-obstruction), as directed by the care plan. The 14-day scheduled Minimum Data Set (MDS) dated 1/29/14, indicated R40 had no cognitive impairment; had diagnoses of diabetes and end stage renal disease (ESRD); and received dialysis services. The dialysis care plan dated 1/16/14, indicated R40 was on hemodialysis secondary to end stage renal disease (ESRD), and identified R40 had a left forearm access site. The care plan indicated R40 was at risk for excess bleeding and infiltration in the left arm AV fistula due to Heparin use at dialysis. Interventions included to monitor the site for signs and symptoms of infection, infiltration, bleeding, and to check for a "buzz" over the site daily. The care plan indicated R40 returns from dialysis with a pressure dressing on the access site that the resident or staff may remove, and there was a potential for bleeding after the removal of the dressing. The care plan further directed staff to monitor the access site every shift for the presence of a bruit (swishing sound heard through a stethoscope) and a thrill (feel for vibration). On 4/2/14, at 7:18 a.m. R40 was observed in his room in bed. When questioned how often the staff in the facility check his left forearm dialysis access site, R40 stated, "They don't usually check it." R40 stated he waits a few hours and		Care plan interventions for R40 have been added to TAR to allow nursing staff the opportunity to document their completed monitoring of hemodialysis access site. All patients on dialysis therapy in the facility have monitoring of access site on individual care plans and TARs. Nursing staff will be re-educated regarding the above by 5-16-14. DON or designee will conduct Audits (record review and visually observe monitoring) to ensure proper access site monitoring and documentation for all patients receiving dialysis monthly X 6 months. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-16-14	

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F 282	Continued From page 6 removes the dressing when he returns to the facility after dialysis. R40's medical records lacked evidence the dialysis access site was being monitored by the facility staff as directed on the care plan. On 4/2/14, at 2:33 p.m. the registered nurse manager (RN)-A confirmed there was no documentation to indicate R40's access site was being monitored for infection, infiltration, bleeding, or patency. RN-A stated the task had not been entered into the electronic treatment record and should have been. RN-A verified the access site should be monitored as directed on the care plan.			
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 provide timely repositioning to promote the healing of pressure ulcers for 1 of 3 residents (R14) reviewed for pressure ulcers. Findings include:	F 314	F314 It is the policy of St. Eligius Health Center to provide interventions to reduce the risk of pressure ulcers. R14 has been re-evaluated by OT for w/c positioning, potential change to her advanced pressure relieving cushion, or change to advanced pressure reduction mattress. Current interventions including: dietary assessments, hourly repositioning attempts with encouragement, and use of pressure reduction devices will be continued. All residents requiring every 1 - 2 hour repositioning will continue	

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F 314	Continued From page 7 R14 had a Stage II (partial thickness loss of dermis presenting as shallow open ulcer) pressure ulcer on her coccyx, and was not provided with timely repositioning. Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined. R14's care plan dated 10/24/13, indicated diagnoses that included mild cognitive impairment and muscular atrophy. The care plan also indicated R14 had a Stage II pressure ulcer on her coccyx, and was on a every one hour repositioning schedule. The quarterly Minimum Data Set (MDS) dated 1/24/14, indicated R14 was severely cognitively impaired, and required extensive assist of 1 staff for bed mobility, transfers,and toileting. The MDS indicated R14 was frequently incontinent of bowel and bladder. The MDS further indicated R14 was at risk for the development of a pressure ulcer, was on a repositioning schedule, and currently had a stage 2 pressure ulcer that was first identified on 12/30/13.	F 314	to have quarterly and prn assessments to review interventions. Interventions to allow for pressure reduction will remain in effect. All nursing staff members will be re-educated regarding the above by 5-16-14. DON or designee will conduct repositioning audits (visually) for all residents requiring every 1 - 2 hour intervention on a weekly basis X 4; then biweekly X 4. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-16-14	

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F 314	Continued From page 8 R14 was not provided repositioning during continuous observation while she was in bed on 4/2/14, from 5:06 a.m. until ~~6:46~~ a.m. At that time, the administrator and licensed practical nurse (LPN)-B, transferred R14 to the toilet, then back into bed to do a dressing change to R14's pressure ulcer. At that time the pressure ulcer was measured and was 0.7 cm x 0.9 cm, less then 0.1 cm depth. On 4/3/14, at 2:44 p.m. register nurse (RN)-A was interviewed and stared R14's hourly repositioning program was determined when the facility identified a red area to R14's coccyx. RN-A further stated she would expect the staff to reposition R14 every hour as directed by the care plan. The facility policy and procedure on pressure ulcers/skin breakdown dated 10/10, directed once resident risk factors have been identified, individual interventions are determined for the resident and their particular risk factors.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	F329 It is the policy of St. Eligius Health Center to identify, assess, and monitor clinical indications for ongoing use of medications. R29 has had bG monitoring documentation added to the TAR. All residents with physician ordered bG monitoring will have results documented in the TAR. Nursing staff will be educated on the above by 5-16-14.	

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F 329	Continued From page 9 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 observation, interview, and document review, the facility failed to consistently complete blood glucose checks (Accuchecks) as ordered by the physician to monitor the effectiveness of an oral blood glucose lowering medication for 1 of 5 residents (R29) whose medications were reviewed. Findings include: The annual Minimum Data Set (MDS) dated 3/13/14, indicated R29 had a diagnosis of diabetes. An Interagency Referral Form (physician's order) dated 3/21/13, directed staff to complete an Accuchecks twice a day - once in the morning, and once two hours after the evening meal. The order further directed staff to call the physician if R29's blood glucose was greater than 200 two times in a row. The Physician Order Report for 3/1/14, to 4/1/14, directed staff to administer		DON or designee will conduct audits (review clinical record) for all residents requiring bG monitoring biweekly X 4 then monthly X 3. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-16-14	

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F 329	Continued From page 10 glipizide (an oral blood glucose lowering medication) 7.5 milligrams (mg) twice a day starting 5/28/13. The Electronic Medication Administration History for March and April 2014, indicated R29 does receive the medication twice daily. On 4/2/14, at 7:11 a.m. R29 was observed in the room in bed, and at 9:14 a.m. when up in the wheelchair. No signs or symptoms of possible high or low blood glucose levels were observed. Review of R29's Accuchecks from 1/1/14, to 4/2/14, were as follows: January 2014 - there were no morning Accuchecks completed on 1/1, 1/5, 1/6, 1/7, 1/10, and 1/24. There was one Accucheck level in January greater than 200 (205) the evening of 1/18, and blood glucose monitoring at that time was completed as ordered. February 2014 - there were no morning Accuchecks completed on 2/4, 2/6, 2/7, 2/9, 2/13, 2/16, 2/17, 2/18, 2/19, 2/20, 2/28, and no evening Accucheck on 2/21. There was one Accucheck level greater than 200 (223) the evening of 2/28; however, the facility would have been unable to determine if there were two blood glucose levels in a row greater than 200 as the morning Accucheck on 2/28, had not been completed. March 2014 - there were no morning Accuchecks completed on 3/6, 3/7, 3/11, 3/17, 3/23, 3/24, and no evening Accuchecks completed on 3/24, and 3/29. There was an Accucheck level greater than 200 (220) the evening of 3/5; however, the facility would have been unable to determine if there were two blood glucose levels in a row greater than 200 as the morning Accucheck on 3/6, had	F 329		

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F 329	Continued From page 11 not been completed. There was also an Accucheck level greater than 200 (266) the evening of 3/19, and blood glucose monitoring at that time was completed as ordered. April 2014 - there was no morning Accucheck completed on 4/1. The remainder of the completed Accuchecks were all under 200. On 4/3/14, at 10:00 a.m. the registered nurse manager (RN)-A confirmed the lack of documented blood glucose checks.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING 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		F356 It is the policy of St. Eligius Health Center to ensure required nursing staffing information is posted as required. Clock hours of shift times have been added to the posted form. Form will be posted as required. Completion date: ~~4-1-14~~ 4/3/2014 is the date of correction ML	

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	245483	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 356		F 356		

Continued From page 12

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 on a daily basis the actual hours worked for both licensed and unlicensed staff. This had the potential to affect all 63 residents currently residing in the facility and the visitors.

Findings include:

During initial tour of the facility on 3/31/14, at 12:10 p.m. the daily staff posting was observed posted on the wall near the front entrance of the facility. The posting lacked identification of the actual shift hours worked by each category of nursing staff directly responsible for resident care.

Under the column for Actual Hours Worked the facility entered the total hours. The posting indicated that on Monday 3/31/14 day shift, six registered nurses worked for a total of 48 hours, two licensed practical nurses for 16 hours, and eight nursing assistants for 58 hours.

The staff posting was observed incorrectly posted on 4/1/14 at 12:50 p.m. and 4/2/14 at 1:15 p.m.

The environmental services director (ESD) was interviewed on 4/2/14 at 1:30 p.m. and verified she had the responsibility to post the staff hours.

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F 356	Continued From page 13 ESD further indicated she was unaware that the actual shifts staff worked were a requirement on the posting. A policy on staff posting was requested but not provided.			
F 441 SS=F	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 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.			

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F 441	Continued From page 14 (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 implement an infection control surveillance plan to identify,document and monitor residents infections. In addition, resident food was stored with usable resident ice packs; proper handwashing technique was not followed for a dressing change for 1 of 3 residents (R14) reviewed for pressure ulcers; and soiled resident linen was placed on the floor. Findings include: Review of the Daily infection Control Logs revealed the facility lacked a system for identifying and tracking resident infections. The day logs for the month of March 2014 revealed the facility's nurse managers would write down daily on the log a residents name, room number, site of the infection and what antibiotic the resident was on. Examples include, R142's name and room number appeared on the log from 3/19/14 -3/31/14. The only other information listed for R142 was Doxycline (antibiotic). R6's was listed on the daily log for 3/30/14-3/31/14 as lungs-Levaquin (antibiotic) 3/29-4/4		F441 It is the policy of St. Eligius Health Center to have an established and maintained Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The Infection Control Tracking form has been revised and is in place on nursing units. DON or designee will conduct audits of the form (review of clinical records) to ensure prevention of development and transmission of disease and infection. This will occur on a monthly basis X 6 months. Staff will be educated on the above by 5-16-14. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Ice packs have been removed from the snack refrigerator. Staff will be educated on the above by 5-16-14. Culinary Services Director or designee will audit refrigerators	

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F 441	Continued From page 15 The log lacked date of unset, signs and symptoms, culture reports, diagnosis and if the infections were health care associated infections or community associated. The information was not available to track and trend resident infections. In addition, there was no system to identify if cultures were ordered to determine appropriate antibiotic usage. Interview with the director of nursing (DON), registered nurse managers (RN-A & RN-D) and Administrator on 4/3/13 at 1:00 p.m. verified that this was the system they used to track and trend infections. DON verified there was no policy to direct a method for tracking resident infections. During observation of medication storage on 4/3/14, at 10:25 a.m. with a licensed practical nurse (LPN-B) a plastic container of oranges was noted to be stored with reusable ice packs in the freezer of the second floor snack refrigerator. LPN-B verified at that time that the ice packs were for resident use (treatments). At 12:30 p.m. RN-A was interviewed and indicated that resident ice packs shouldn't be in the [snack] refrigerator. Nursing assistant (NA)-C was observed to put soiled linen on the floor. On 4/2/14, at 7:22 a.m. NA-C was observed to be making R14's bed. NA-C dropped a soiled nightgown and a blue pad onto the floor. When she had completed making the bed, NA-C folded the blue pad and placed it on the foot of R14's bed. When questioned, NA-C stated she usually put soiled linen into a linen bag, but she was unable to find one. NA-C verified soil[illegible] linen		(visualize contents) weekly X 4, biweekly X 4. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. All CNA's will be re-educated on the proper handling of linen by 5-16-14. DON or designee will conduct audits (observe staff) weekly X 4, biweekly X 4. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Nursing Staff will be re-educated on proper dressing change policy and procedure. A return demonstration will be required of each member of the nursing staff in the presence of the DON or designee by 5-16-14. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-16-14	

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F 441	Continued From page 16			

should go into a lined bag.

On 4/2/14, at 7:30 a.m. registered nurse (RN)-C was interviewed and stated soiled lined should go into a linen bag.

The facility policy and procedure on laundry and linen dated 4/12, directed all soiled linen must be placed directly into a covered laundry bag.

Proper handwashing procedures were not followed during a pressure ulcer dressing change on R14.

On 4/2/14, at 6:46 a.m. the administrator and licensed practical nurse (LPN)-B transferred R14 from the bed to the toilet, then back into bed. LPN-B washed her hands, donned clean gloves, and arranged the dressing supplies. LPN-B then discarded her gloves, donned clean gloves, and removed the soiled dressing. LPN-B discarded the soiled gloves, did not wash her hands, then donned clean gloves. LPN-B proceeded to cleanse the pressure ulcer with normal saline, then placed a clean dressing on the pressure ulcer. Upon completion of the dressing change at 7:03 a.m. LPN-B stated she should have washed her hands between glove changes when going from a soiled dressing to a clean dressing.

On 4/3/14, at 2:44 p.m. RN-B was interviewed, and stated hands should be washed between glove changes when going from a soiled dressing to a clean dressing.

The facility policy and procedure on dry/clean dressings dated 10/10, directed to wash and dry hands thoroughly, put on clean gloves and remove soiled dressing, wash and dry hands

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F 441	Continued From page 17 thoroughly, put on clean gloves to cleanse the wound.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that 10 of 40 resident rooms (R8, R5, R107, R73, R102, R70, R116, R22, R20, R40) were maintained and repaired in an sanitary manner related to walls, flooring and odors. In addition, there was a refrigerator in the kitchen with rusty shelves. Findings include; During the environmental tour with the facilities environmental services director (ESD) on 4/3/14 at 12:45 p.m. the following was noted: R8's room had large gouges in the wall on the right side of the hallway when entering the room. The linoleum on the bathroom floor had gouges near the left side of the entry. The room had a strong musty odor. ESD indicated the bathroom floor needs to be replaced. ESD further stated, "That could be the source of the odor." The bathrooms used by R5, R107, R73 and R102 had peeling wallpaper that was stained yellow. ESD indicated that there was a [water] leak that	F 465	F465 It is the policy of St. Eligius Health Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Walls and flooring in R8's room have been repaired. Bathrooms used by R5,107, 73, 102 had wallpaper re-affixed. R22's plaster was repaired for the 4th time within the past 12 months. R20's bathroom floor has no stain. R40's heater and door frame have been touched up.	

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F 465	Continued From page 18 caused the staining. R70's bathroom had rust under the suspended toilet. The heat register had an loose piece of metal approximately two by four inches long. ESD verified the findings and indicated the flooring in R70's bathroom should be replaced and that R70's heat register is on the list to be replaced. R116's closet had scratches and black marks along the closet doors. ESD verified the findings. R22's room had several areas of missing plaster behind the head of the bed. ESD indicated that was caused by the head of the resident's old bed being pushed against the wall by staff. ESD indicated that R22 had received a new bed two weeks ago. R20's bathroom floor had a white stain below the sink. ESD indicated she was not sure what it was. ESD further indicated it possible could be a paint spill. R40's room had paint scraped off of the baseboard heater at the foot of the bed and the bathroom door frame. A policy was requested regarding routine maintenance for resident rooms and was not provided. On 3/31/14, at 12 noon during tour of the kitchen with the culinary service director (CSD) a small standing refrigerator was observed to have three metal wire shelves that were totally rusted. The shelves were approximately two feet by a foot and a half. The refrigerator contained yogurt and left overs, open packages of sandwich meat,		R70 has no rust on floor. R116 closet door touched up with paint. ESD will continue with weekly audits (visualize repair completion) and monthly walk-through observation of building to note and prioritize repair needs. Completion Date: 4-9-14 Then refrigerator shelves are free of rust. CSD will continue with current weekly cleaning schedule. All other shelving has been inspected and found to be free of rust. Culinary staff will be educated by 5-14-16 to alert ESD of any needed repairs. Completion date: 5-16-14	

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F 465	Continued From page 19 cheeses, Mayonnaise, other compliments, . Per interview with CSD on 3/31/14, at 12:00 noon she said this refrigerator holds foods that the facility used on a daily basis, like leftovers, tomatoes and lettuce, things to make sandwiches with. The CSD stated that they do a weekly cleaning of the shelves. The schedule for April indicated the cleaning was documented weekly. The CSD stated that it would be hard to ensure that the selves were clean because of the rust.			

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F548302

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Eligius Health Care Center 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 444 Cedar St., Suite 145 St. Paul, MN 55101-5145 OR,	K 000	POC ok TL 6/4/14 LAST DATE: 4/8/14 RECEIVED APR 30 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-13-14

EXIT: 4-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO/Admin	4/27/14

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

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K 000	Continued From page 1 By Email to: Marian.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St. Eliguis Health Center is a 2-story building with basement. The original building was constructed in 1971 with an addition constructed in 2005. The 1971 building is of type II(111) construction and the 2005 building is type II(111) construction. The 2005 building is support service only. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected.The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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K 052	Continued From page 2 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 70(99) and NFPA 72(99) edition. 9.6.1.4.This deficient practice could affect all building occupants. Findings include: At the conclusion of the inspection tour at approximately 10:00AM, on 4-1-14, review of available documentation indicated that the last annually required inspection, testing, and maintenance of the fire alarm system, in accordance with NFPA 72, was conducted on 3-7-13. This deficient practice was verified by the facility Maintained Director (RP) at the time of this inspection.	K 052	K052 It is the policy of St. Eligius Health Center to install, test and maintain a fire alarm system in accordance with NFPA 70 and 72. The annual fire alarm inspection was conducted on 4-3-14. The ESD has assumed the responsibility of scheduling and ensuring the timely completion of the annual inspection. The ESD will meet with the local Fire Marshall by 5-31-14 to obtain additional materials pertaining to routine maintenance requirements and documentation of completion.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating			

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K 062	Continued From page 3 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 record review,observation and interview, the facility has failed to properly maintain the sprinkler system. This deficient practice could affect all occupants including residents, staff and visitors. Findings include: At the conclusion of the tour on 4-1-14 at 10:30AM, it was discovered, during review of available documentation, and interview with the Director of Facility Maintenance , that the facility did not have proper documentation to show that the quarterly fire sprinkler flow testing as required, by NFPA 25 Section 9.7.5, was being conducted. This deficient practice was confirmed by the Director of Maintenance (RP) at the time of exit.	K 062	K062 It is the policy of St. Eligius Health Center to continuously maintain automatic sprinkler systems in reliable operating condition and ensure they are tested and inspected periodically. Quarterly flow testing will include measurement of pressures and documentation of results beginning 2Q2014 as the inspection occurred on the last day of 1Q2014. The ESD has assumed the responsibility of scheduling and ensuring the timely completion and documentation of the quarterly testing. The ESD will meet with the local Fire Marshall by 5-31-14 to obtain additional materials pertaining to routine maintenance requirements and documentation of completion. SEE UPDATE FOR K-062	

K052
It is the policy of St. Eligius Health Center to install, test and maintain a fire alarm system in accordance with NFPA 70 and 72.
The annual fire alarm inspection was conducted on 4-3-14.
The ESD has assumed the responsibility of scheduling and ensuring the timely completion of the annual inspection.

K062
It is the policy of St. Eligius Health Center to continuously maintain automatic sprinkler systems in reliable operating condition and ensure they are tested and inspected periodically. Quarterly flow testing will include measurement of pressures and documentation of results beginning 4-8-14, and will continue to be documented on a quarterly basis. The ESD has assumed the responsibility of scheduling and ensuring the timely completion and documentation of the quarterly testing.

POC o/c 6-4-14
LAST DATE 4/8/14

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 1349

April 15, 2014

Ms. Melody Krattenmaker, Administrator
St Eligius Health Center
7700 Grand Avenue
Duluth, Minnesota 55807

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5483023
Complaint Numbers: H5483026 and H54830274

Dear Ms. Krattenmaker:

The above facility was surveyed on March 31, 2014 through April 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5483026 and H54830274. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

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 Patricia Halverson at the number above.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00593	A. BUILDING: _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIGIUS HEALTH CENTER	7700 GRAND AVENUE DULUTH, MN 55807

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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: On 3/31/14, through 4/3/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000		

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2 000	Continued From page 1 Certification Program; 11 East Superior Street; Suite 290, Duluth, MN 55802 In addition, complaint investigations were also completed at the time of the recertification survey. Investigation of complaints H5483026, and H5483027, were completed. The complaints related to H5483026, and H5483027, were not substantiated.	2 000		
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). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address Coumadin use and the potential for bleeding for 2 of 5 residents (R107, R31) reviewed for unnecessary medications. Findings include: R107's physician order dated 3/24/14, directed Coumadin 6 milligrams (mg) every evening for a diagnosis of pulmonary embolism/infarction (a blockage of the artery in the lungs, that can be caused by a blood clot).	2 560		

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2 560	Continued From page 2 The care plan dated 12/19/14, directed the use of Coumadin, but did not identify potential side effects and monitoring. On 4/3/14, at 9:36 a.m. registered nurse (RN)-A was interviewed and verified monitoring for indications of bleeding as a side effect of Coumadin should be on the care plan. The facility policy and procedure on comprehensive care plans dated 10/10, directs an individual comprehensive care plan be developed that includes measurable objectives and timetables to meet the resident's medical needs. R31's physician order dated 3/20/14, directed Coumadin 1.5 milligrams (mg) daily on Sundays ,Tuesday, Thursday and Saturdays and 2 mg on Monday, Wednesday and Friday. R31's care plan dated 5/8/13, identified diagnoses to include atrial fibrillation, cerebral vascular accident and history of a subarachnoid hemorrhage. The care plan lacked indications for monitoring potential side effects On 4/3/14, at 12:00 p.m. registered nurse (RN)-A was interviewed and verified a care plan did not identify potential adverse response or monitoring for us of Coumadin. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure care plans are developed and reflect each residents current care needs including high risk medications.	2 560		

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2 560	Continued From page 3 The DON or designee could educate all appropriate staff on the policies/procedures, and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositinoing as directed by the plan of care for 1 of 3 residents (R14) reviewed for pressure ulcers; or to monitor the vascular access site for 1 of 1 residents (R40) reviewed for dialysis. Findings include: R14 was not provided every one hour repositioning for a Stage II (partial thickness loss of dermis presenting as shallow open ulcer) coccyx pressure ulcer as directed by the care plan. R14's care plan dated 10/24/13, indicated a Stage II pressure ulcer on the coccyx with hourly repositioning. R14 was not provided repositioning during continuous observation on 4/2/14, from 5:06 a.m.	2 565		

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2 565	Continued From page 4	2 565		

until 6:46 a.m. At that time, the administrator and licensed practical nurse (LPN)-B, transferred R14 to the toilet, then back into bed to do a dressing change to R14's pressure ulcer.

On 4/3/14, at 2:44 p.m. register nurse (RN)-A stated staff were expected to reposition R14 every hour as directed by the care plan.

The facility policy and procedure on pressure ulcers/skin breakdown dated 10/104/11, directed once risk factors have been identified, care planning and interventions are individualized for the resident and their particular risk factors.

R40's hemodialysis access site was not monitored for infection, infiltration (blood leaking into the tissues), bleeding, and patency (un-obstruction), as directed by the care plan.

The 14-day scheduled Minimum Data Set (MDS) dated 1/29/14, indicated R40 had no cognitive impairment; had diagnoses of diabetes and end stage renal disease (ESRD); and received dialysis services.

The dialysis care plan dated 1/16/14, indicated R40 was on hemodialysis secondary to end stage renal disease (ESRD), and identified R40 had a left forearm access site. The care plan indicated R40 was at risk for excess bleeding and infiltration in the left arm AV fistula due to Heparin use at dialysis. Interventions included to monitor the site for signs and symptoms of infection, infiltration, bleeding, and to check for a "buzz" over the site daily. The care plan indicated R40 returns from dialysis with a pressure dressing on the access site that the resident or staff may remove, and there was a potential for bleeding after the removal of the dressing. The care plan

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2 565	Continued From page 5 further directed staff to monitor the access site every shift for the presence of a bruit (swishing sound heard through a stethoscope) and a thrill (feel for vibration). On 4/2/14, at 7:18 a.m. R40 was observed in his room in bed. When questioned how often the staff in the facility check his left forearm dialysis access site, R40 stated, "They don't usually check it." R40 stated he waits a few hours and removes the dressing when he returns to the facility after dialysis. R40's medical records lacked evidence the dialysis access site was being monitored by the facility staff as directed on the care plan. On 4/2/14, at 2:33 p.m. the registered nurse manager (RN)-A confirmed there was no documentation to indicate R40's access site was being monitored for infection, infiltration, bleeding, or patency. RN-A stated the task had not been entered into the electronic treatment record and should have been. RN-A verified the access site should be monitored as directed on the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a system to ensure all resident care plans are followed by staff, and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position	2 905		

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2 905	Continued From page 6 of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning to promote the healing of pressure ulcers for 1 of 3 residents (R14) reviewed for pressure ulcers. Findings include: R14 had a Stage II (partial thickness loss of dermis presenting as shallow open ulcer) pressure ulcer on her coccyx, and was not provided with timely repositioning. Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth	2 905		

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2 905	Continued From page 7	2 905		

cannot be determined.
R14's care plan dated 10/24/13, indicated diagnoses that included mild cognitive impairment and muscular atrophy. The care plan also indicated R14 had a Stage II pressure ulcer on her coccyx, and was on a every one hour repositioning schedule.
The quarterly Minimum Data Set (MDS) dated 1/24/14, indicated R14 was severely cognitively impaired, and required extensive assist of 1 staff for bed mobility, transfers,and toileting. The MDS indicated R14 was frequently incontinent of bowel and bladder. The MDS further indicated R14 was at risk for the development of a pressure ulcer, was on a repositioning schedule, and currently had a stage 2 pressure ulcer that was first identified on 12/30/13.

R14 was not provided repositioning during continuous observation while she was in bed on 4/2/14, from 5:06 a.m. until 6:46 a.m. At that time, the administrator and licensed practical nurse (LPN)-B, transferred R14 to the toilet, then back into bed to do a dressing change to R14's pressure ulcer. At that time the pressure ulcer was measured and was 0.7 cm x 0.9 cm, less then 0.1 cm depth.

On 4/3/14, at 2:44 p.m. register nurse (RN)-A was interviewed and stared R14's hourly repositioning program was determined when the facility identified a red area to R14's coccyx. RN-A further stated she would expect the staff to reposition R14 every hour as directed by the care plan.

The facility policy and procedure on pressure ulcers/skin breakdown dated 10/10, directed once resident risk factors have been identified, individual interventions are determined for the

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2 905	Continued From page 8 resident and their particular risk factors. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure all residents are repositioned in a timely manner based on their assessed needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 905		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement infection control priactice for resident food with usable resident ice packs and handwahsing for 1 of 3 residents (R14) reviewed for pressure ulcers; and soiled resident linen was placed on the floor. Findings include: Nursing assistant (NA)-C was observed to put soiled linen on the floor.	21385		

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21385	Continued From page 9 On 4/2/14, at 7:22 a.m. NA-C was observed to be making R14's bed. NA-C dropped a soiled nightgown and a blue pad onto the floor. When she had completed making the bed, NA-C folded the blue pad and placed it on the foot of R14's bed. When questioned, NA-C stated she usually put soiled linen into a linen bag, but she was unable to find one. NA-C verified soiled lined should go into a lined bag. On 4/2/14, at 7:30 a.m. registered nurse (RN)-C was interviewed and stated soiled lined should go into a linen bag. The facility policy and procedure on laundry and linen dated 4/12, directed all soiled linen must be placed directly into a covered laundry bag. Proper handwashing procedures were not followed during a pressure ulcer dressing change on R14. On 4/2/14, at 6:46 a.m. the administrator and licensed practical nurse (LPN)-B transferred R14 from the bed to the toilet, then back into bed. LPN-B washed her hands, donned clean gloves, and arranged the dressing supplies. LPN-B then discarded her gloves, donned clean gloves, and removed the soiled dressing. LPN-B discarded the soiled gloves, did not wash her hands, then donned clean gloves. LPN-B proceeded to cleanse the pressure ulcer with normal saline, then placed a clean dressing on the pressure ulcer. Upon completion of the dressing change at 7:03 a.m. LPN-B stated she should have washed her hands between glove changes when going from a soiled dressing to a clean dressing. On 4/3/14, at 2:44 p.m. RN-B was interviewed,	21385		

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21385	Continued From page 10 and stated hands should be washed between glove changes when going from a soiled dressing to a clean dressing. The facility policy and procedure on dry/clean dressings dated 10/10, directed to wash and dry hands thoroughly, put on clean gloves and remove soiled dressing, wash and dry hands thoroughly, put on clean gloves to cleanse the wound. During observation of medication storage on 4/3/14, at 10:25 a.m. with a licensed practical nurse (LPN-B) a plastic container of oranges was noted to be stored with reusable ice packs in the freezer of the second floor snack refrigerator. LPN-B verified at that time that the ice packs were for resident use (treatments). At 12:30 p.m. RN-A was interviewed and indicated that resident ice packs shouldn't be in the [snack] refrigerator. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and	21390		

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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) COMPLETE DATE
21390	Continued From page 11 procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation,interview and document review the facility failed to implement an infection control surveillance plan to identify,document and monitor residents infections. . Findings include: Review of the Daily infection Control Logs revealed the facility lacked a system for	21390		

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	00593	A. BUILDING: _____ B. WING _____	04/03/2014

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21390	Continued From page 12 identifying and tracking resident infections. The day logs for the month of March 2014 revealed the facility's nurse managers would write down daily on the log a residents name, room number, site of the infection and what antibiotic the resident was on. Examples include, R142's name and room number appeared on the log from 3/19/14 -3/31/14. The only other information listed for R142 was Doxycline (antibiotic). R6's was listed on the daily log for 3/30/14-3/31/14 as lungs-Levaquin (antibiotic) 3/29-4/4 The log lacked date of unset, signs and symptoms, culture reports, diagnosis and if the infections were health care associated infections or community associated. The information was not available to track and trend resident infections. In addition, there was no system to identify if cultures were ordered to determine appropriate antibiotic usage. Interview with the director of nursing (DON) , registered nurse managers (RN-A & RN-D) and Administrator on 4/3/13 at 1:00 p.m. verified that this was the system they used to track and trend infections. DON verified there was no policy to direct a method for tracking resident infections. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure an effective system for identifying, tracking, trending, and monitoring of all infections is in place.	21390		

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21390	Continued From page 13 The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21390		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, 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 and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21535		

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21535	Continued From page 14 review, the facility failed to consistently complete blood glucose checks (Accuchecks) as ordered by the physician to monitor the effectiveness of an oral blood glucose lowering medication for 1 of 5 residents (R29) whose medications were reviewed. Findings include: The annual Minimum Data Set (MDS) dated 3/13/14, indicated R29 had a diagnosis of diabetes. An Interagency Referral Form (physician's order) dated 3/21/13, directed staff to complete an Accuchecks twice a day - once in the morning, and once two hours after the evening meal. The order further directed staff to call the physician if R29's blood glucose was greater than 200 two times in a row. The Physician Order Report for 3/1/14, to 4/1/14, directed staff to administer glipizide (an oral blood glucose lowering medication) 7.5 milligrams (mg) twice a day starting 5/28/13. The Electronic Medication Administration History for March and April 2014, indicated R29 does receive the medication twice daily. On 4/2/14, at 7:11 a.m. R29 was observed in the room in bed, and at 9:14 a.m. when up in the wheelchair. No signs or symptoms of possible high or low blood glucose levels were observed. Review of R29's Accuchecks from 1/1/14, to 4/2/14, were as follows: January 2014 - there were no morning Accuchecks completed on 1/1, 1/5, 1/6, 1/7, 1/10, and 1/24. There was one Accucheck level in January greater than 200 (205) the evening of 1/18, and blood glucose monitoring at that time	21535		

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21535	Continued From page 15 was completed as ordered. February 2014 - there were no morning Accuchecks completed on 2/4, 2/6, 2/7, 2/9, 2/13, 2/16, 2/17, 2/18, 2/19, 2/20, 2/28, and no evening Accucheck on 2/21. There was one Accucheck level greater than 200 (223) the evening of 2/28; however, the facility would have been unable to determine if there were two blood glucose levels in a row greater than 200 as the morning Accucheck on 2/28, had not been completed. March 2014 - there were no morning Accuchecks completed on 3/6, 3/7, 3/11, 3/17, 3/23, 3/24, and no evening Accuchecks completed on 3/24, and 3/29. There was an Accucheck level greater than 200 (220) the evening of 3/5; however, the facility would have been unable to determine if there were two blood glucose levels in a row greater than 200 as the morning Accucheck on 3/6, had not been completed. There was also an Accucheck level greater than 200 (266) the evening of 3/19, and blood glucose monitoring at that time was completed as ordered. April 2014 - there was no morning Accucheck completed on 4/1. The remainder of the completed Accuchecks were all under 200. On 4/3/14, at 10:00 a.m. the registered nurse manager (RN)-A confirmed the lack of documented blood glucose checks. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure medications are being consistently monitored for effectiveness for ongoing use as ordered by the physician. The DON or designee could educate all appropriate staff on the	21535		

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21535	Continued From page 16 policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21535		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure that 10 of 40 resident rooms (R8, R5, R107, R73, R102, R70, R116, R22, R20, R40) were maintained and repaired in an sanitary manner related to walls, flooring and odors. In addition, there was a refrigerator in the kitchen with rusty shelves. Findings include; During the environmental tour with the facilities environmental services director (ESD) on 4/3/14 at 12:45 p.m. the following was noted: R8's room had large gouges in the wall on the right side of the hallway when entering the room. The linoleum on the bathroom floor had gouges near the left side of the entry. The room had a	21685		

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21685	Continued From page 17 strong musty odor. ESD indicated the bathroom floor needs to be replaced. ESD further stated, "That could be the source of the odor." The bathrooms used by R5, R107, R73 and R102 had peeling wallpaper that was stained yellow. ESD indicated that there was a [water] leak that caused the staining. R70's bathroom had rust under the suspended toilet. The heat register had an loose piece of metal approximately two by four inches long. ESD verified the findings and indicated the flooring in R70's bathroom should be replaced and that R70's heat register is on the list to be replaced. R116's closet had scratches and black marks along the closet doors. ESD verified the findings. R22's room had several areas of missing plaster behind the head of the bed. ESD indicated that was caused by the head of the resident's old bed being pushed against the wall by staff. ESD indicated that R22 had received a new bed two weeks ago. R20's bathroom floor had a white stain below the sink. ESD indicated she was not sure what it was. ESD further indicated it possible could be a paint spill. R40's room had paint scraped off of the baseboard heater at the foot of the bed and the bathroom door frame. A policy was requested regarding routine maintenance for resident rooms and was not provided. On 3/31/14, at 12 noon during tour of the kitchen	21685		

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21685	Continued From page 18 with the culinary service director (CSD) a small standing refrigerator was observed to have three metal wire shelves that were totally rusted. The shelves were approximately two feet by a foot and a half. The refrigerator contained yogurt and left overs, open packages of sandwich meat, cheeses, Mayonnaise, other compliments, . Per interview with CSD on 3/31/14, at 12:00 noon she said this refrigerator holds foods that the facility used on a daily basis, like leftovers, tomatoes and lettuce, things to make sandwiches with. The CSD stated that they do a weekly cleaning of the shelves. The schedule for April indicated the cleaning was documented weekly. The CSD stated that it would be hard to ensure that the selves were clean because of the rust. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the environmental services staff to develop a maintenance program to ensure odors, and damaged floors, and walls are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		