### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: O7JC

### ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

PA	RII-IO BE COMPLETED BY II	HE STATE SURVEY A	GENCY	Facility ID	1: 00593
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245483 2.STATE VENDOR OR MEDICAID NO. (L2) 940220900	3. NAME AND ADDRESS OF FACILIT (L3) ST ELIGIUS HEALTH CENT (L4) 7700 GRAND AVENUE (L5) DULUTH, MN	ER	1 3	I. Initial 2. Red 3. Termination 4. CH	(L8) certification IOW mplaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA	`	L7)	7. On-Site Visit 9. Otl 3. Full Survey After Complaint	•
6. DATE OF SURVEY 05/20/2014 (L34)  8. ACCREDITATION STATUS: 06/10/2014 (L10)  0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	10 NF 14 CORF 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE		CAL YEAR ENDING DATE:	(L35)
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  77 (L18  13.Total Certified Beds	D. N. C. C. T. St. D.	2. Te 3. 24 4. 7- 5. Li	4 Hour RN -Day RN (Rural SNF)	6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room	
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SN  77  (L37) (L38) (L38)		15. FACILITY 1861 (e) (1)	MEETS or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICAB See Attached Remarks  17. SURVEYOR SIGNATURE	LE SHOW LTC CANCELLATION DATE):  Date :		JRVEY AGENCY APPROVAL		e:
Patricia Halverson, Unit Super	<u>visor</u> 06/10/2014	(L19) Enf	forcement Spec	ialist o	07/24/2014 (L20)
PART II - 7	TO BE COMPLETED BY HCFA RE	GIONAL OFFICE OF	R SINGLE STATE AGE	ENCY	
19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate  2. Facility is not Eligible  (L2)	20. COMPLIANCE WITH CI RIGHTS ACT:	2	. Statement of Financial Solver 2. Ownership/Control Interest D 3. Both of the Above :	,	
22. ORIGINAL DATE 23. LTC AGRE  OF PARTICIPATION BEGINNI  05/01/1987  (L24) (L41)	EMENT 24. LTC AGREEMEN NG DATE ENDING DATE  (L25)	VOLUNTARY 01-Merger, Clo	<del>-</del>	(L30)  INVOLUNTARY  05-Fail to Meet Health  06-Fail to Meet Agreer	-
A. Suspen	TIVE SANCTIONS sion of Admissions:  (L44) Suspension Date:  (L45)		oluntary Termination	OTHER 07-Provider Status Ch 00-Active	ange
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARK	S		
(L28)	03001	(L31)			
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DAT 06/10/2014		NATION 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, Enforcement Specialist

Program Assurance Unit

Mary Meath

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

Form Approved OMB NO. 0938-0390

### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245483	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/20/2014
Name	of Facility		Street Address, City, State, Zip Code	
ST	ELIGIUS HEALTH CENTER		7700 GRAND AVENUE	
			DUI UTH, 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
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0242		_05/16/2014		ID Prefix	F0279		05/16/2014		ID Prefix	F0282		05/16/2014
	483.15(b)		-		ū	483.20(d), 483.20(k)(1	1)				483.20(k)(3)(ii)		_
LSC				<u> </u>	LSC					LSC			
			Correction					Correction					Correction
ID Prefix	F0314		Completed <b>05/16/2014</b>		ID Prefix	F0329		Completed <b>05/16/2014</b>		ID Prefix	F0356		Completed <b>04/03/2014</b>
	483.25(c)		-			483.25(I)		-			483.30(e)		_ 04//00/2014
LSC	403.23(0)		-		LSC	403.23(1)					403.30(e)		_
			•	1					+				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0441		_05/16/2014		ID Prefix	F0465		05/16/2014		ID Prefix			_
Reg. # LSC	483.65		-		Reg. # LSC	483.70(h)				Reg. #			_
			-			-			-				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			_		ID Prefix					ID Prefix			_
Reg. #			-		Reg. #					Reg. #			_
LSC			-		LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
Reviewed By		Reviewed I	Ву	Da	te:	Signature of S	Surve	yor:				Date:	
State Agency		MM/F	Н	06/	/10/201	1 -		-				05/2	20/2014
Reviewed By	· —	Reviewed I	Ву	Da	te:	Signature of S	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl						-				a Summary of		
	4/3/2	2014				Uncor	recte	d Deficiencies	(CIV	IS-2567) Sent	to the Facility?	YES	NO

### Form Approved OMB NO. 0938-0390

### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245483	( <b>Y2) Multiple Constru</b> A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 6/10/2014
Name	of Facility		Street Address, City, State, Zip Code	
ST	ELIGIUS HEALTH CENTER		7700 GRAND AVENUE	
ST ELIGIUS HEALTH CENTER			DUI UTH. 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	0	(5)	Date	(Y4)	Item		(Y5)	Date	(Y	1) Item		(Y5)	Date
		(	Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix		'	04/03/2014					04/08/2014					_
•	NFPA 101	_			-	NFPA 101				Reg. #			_
	K0052	_			LSC	K0062							_
		,	Correction					Correction					Correction
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	-		Completed		ID Prefix			Completed		ID Prefix			
Reg. #					Reg. #					Reg. #			
		_			LSC					LSC			_
		(	Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Profix			Completed
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		(	Correction					Correction					Correction
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Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			<del>-</del>
			Correction					Correction					Correction
ID Prefix		,	Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#								
		_								LSC			_
Reviewed By				1	te:	Signature of						Date:	
State Agency	, MM,	PS	S	06	5/10/20	14	03	005				06/1	10/2014
Reviewed By	Reviewe	d B	у	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:					Check fo	or any	Uncorrected I	Defi	ciencies. Was	a Summary of		
	4/1/2014					Unco	rrecte	d Deficiencies	(C	MS-2567) Sent	to the Facility?	YES	NO

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: O7JC22

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: O7JC

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

		PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY A	GENCY		Facility ID: 00593
MEDICARE/MEDICAID PRO     (L1)			3. NAME AND ADD (L3) ST ELIGIUS (L4) 7700 GRAND (L5) DULUTH, MI	HEALTH CENT		(Le	5) 55807	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANG (L9)			7. PROVIDER/SUP	05 HHA	09 ESRD	13 PTIP	.7) 22 CLIA	7. On-Site Visit  8. Full Survey After C	9. Other
DATE OF SURVEY     ACCREDITATION STATUS     Unaccredited     AOA	04/03/2014 : 1 TJC 3 Other	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	5 DATE: (L35)
11. LTC PERIOD OF CERTIFIC From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	77 77		X B. Not in Comp	ce With quirements Based On: cceptable POC	n	2. Te 3. 24 4. 7-	roved Waivers Of The echnical Personnel Hour RN Day RN (Rural SNF) ife Safety Code	E Following Requirements:	tor
14. LTC CERTIFIED BED BRE. 18 SNF 18 (L37)	AKDOWN 8/19 SNF 77 (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY 1	MEETS or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY  See Attached Remarks  17. SURVEYOR SIGNATURE  5ZWK^Z⊲Z €			Date :	ATION DATE): 06/04/2014	(L19)		URVEY AGENCY AP	proval d <u>w</u> Wf Eb <b>W</b> [S	
	PAR	T II - TO	BE COMPLETEI	D BY HCFA R		OFFICE OR	R SINGLE STAT	E AGENCY	(L20)
DETERMINATION OF EL	gible to Participate	(L21)		PLIANCE WITH C	CIVIL	2.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  05/01/1987  (L24)  25. LTC EXTENSION DATE:	(I 27. AI			4. LTC AGREEMI ENDING DAT (L25)		VOLUNTARY 01-Merger, Clo 02-Dissatisfact 03-Risk of Invo		INVOLUN'   05-Fail to M   OTHER	(L30) FARY feet Health/Safety feet Agreement Status Change
	(L27) B.	Rescind Susp	pension Date:	(L44)				307184110	
28. TERMINATION DATE:  31. RO RECEIPT OF CMS-1539	(L28	3)	. INTERMEDIARY/C/ 03001  DETERMINATION O		(L31)	30. REMARKS	S		
	(L32	!)			(L33)	DETERMIN	NATION APPRO	VAL	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00593

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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;

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

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

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

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

### **DEPARTMENT CONTACT**

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

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA APR 2 8 2014 STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 04/03/2014 MN Dept of Health B. WING STREET ADDRESS, CITY, STATE, ZIP GODE 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 ST ELIGIUS HEALTH CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X4) ID PREFIX TAG DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG F 000 F242 It is the policy of St. Eligius F 000 INITIAL COMMENTS Health Center to ensure THE FACILITY PLAN OF CORRECTION (POC) residents have the right to WILL SERVE AS YOUR ALLEGATION OF choose activities, schedules, and COMPLIANCE UPON THE DEPARTMENT'S health care consistent with his ACCEPTANCE, YOUR SIGNATURE AT THE or her interests, assessments, BOTTOM OF THE FIRST PAGE OF THE and plans of care; interact with CMS-2567 FORM WILL BE USED AS members of the community both VERIFICATION OF COMPLIANCE. inside and outside the facility; UPON RECEIPT OF AN ACCEPTABLE POC, AN and make choices about aspects ONSITE REVISIT OF YOUR FACILITY MAY BE of his or her life in the facility CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE that are significant to the REGULATIONS HAS BEEN ATTAINED IN resident. ACCORDANCE WITH YOUR VERIFICATION. The facility will continue to provide R135 with choices per CENSUS: 64 the regulation. All residents will continue to be A recertification survey was conducted and 05/05/14 complaint investigations were also completed at PHL/mpm encouraged to make the above the time of the standard survey. Investigation of decisions as is current practice complaints H5483026, and H5483027, were demonstrated by policy and completed. The complaints related to H5483026, and H5483027, were not substantiated. procedure. F 242 F 242 483.15(b) SELF-DETERMINATION - RIGHT TO Audits will be conducted with residents (staff will speak MAKE CHOICES SS=D directly with random residents) The resident has the right to choose activities, to assess and ensure that they schedules, and health care consistent with his or are being offered choices and her interests, assessments, and plans of care; those choices are being honored. interact with members of the community both inside and outside the facility; and make choices These audits will be conducted about aspects of his or her life in the facility that on 5% of the resident population are significant to the resident. monthly by Activity Director X 6 months. This REQUIREMENT is not met as evidenced (X6) DATE by. TITLE

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE 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 day 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 1/2 the following the date of survey whether or not a plan of correction is provided. 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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OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION 04/03/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ST ELIGIUS HEALTH CENTER (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PREFIX Results will be provided to QA TAG Committee (including the F 242 Medical Director) to determine F 242 | Continued From page 1 Based on interview and document review, the further audit necessity and facility failed to honor bathing preferences for 1 of 3 residents (R135) who were reviewed for frequency. Completion Date: 5-16-14 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 whiri 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 If continuation sheet Page 2

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	DEPART	MENT OF HEALTH	AND HUMAN SERVICES			- VOTELICTION	(X3) DATE	SURVEY
	CENTERS	FOR MEDICARE	A WILD OF THE PRINCIPPI IER/CLIA	(X2) MUL	TIPLE C	CONSTRUCTION		
	· · · · · · · · · · · · · · · · · · ·	F DEFICIENCIES CORRECTION	(X1) PROVIDENSO! IDENTIFICATION NUMBER:	A. BUILD	ING		04/0	3/2014
	AND PLAN OF	COMME		B. WING		ZIR CODE	<u> </u>	
			245483	1	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	NAME OF P	ROVIDER OR SUPPLIER	<del></del>		770	O GRAND AVENUE		
					DU	ILUTH, MN 55807  PROVIDER'S PLAN OF CORRECTION SHOP	TION	(X5) COMPLETION
	ST ELIGIL	JS HEALTH CENTE		ID		PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHO)  CROSS-REFERENCED TO THE APPR  DEFICIENCY)	JLD BE OPRIATE	DATE
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			2000 2	F	242			
	F 242	Continued From F	d 3/26/14, did not address					
					279	F279	-ic	
	- 070	bathing preference 483.20(d), 483.20		1	2,0	It is the policy of blo built	gius	
	F 279	COMPREHENS!	VE CARE PLANS			L LL - LLA Conter to develo	μα	
	33-0		" secults of the assessmen	ıt		comprehensive care pla	11 101 1des	1
		i i i recion revie	W Allu 1011-			each resident that inclu	and MC2	
		comprehensive	olan of care.			measurable objectives	and ident'i	r
			comprehensive car	е		timetables to meet a re	esident :	3
		The facility must	develop a comprehensive car sident that includes measurable motables to meet a resident's	е		medical, nursing, and r	nemal,	۵
		plan for each re-	sident's	1		and psychosocial needs	, liiat air	_
•		medical nursing	imetables to Meet a room g, and mental and psychosocia dentified in the comprehensive	, l		identified in the comp	7 D31,c	
		needs that are r	g, and mental and poyethersive dentified in the comprehensive			assessment. R107's an	u Not s modified	Lto
		accessment.		1		care plans have been r	rside	
		The care plan r	nust describe the services that to attain or maintain the reside	are		include monitoring for effects of Coumadin the	herany.	-
		to he furnished	nust describe the services are to attain or maintain the reside the physical mental, and	-		This monitoring has al	so been	•
		highest practice	able privoted under	1		added as a task to the	MAR for	r
-		psychosocial w	reli-belling as that would otherwi	se		nursing staff to observ	ve and	
		§483.25; and a	ny services but are not provid	ed		nursing stair to observ	ia	•
		be required un	der §483.25 but ale het p dent's exercise of rights under dies the right to refuse treatme	nt		indicate completion v	ıα	
		Leasa 10 inclus	allig the right to	110		electronic signature. A report of all resider	nts on	
		under §483.10	(b)(4).			anticoagulant therapy	v has bee	en
		}				generated. All reside	nts on s	such
		This RECITIES	EMENT is not met as evidenc	ea		therapy have been at	idited to	
		by:	to the standard docum	nent		ensure care plans an	d MARs h	nave
		Based on obs	servation, interview and docum cility failed to develop a care p gradin use and the potential for	lan to		observation for side	effects a	and
		review, the fac	cility laned to do the potential for			documentation of co	mpletior	n I
		address Cour	of 5 residents (R107, R31)			included.		
		reviewed for	unnecessary medications.		e	Nursing staff will be	educate	ed on '
		1			ĺ	the above by 5-16-14	4.	ı
		Findings inch	ıde:			the above by 5 to t		
		DAOTIA physi	cian order dated 3/24/14, direc	ted				ion sheet Page 3
		K 10/ S billy si		ID: 07JC11		Facility ID; 00593	if continuati	IOU SUCOL, -9
	1			31 J. O F V O I I				

(X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 04/03/2014 AND PLAN OF CORRECTION B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION ST ELIGIUS HEALTH CENTER (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PREFIX DON or designee will conduct a TAG full house audit (record review) F 279 of residents on anticoagulant Continued From page 3 Coumadin 6 milligrams (mg) every evening for a F 279 therapy monthly X 3 months, diagnosis of pulmonary embolism/infarction (a with random audits of residents blockage of the artery in the lungs, that can be on anticoagulation therapy caused by a blood clot). monthly for 3 months. Results The care plan dated 12/19/14, directed the use of will be provided to QA Coumadin, but did not identify potential side Committee (including the Medical Director) to determine effects and monitoring. further audit necessity and On 4/3/14, at 9:36 a.m. registered nurse (RN)-A was interviewed and verified monitoring for frequency. indications of bleeding as a side effect of Completion Date: 5-16-14 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 The care plan lacked indications for monitoring hemorrhage. 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 282 F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED If continuation sheet Page 4 Facility ID: 00593 Event ID: 07JC11

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PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 04/03/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 ST ELIGIUS HEALTH CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE DATE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID TAG DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG F282 It is the policy of St. Eligius Continued From page 4 F 282 Health Center to ensure resident PERSONS/PER CARE PLAN SS=D care plans are followed. The services provided or arranged by the facility R14 has been re-evaluated by OT must be provided by qualified persons in accordance with each resident's written plan of

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:

care.

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. 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

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.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES R MEDICARE & MEDICAID SERVICES

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ATEMENT OF D	EFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	COV	APLETED
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NAME OF PROV	IDER OR SUPPLIER			7700 GRAND AVENUE		
		8		DULUTH, MN 55807		DVE)
ST ELIGIUS I	HEALTH CENTER		ID.	PROVIDER'S PLAN OF COR	RECTION SHOULD BE	(X5) COMPLETION DATE
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ulcon pla the R4 mini (u TI da in st	ace risk factors in anning and inter- e resident and the resident and the solution on itored for infector to the tissues), the solution, and the solution of t	own dated 10/104/11, directed ave been identified, care ventions are individualized for neir particular risk factors. is access site was not ction, infiltration (blood leaking bleeding, and patency as directed by the care plan.  duled Minimum Data Set (MDS) dicated R40 had no cognitive diagnoses of diabetes and end se (ESRD); and received  plan dated 1/16/14, indicated odialysis secondary to end stag SRD), and identified R40 had a	Ē	Care plan interventions for have been added to TAR to nursing staff the opportuni document their completed monitoring of hemodialysis access site.  All patients on dialysis the the facility have monitorin access site on individual coplans and TARs.  Nursing staff will be re-ed regarding the above by 5-DON or designee will concaudits (record review and visually observe monitorinensure proper access site	rapy in are ucated 16-14. luct	
re le	enal disease (Exect forearm accept forearm accept for a trisk for signs of the site for signs of the access site to the access site to the access site to the access and the after the removal further directed a trisk for the sound heard through for the trisk for the	ss site. The care plan indicated or excess bleeding and left arm AV fistula due to Heparanterventions included to monitor and symptoms of infection, ing, and to check for a "buzz" y. The care plan indicated R40 ysis with a pressure dressing on that the resident or staff may are was a potential for bleeding all of the dressing. The care plar staff to monitor the access site e presence of a bruit (swishing ough a stethoscope) and a thril	in n	monitoring and document for all patients receiving monthly X 6 months. Resu be provided to QA Commi (including the Medical Dir to determine further audi necessity and frequency. Completion Date: 5-16-14	dialysis lts will ttee ector) t	

OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING 04/03/2014 AND PLAN OF CORRECTION B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION ST ELIGIUS HEALTH CENTER (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES 1D **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG Continued From page 6 removes the dressing when he returns to the F 282 1 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 F 314 483.25(c) TREATMENT/SVCS TO F314 It is the policy of St. Eligius PREVENT/HEAL PRESSURE SORES provide Center SS=D Health Based on the comprehensive assessment of a interventions to reduce the risk resident, the facility must ensure that a resident of pressure ulcers. who enters the facility without pressure sores R14 has been re-evaluated by OT does not develop pressure sores unless the for w/c positioning, potential individual's clinical condition demonstrates that change to her advanced pressure they were unavoidable; and a resident having pressure sores receives necessary treatment and relieving cushion, or change to services to promote healing, prevent infection and reduction pressure advanced prevent new sores from developing. mattress. Current interventions including: dietary assessments, This REQUIREMENT is not met as evidenced hourly repositioning attempts with encouragement, and use of Based on observation, interview and document by: pressure reduction devices will review, the facility failed to provide timely repositioning to promote the healing of pressure be continued. All residents requiring every 1 - 2 ulcers for 1 of 3 residents (R14) reviewed for hour repositioning will continue pressure ulcers. If continuation sheet Page 7 c Findings include:

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DEPART	MENT OF HEALTH	AND HUMAN CERVICES			TUOTION	(X3) DATE COMP	SURVEY
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NAME OF F	PROVIDER OR SUPPLIER			770	O GRAND AVENUE		
1				DU	ILUTH, MN 55807	ON	(X5)
ST ELIG	US HEALTH CENTE		T ID	$\top$	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
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					to have qualters	review	
		_	F3	14	assessments to		•
F 314	Continued From p	page /		1	. Interveni	1005 LO	
					allow for pressure reduct	ion will	
	R14 had a Stage	II (partial thickness loss of			· '++		
	dermis presenting	g as shallow open ulcer)			All nursing staff members	s will be	
					All nursing stair members	e above	<u> </u>
	pressure dicer on provided with time	ely repositioning.			re-educated regarding the	, C 0, D 0 , C	
	I Down a LUCRE O	17065 (0011104 -)		•	1 E 16-14		
	Pressure Ulcer A	avisory ranes			- at a decidable will Coll	aucr	_
	Stage II: Partial t	loss of dermis presenting as a			Licaina 20015 (VISC	accy, io.	<b>.</b>
	Partial thickness	er with a red pink wound bed,			u sidonte remini nug Ev		L
	shallow open unc	May also present as an intact or			- intorvention ou a v	(CC)	
	Without slough.	erum-filled or sero-sanginous			basis X 4; then biweekly	X 4.	
	Len II-liator Ura	SPINS as a simily			basis X 4; then biweeling	to OA	
ľ	ulcer without slo	ugh or bruising.			Results will be provided	20 -0.	
	Linctoreable/UII	classified. I all aller	-		Committee INCHIGHIS U	10	
	tissue loss - der	oth unknown	of		Madical Director) to del	Gillinic	
					further audit necessity	and	
	the ulcer is com	pletely obscured by slough	ar -		Communication		
	(vellow, tan, gra	pletely obscured by slotes. ly, green or brown) and/or escha black) in the wound bed. Until	~"		Completion Date: 5-16-	14	
-	(tan, brown or b	plack) in the wound bed. Until			Completion page.		
}	l avnose the bas	e of the would, the same					
.	cannot be dete	rminea.					
	R14's care plar	rmined.  n dated 10/24/13, indicated included mild cognitive impairm	ent				
	diagnoses that	atrophy. The care plan also					
	indicated K141	d was on a every one hour					
	repositioning s	chedule.					
	1/24/14 indica	ited R14 was severely cognitively	ly				
	impaired and	required extensive assist of 1 st	an				
	for hed mobilit	required extensive assist of the My, transfers, and toileting. The My, transfers, and toileting the My, transfers, and transfers, and the My, transfers, and tra	ואסן				
	indicated R14	y, transfers, and tolleany. The was frequently incontinent of both was further indicated R14 v	Mas				
	and bladder.	was frequently incommon R14 v The MDS further indicated R14 v	r	- 1			
	at risk for the	development of a pressure ulcer	v				
	was on a repo	development of a procession of the process of the p	,				
	had a stage 2	pressure dicci trial tri			_1	continuation	n sheet Page 8 of
	identified on 1	2/30/13.	071011		Facility ID: 00593	GOLIUNUALIO	,, = =

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^ 7	MENT O	F HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				(X3) DATE SURI	/EY	
=PARTI	S FOR A	<b>MEDICARE</b>	LUDED/CLIPPI JER/CLIA	(X2) MUL	TIPLE CON	STRUCTION	COMPLETE		
	OF DEFICIE CORREC	ENCIES	(X1) PROVIDENCE TELES IDENTIFICATION NUMBER:	A. BUILD	ING		04/03/20	14	
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		OR SUPPLIER			DULU	TU MN 55807	011	(X5)	
T ELIGI	US HEAL	TH CENTE	R	T ID	1	PROVIDER'S PLAN OF CORRECT!	D BE COM	MPLETION DATE	
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TAG	, NEO								
F 314	R14 w continue 4/2/14 the add (LPN) into be press was rether (On 4/2) intervention furth repo	uous obser, from 5:06 iministrator. B, transfe ed to do a ure ulcer. Aneasured 0.1 cm depuisewed and ram was defified a red er stated s sition R14	vided repositioning during vation while she was in bed on a.m. until-6:46-a.m. At that time and licensed practical nurse red R14 to the toilet, then back dressing change to R14's at that time the pressure ulcer and was 0.7 cm x 0.9 cm, less th.  44 p.m. register nurse (RN)-A w stared R14's hourly repositionistermined when the facility area to R14's coccyx. RN-A ne would expect the staff to every hour as directed by the care	as	314				27
	The ulce residential individual with additional columns of the col	facility policists proceeding the policies of	cy and procedure on pressure akdown dated 10/10, directed o ctors have been identified, ventions are determined for the neir particular risk factors.  G REGIMEN IS FREE FROM RY DRUGS  Is drug regimen must be free frodrugs. An unnecessary drug is ed in excessive dose (including apy); or for excessive duration; late monitoring; or without adect its use; or in the presence of requences which indicate the deduced or discontinued; or any of the reasons above.	om any or uate	F 329	assess, and monitor clining indications for ongoing medications. R29 has had bG monitor documentation added TAR. All residents with physordered bG monitoring results documented in Nursing staff will be ethe above by 5-16-14.	nical use of oring to the sician g will have the TAR. ducated or	า	20
	Die	2000 011 0		2: 07JC11	F	acility ID: 00593	1 0011-111-111		

OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING . AND PLAN OF GORRECTION 04/03/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION ST ELIGIUS HEALTH CENTER (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID 1/ PREFIX TAG Continued From page 9 resident, the facility must ensure that residents F 329 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug DON or designee will conduct therapy is necessary to treat a specific condition audits (review clinical record) as diagnosed and documented in the clinical for all residents requiring bG record; and residents who use antipsychotic monitoring biweekly X 4 then drugs receive gradual dose reductions, and monthly X 3. Results will be behavioral interventions, unless clinically contraindicated, in an effort to discontinue these provided to QA Committee (including the Medical Director) drugs. to determine further audit necessity and frequency. Completion Date: 5-16-14 This REQUIREMENT is not met as evidenced Based on observation, interview, and document bv: 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 If continuation sheet Page 10 of 3/1/14, to 4/1/14, directed staff to administer Facility ID: 00593 Event ID: 07JC11

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#### PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES A. BUILDING \_\_ 04/03/2014 AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ST ELIGIUS HEALTH CENTER (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG F 329 Continued From page 10 glipizide (an oral blood glucose lowering F 329 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

FORM CMS-2567(02-99) Previous Versions Obsolete

determine if there were two blood glucose levels

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

in a row greater than 200 as the morning Accucheck on 2/28, had not been completed.

were two blood glucose levels in a row greater than 200 as the morning Accucheck on 3/6, had Event ID: 07JC11

Facility ID: 00593

If continuation sheet Page 11 (

PRINTED: 04/15/2014 FORM APPROVED

		AND HIIMAN SERVICES				OMB NO	. 0938-0391	7
DEPART	MENT OF HEALTH	AND HUMAN SERVICES			TOTION	CAU (EV)	TE SURVEY	
CENTER	S FOR MEDICARE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	CON	MPLETED	
STATEMENT	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _				
AND PLAN O	1 00111120111		B. WING	2			/03/2014	-
		245483	B. WINC	1 87	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>:</u>		
NAME OF I	PROVIDER OR SUPPLIER			77	700 GRAND AVENUE			
1				D	DI UTH. MN 55807		(VE)	$\dashv$
ST ELIG	US HEALTH CENTE		ID	١	PROVIDER'S PLAN OF CORRE	CTION OUI D BE	(X5) COMPLETION	1
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI	FIX	PROVIDER'S PLAN OF CONTROL  (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE	-
			F	329				
F 329	Continued From p	There was also an						
	not been complet	ed. There was also an greater than 200 (266) the			· .			
			ıt					
	that fime was cor	npleted as ordered.						
			1	F3	56		\(\frac{1}{2}\)	1
	April 2014 - there	was no morning Accucheck		lt	is the policy of St. Eligius			
·	completed on 4/1	The remainder of the checks were all under 200.		Ш	aalth Center to ensure rec	quirea		
				ทเ	ursing staffing information	i is		
	On 4/3/14, at 10:	00 a.m. the registered nurse		n/	osted as required.			
		CONTINUED THE PACK OF		(	lock hours of shift times n	ave		
				h	oon added to the posted t	orm.		
F 35	6 483.30(e) POST	ED NURSE STAFFING	-	F	orm will be posted as requ	uired.		
SS=	INFORMATION			C	ompletion date: 4-1-14			
	The facility must	t post the following information	Oli		•		•	
	a daily basis:				4/3/2014 is	the date	of correcti	on
	o Facility name.				4/3/2014 IS ML	s tile date	or correcti	OII
	o The current da		ed		MIL			
	Lunlicensed nurs	sing stail directly responden	DI					
	resident care pe	er snitt:						
	- Registered	nurses.						
	- Licensed	es (as defined under State law	).					
	- Certified n	urse aides.						
	o Resident cen	sus.						
	Į.							
		st post the nurse staffing data e on a daily basis at the beginn	ing					
	specified above	Data must be posted as follows	s:					
1								
	o in a promine	nt place readily accessible to						
	residents and	visitors.						
		st, upon oral or written reques	t,					
	The facility mu	affing data available to the pub	olic					
1	make Iluise st	uimig	1			ontinuatio	n sheet Page	12 of

### PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY COMPLETED CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A, BUILDING STATEMENT OF DEFICIENCIES 04/03/2014 AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE B. WING 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ST ELIGIUS HEALTH CENTER DATE CROSS-REFERENCED TO THE APPROPRIATE ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PREFIX TAG F 356 Continued From page 12 for review at a cost not to exceed the community F 356 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 Based on observation, interview and document review the facility failed to post on a daily basis bv: 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. 11; 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

### PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING . STATEMENT OF DEFICIENCIES 04/03/2014 AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE B. WING 245483 7700 GRAND AVENUE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5)PROVIDER'S PLAN OF CORRECTION COMPLETION ST ELIGIUS HEALTH CENTER (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** DEFICIENCY) TAG (X4) ID PREFIX TAG Continued From page 13 ESD further indicated she was unaware that the F 356 actual shifts staff worked were a requirement on the posting :. A policy on staff posting was requested but not $\vec{x}$ 483.65 INFECTION CONTROL, PREVENT F 441 SPREAD, LINENS SS=F 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 (2) Decides what procedures, such as isolation, in the facility; 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 If continuation sheet Page 14 o professional practice. Facility ID: 00593

PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

ENTERS	MENT OF HEALTH S FOR MEDICARE	A IVILDIO IID	(X2) MUL	TIPLE CONSTRUCTION	COM	PLETED
TEMENT OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	04/	03/2014
		245483	B. WING	STREET ADDRESS, CITY, STATE, ZI	P CODE	
	ROVIDER OR SUPPLIER			7700 GRAND AVENUE		
				DULUTH MN 55807		(X5)
r ELIGII	JS HEALTH CENTE	N PERIODENCIES	ID.	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLETION DATE
X4) ID REFIX TAG	SUMMARY ST (EACH DEFICIENT REGULATORY OR	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	CBOSS-RFFERENCED 10	THE APPROPRIENCE	
				F441		
F 441	Continued From p	page 14		It is the policy of St. El	igius 	
• • • • •				Health Center to have	an	
	(c) Linens	nandle, store, process and		established and mainta	ineu	
	Personnel must r	nandle, store, process and so as to prevent the spread of		Infection Control Progr	alli	
	transport intens so infection.	······································		designed to provide a s	sale,	
	Muconon.			sanitary and comfortal	Je proventi	
				environment and to he	etp prevent	
		MENT is not met as evidenced		the development and		
	This REQUIREN	TENT IS HOLLING		transmission of diseas	e and	
	by:	vation,interview and document	30	infection.	- lain a	
	review the facilit	vation, interview and govern- y failed to implement an infection of the property of the proper	nd	The Infection Control	Tracking	
	control surveilla	y failed to implement an imperior and imperior and increase in addition, resident in addition, resident in addition, resident and increase in addition, resident in a second in	ent	form has been revised	and is in	
	monitor resident	is illectione: maident ice packs	1	place on nursing units	5. ·	
	food was stored	Shing technique was not followed to the state of the stat	ed	DON or designee Will	conduct	
	for a dressing C	hange for 1 of 3 residents (R14	ł) anf	audits of the form (re	eview of	
	I was downed for Dre	SSUIC UICCIO, CITA	J114 .	clinical records) to el	nsure	
	linen was place	d on the floor.		prevention of develop	pment and	
	1			transmission of disea	se and	
	Findings includ			infection. This will o	occur on a	
	Review of the I	Daily infection Control Logs		monthly basis X 6 mg	onths.	
	revealed the fa	cility lacked a system for		ceaff will be educate	ed on the	
	identifying and	tracking resident infections.		above by 5-16-14. Re	esults will be	
				provided to OA COM	mittee	
	The day logs in	or the month of March 25 acility's nurse managers would the log a residents name, room	write	(including the Medic	al Director)	•
	down daily on	the log a residents name, room	1 tic	to determine furthe	r audit	
	I number, site o	I THE HUCOTON THE	цС	necessity and freque	ency.	
	the resident w	as on.			į	
		D142's name and room		Ice packs have beer	removed	
	Examples inc	ared on the log from 3/19/14  are with a ther information listed for		from the snack retr	igerator.	
	I OIOAIAA INA	ULIA OFFICE INSTITUTE	r	Staff will be educat	ed on the	
	R142 was Do	oxycline (antibiotic).		above by 5-16-14.		
					irector or	
	R6's was liste	nd on the daily log for 3/30/14- ngs-Levaquin (antibiotic) 3/29-4	1/4	Culinary Services Didesignee will audit	refrigerators	sheet Page 15
	3/31/14 as lur	ngs-Levaquiii (ariazioar)	 D: 07JC11	Facility ID: 00593	Ti 00110	-

PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING STATEMENT OF DEFICIENCIES 04/03/2014 AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE 245483 7700 GRAND AVENÚE NAME OF PROVIDER OR SUPPLIER DULUTH, MN 55807 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ST ELIGIUS HEALTH CENTER CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PRÉFIX (visualize contents) weekly X 4, TAG biweekly X 4. Results will be provided to QA Committee

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(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

T - Land Board 16 h

### PRINTED: U4/To/ZU14 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING\_ AND PLAN OF CORRECTION 04/03/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 245483 NAME OF PROVIDER OR SUPPLIER 7700 GRAND AVENUE DULUTH, MN 55807 ST ELIGIUS HEALTH CENTER PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES !D DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG Continued From page 16 F 441 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

#### FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/03/2014 B. WING 245483 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7700 GRAND AVENUE DULUTH, MN 55807 ST ELIGIUS HEALTH CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) F 441 Continued From page 17 thoroughly, put on clean gloves to cleanse the wound. F 465 483.70(h) F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABL SS=E F 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 F465 It is the policy of St. Eligius with rusty shelves. Health Center to provide a safe, functional, sanitary, and Findings include; comfortable environment for During the environmental tour with the facilities residents, staff and the public. environmental services director (ESD) on 4/3/14 Walls and flooring in R8's room at 12:45 p.m. the following was noted: have been repaired. R8's room had large gouges in the wall on the Bathrooms used by R5,107, 73, right side of the hallway when entering the room. 102 had wallpaper re-affixed. The linoleum on the bathroom floor had gouges

near the left side of the entry. The room had a

"That could be the source of the odor."

strong musty odor. ESD indicated the bathroom floor needs to be replaced. ESD further stated,

The bathrooms used by R5, R107, R73 and R102

had peeling wallpaper that was stained yellow. " ESD indicated that there was a [waterl leak ther months.

R22's plaster was repaired for

the 4<sup>th</sup> time within the past 12

R20's bathroom floor has no

R40's heater and door frame

I have been touched up.

					FO	RM APPROVED NO. 0938-0391	
		AND HUMAN SERVICES			(1/2)	DATE SURVEY	
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			COMPLETED	
CENTERS FOR MEDICARL & MEDICARL & MEDICARLA & MEDICARL			A. BUILDING				
STATEMENT OF DEFICIENCIES   (X1) PROVIDERSOLT LIBERTY   NUMBER:			A. Bollomo			04/03/2014	
MD I A		245483	B. WING		TATE 7IP CODE		
	_		1	STREET ADDRESS, CITY, S	IAIL, Zii God		
NAME OF P	ROVIDER OR SUPPLIEF			7700 GRAND AVENUE			
				DULUTH, MN 55807	LAN OF CORRECTION	(X5) COMPLETION	
ST ELIGI	JS HEALTH CENTE		ID	PROVIDER'S P	LAN OF CURRESTICIN TVE ACTION SHOULD BE SED TO THE APPROPRIAT	- ATC	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES  OY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFI TAG		TVE ACTION SHOOLS BE ED TO THE APPROPRIAT FIGIENCY)		
PREFIX	(EACH DEFICIENT REGULATORY OR	CY MUST BE PRECEDED 5.1. LSC IDENTIFYING INFORMATION)					
TAG	Na -			70 has no rust on fl	loor, R116		
			R	70 has no rust on the	un with		
F 465	Continued From	page 18	C	loset door touched	ир т	1	
, ,00	caused the staini	ng	√	aint.	ith weekly		
			E	SD will continue w	nui moonii nair	ţ	
	R70's bathroom	nad rust under the suspended egister had an loose piece of talk two by four inches long. ES	-	/	1711		
1	toilet. The hear is	egister had an loose place of tely two by four inches long. ES tops and indicated the flooring in	υ.				
1	metal approxima	tely two by four inches long.  Igs and indicated the flooring in should be replaced and that		h obcarvacio	II OI DUILENIS		
	P70's bathroom	should be replaced and that tor is on the list to be replaced	_	to note and prioriti	ize repair	Y	
	RZ0's heat regis	ter is on the list to be replaced		40		¥	
		i i and black marks		Completion Date:	4-9-14		
/	R116's closet ha	d scratches and black mediands doors. ESD verified the findings	5.				
1	along the closer	00013, 1202	~~ X 4	Then refrigerator	shelves are		
\	pagis room had	several areas of missing plaste	) 1	a fourt			
	behind the head	several areas of miscary per several areas of miscary per that of the head of the resident's old be	ed	aco ill continue	with current		
	/ was caused by	life flead of all by staff FSD	pro P	- Uu claaning S	cheans. 🗥		
	being pushed a	the nead of the resident file feet and the gainst the wall by staff. ESD 22 had received a new bed two		other shelving ha	is been		
	indicated that R	22 Had 1000.10	7	other shelving ha inspected and fo	und to be free		
	weeks ago.	I -low f	he	of rust.	1tod	·	
· · · · ·	: Ran's bathroom	n floor had a white stain below t gtod she was not sure what it w	ias.	+ - ff \\/1	Il be educated		
1 1/27	sink. ESD indic	n floor had a write state below ated she was not sure what it w lighted it possible could be a pa	int ("	by 5-14-16 to ale	ert ESD of any		
	ESD further inc	ated she was not sure made licated it possible could be a pa	64	and repairs.			
191	spill.			Completion date	e: 5-16-14		
1:17	- 101 m ha	d paint scraped off of the	lije:	Completion			
	R40's room na	d paint scraped off of the hed and the terms.	e .:				
	bathroom door	frame.	. J' / 1				
			1000				
	A policy was re	equested regarding routine					
1 (	maintenance	or resident rooms and was not					
`	provided.						
	On 2/31/14 at	: 12 noon during tour of the kitch	nen				
	with the culina	12 noon during tout of the try service director (CSD) a sma treator was observed to have the	an aree				
	standing refrig	ry service director (COD) a control of the property of the control	he_				
	metal wire site	elves the foot by a foc	ot .				
	shelves were	approximates contained vocut	and				
	and a half.	ne retrigerator contained year en packages of sandwich meat	<u>'                                      </u>	ID: 00502	If continu	lation sheet Page 1901,20	
	lett overs, ope	Event II	07/04/	Facility ID: 00593			
FORM C	MS-2567(02-93,175evious	Versions Obsolete	7. Y				
	18.4	And the second s	•	•			
•	, 73;	TO THE WAY				^	

### דתוועובט. טאו ואובטוו FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_\_ AND PLAN OF CORRECTION 04/03/2014 B. WING 245483 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7700 GRAND AVENUE ST ELIGIUS HEALTH CENTER DULUTH, MN 55807 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID **PREFIX** DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY TAG Continued From page 19 F 465 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.

#### PRINTED: 04/15/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 04/01/2014 245483 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7700 GRAND AVENUE ST ELIGIUS HEALTH CENTER **DULUTH. MN 55807** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY Coc of welling 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. APR 3 0 2014 PLEASE RETURN THE PLAN OF

State Fire Marshal Division 444 Cedar St., Suite 145

Health Care Fire Inspections

St. Paul. MN 55101-5145 OR,

**DEFICIENCIES (K TAGS) TO:** 

CORRECTION FOR THE FIRE SAFETY

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

TITLE

MN DEPT. OF PUBLIC SAFETY

STATE FIRE MARSHAL DIVISION

(X6) DATE

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.

Facility ID: 00593

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

PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
245483		B, WING			04/01/2014		
NAME OF PROVIDER OR SUPPLIER  ST ELIGIUS HEALTH CENTER				7	TREET ADDRESS, CITY, STATE, ZIP CODE 700 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 PROVIDER'S PLAN OF CORRECTIC REFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)		BE	(X5) COMPLETION DATE
K 052 SS=F	DEFICIENCY MUS FOLLOWING INFO  1. A description of volto correct the deficition.  2. The actual, or proposed in 1971.  St. Eliguis Health Consequent a reoccurrent a reoccurrent and 1971 with an addition 1971 with an addition 1971 with an addition 1971 building is 2005 building is 2005 building is 2005 building is supplied in 1971 with an additional in 1971 with an addit	ate.mn.us  RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  oposed, completion date.  If title of the person rection and monitoring to ence of the deficiency  enter is a 2-story building with inal building was constructed lition constructed in 2005. The type II(111) construction and type II(111) construction. The oport service only. Therefore, was inspected as one building.  sprinkler protected. The facility alarm system with smoke ridors and spaces open to the nitored for automatic fire tion. The facility has a for 7 beds and had a census of e survey.  42 CFR Subpart 483.70(a) is		000			
	•						

Event ID: 07JC21

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

PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		045402	B. WING		04/01/2014		
		245483	B. WING	ATTENT ADDRESS OF STATE ZIR CODE	1 04/1	71/2014	
	PROVIDER OR SUPPLIER  US HEALTH CENTER		11	STREET ADDRESS, CITY, STATE, ZIP CODE 7700 GRAND AVENUE DULUTH, MN 55807			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 052	installed, tested, an with NFPA 70 Natio 72. The system has	nd maintained in accordance nal Electrical Code and NFPA s an approved maintenance n complying with applicable	K 05	52			
K 062 SS=F	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. NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating			K052 It is the policy of St. Eligius Health Center to install, test a maintain a fire alarm system in accordance with NFPA 70 and 3 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 Fi Marshall by 5-31-14 to obtain additional materials pertaining to routine maintenance requirements and documentat of completion.	n 72. on d n ire		

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

PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245483	B. WING			04/	01/2014
	PROVIDER OR SUPPLIER			77	REET ADDRESS, CITY, STATE, ZIP CODE 700 GRAND AVENUE ULUTH, MN 55807		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	periodically. 19.7 9.7.5  This STANDARD is Based on record reinterview, the facility maintain the sprinkl practice could affect residents, staff and Findings include:  At the conclusion of 10:30AM, it was dis	nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, s not met as evidenced by: eview, observation and y has failed to properly ler system. This deficient of all occupants including	li H s c t p Q ir p re	(062) t is	the policy of St. Eligius lth Center to continuously ntain automatic sprinkler ems in reliable operating dition and ensure they are ed and inspected odically. Iterly flow testing will ude measurement of its beginning 2Q2014 as the ection occurred on the last of 1Q2014. The ESD has		
	Director of Facility Midd not have prope the quarterly fire sp required, by NFPA 2 conducted.  This deficient practi	Maintenance, that the facility or documentation to show that brinkler flow testing as 25 Section 9.7.5, was being lice was confirmed by the ance (RP) at the time of exit.	a so d to to	ssurche ime locu esti he l o ol erta	med the responsibility of eduling and ensuring the ely completion and umentation of the quarterly ing. The ESD will meet with local Fire Marshall by 5-31-14 btain additional materials aining to routine attended requirements and umentation of completion.	SEE	JPA PE

Cocore alglia

## 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.





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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

St Eligius Health Center April 15, 2014 Page 2

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 Meeth

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

5483s14.rtf

PRINTED: 04/15/2014 FORM APPROVED

Minnesota Department of Health

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SU COMPLET	
		00593	B. WING		04/03	/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ITE, ZIP CODE		
ST ELIGIU	IS HEALTH CENTER		AND AVENUE MN 55807			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not corrected not corrected shall be with a schedule of finithe Minnesota Depart.  Determination of whe corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessmither as a survey.	ther a violation has been				
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.				
	Department's staff, vi the following correction corrections are comp make a copy of these original to the Minnes	: 4/3/14, surveyors of this sited the above provider and on orders are issued. When leted, please sign and date, orders and return the ota Department of Health, se Monitoring, Licensing and				

Minnesota Department of Health

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

TITLE (X6) DATE

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00593	B. WING		04/03/2014
					04/03/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	
ST ELIGIU	IS HEALTH CENTER		AND AVENUE , MN 55807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	Continued From page	± 1	2 000		
	Certification Program; Suite 290, Duluth, MN	11 East Superior Street;			
	completed at the time Investigation of compl H5483027, were com	of the recertification survey.			
2 560	MN Rule 4658.0405 S Plan of Care; Content	Subp. 2 Comprehensive	2 560		
	objectives and timetal long- and short-term of and mental and psychidentified in the comprassessment. The commust include the indiv	of care must list measurable coles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident mprehensive plan of care idual abuse prevention plan a Statutes, section 626.557,			
	by: Based on observation review, the facility faile				
	Findings include:				
	Coumadin 6 milligram diagnosis of pulmonal	er dated 3/24/14, directed is (mg) every evening for a ry embolism/infarction (a in the lungs, that can be it).			

Minnesota Department of Health

STATE FORM 6899 O7JC11 If continuation sheet 2 of 19

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00593	B. WING		04	1/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E, ZIP CODE			
ST ELIGIU	JS HEALTH CENTER		AND AVENUE , MN 55807				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 560	Continued From page	2	2 560				
		2/19/14, directed the use of t identify potential side					
	On 4/3/14, at 9:36 a.r was interviewed and indications of bleeding Coumadin should be	g as a side effect of					
	an individual compreh developed that includ	olans dated 10/10, directs					
	Coumadin 1.5 milligra	dated 3/20/14, directed ams (mg) daily on Sundays and Saturdays and 2 mg on and Friday.					
	vascular accident and hemorrhage.	d 5/8/13, identified atrial fibrillation, cerebral history of a subarachnoid indications for monitoring					
	was interviewed and	.m. registered nurse (RN)-A verified a care plan did not erse response or monitoring					
	The Director of Nursir develop, review and/o procedures to ensure	care plans are developed ents current care needs					

Minnesota Department of Health

STATE FORM 6899 O7JC11 If continuation sheet 3 of 19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00593	B. WING		04/03/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 04/03/2014	
ST ELIGIU	IS HEALTH CENTER		ND AVENUE MN 55807			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 560	Continued From page	e 3	2 560			
	develop a monitoring compliance.	e could educate all ne policies/procedures, and system to ensure ongoing CORRECTION: Twenty One				
2 565		Subp. 3 Comprehensive	2 565			
		nprehensive plan of care ersonnel involved in the				
	by: Based on observation review, the facility fail	access site for 1 of 1				
	Findings include:					
	of dermis presenting coccyx pressure ulce plan. R14's care plan dated Stage II pressure ulce repositioning. R14 was not provided	age II (partial thickness loss as shallow open ulcer) r as directed by the care d 10/24/13, indicated a er on the coccyx with hourly				

Minnesota Department of Health

STATE FORM 6899 O7JC11 If continuation sheet 4 of 19

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		00593	B. WING		04	1/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	, ZIP CODE			
ST ELIGIL	JS HEALTH CENTER		AND AVENUE				
	-	DULUTH	, MN 55807				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 565	Continued From page	e 4	2 565				
	licensed practical nur	time, the administrator and se (LPN)-B, transferred R14 k into bed to do a dressing sure ulcer.					
		m. register nurse (RN)-A ected to reposition R14 d by the care plan.					
	ulcers/skin breakdow once risk factors have planning and interver	I procedure on pressure n dated 10/104/11, directed e been identified, care tions are individualized for particular risk factors.					
	into the tissues), blee	n, infiltration (blood leaking					
	dated 1/29/14, indicate	d Minimum Data Set (MDS) ted R40 had no cognitive noses of diabetes and end ESRD); and received					
	R40 was on hemodia renal disease (ESRD left forearm access si R40 was at risk for exinfiltration in the left a use at dialysis. Intervithe site for signs and infiltration, bleeding, a over the site daily. The returns from dialysis the access site that the remove, and there was	n dated 1/16/14, indicated lysis secondary to end stage ), and identified R40 had a te. The care plan indicated cess bleeding and rm AV fistula due to Heparin entions included to monitor symptoms of infection, and to check for a "buzz" he care plan indicated R40 with a pressure dressing on the resident or staff may as a potential for bleeding the dressing. The care plan					

Minnesota Department of Health

STATE FORM 6899 O7JC11 If continuation sheet 5 of 19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SUF	
74101 2741	or contraction	IDENTIFICATION NOMBER.	A. BUILDING: _		J J J J J J J J J J J J J J J J J J J	
		00593	B. WING		04/03/	/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST ELIGIU	IS HEALTH CENTER	7700 GRAI DULUTH, I	ND AVENUE MN 55807			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 565	further directed staff the every shift for the presound heard through (feel for vibration).  On 4/2/14, at 7:18 a.r room in bed. When questaff in the facility cheacess site, R40 stated removes the dressing facility after dialysis.  R40's medical record dialysis access site with facility staff as directed on 4/2/14, at 2:33 p.r manager (RN)-A confidocumentation to indibeing monitored for irror patency. RN-A staff entered into the elect should have been. RI should be monitored SUGGESTED METH	o monitor the access site sence of a bruit (swishing a stethoscope) and a thrill m. R40 was observed in his uestioned how often the eck his left forearm dialysis ed, "They don't usually he waits a few hours and g when he returns to the est selected evidence the eas being monitored by the ed on the care plan.	2 565			
	develop a system to e plans are followed by monitoring system to TIME PERIOD FOR 0	ensure all resident care				
2 905	(21) Days  MN Rule 4658.0525 Subp. 4. Positioning.	Subp. 4 Rehab - Positioning	2 905			
		ody alignment. The position				

Minnesota Department of Health

STATE FORM 6899 O7JC11 If continuation sheet 6 of 19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
AND PLAN (	J. CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	LIED
		00593	B. WING		04/0	3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
o= =: .o.:		7700 GRAN	ND AVENUE			
STELIGIC	IS HEALTH CENTER	DULUTH, N	/IN 55807			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 905	of residents unable to must be changed at le including periods of ti been put to bed for the has documented that hours during this time the physician has ord.  This MN Requirement by: Based on observation review, the facility fail repositioning to promulcers for 1 of 3 residing pressure ulcers.  Findings include:  R14 had a Stage II (pressure ulcer on her provided with timely ressure ulcer Advisor Stage II: Partial thickness loss shallow open ulcer without slough. May a open/ruptured serum filled blister. Presents ulcer without slough of Unstageable/Unclass tissue loss - depth un Full thickness tissue I the ulcer is completel (yellow, tan, gray, gree (tan, brown or black)	change their own position east every two hours, me after the resident has the night, unless the physician repositioning every two experiod is unnecessary or thered a different interval.  It is not met as evidenced the interview and document the document the document the document the healing of pressure the healing of	2 905			
		ne wound, the true depth				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00593	B. WING		04/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•
ST ELIGIL	JS HEALTH CENTER	7700 GRAN DULUTH, N	ND AVENUE IN 55807		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 905	and muscular atrophy indicated R14 had a sher coccyx, and was repositioning schedul. The quarterly Minimu 1/24/14, indicated R1 impaired, and require for bed mobility, transindicated R14 was freand bladder. The MD at risk for the develop was on a repositionin had a stage 2 pressur identified on 12/30/13 R14 was not provided continuous observation 4/2/14, from 5:06 a.m. the administrator and (LPN)-B, transferred linto bed to do a dress pressure ulcer. At that was measured and withen 0.1 cm depth.  On 4/3/14, at 2:44 p.r. interviewed and stare program was determined the field of the red area to further stated she wore reposition R14 every plan.  The facility policy and	d. 10/24/13, indicated ed mild cognitive impairment v. The care plan also Stage II pressure ulcer on on a every one hour e. m Data Set (MDS) dated 4 was severely cognitively dextensive assist of 1 staff of sters, and toileting. The MDS equently incontinent of bowel S further indicated R14 was oment of a pressure ulcer, g schedule, and currently re ulcer that was first st. description of the toilet, then back sing change to R14's at time the pressure ulcer was 0.7 cm x 0.9 cm, less and R14's hourly repositioning ned when the facility of R14's coccyx. RN-A and currently red was directed by the care of procedure on pressure	2 905		
	ulcers/skin breakdow resident risk factors h	n dated 10/10, directed once			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		00593	B. WING		04/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ST ELIGIU	S HEALTH CENTER		ND AVENUE		
		DULUTH,	MN 55807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 905	Continued From page	e 8	2 905		
	resident and their par	ticular risk factors.			
	The Director of Nursin develop a system to e repositioned in a time assessed needs. The DON or designed appropriate staff on the ensure ongoing company to the company to t	ne system, and monitor to			
21385	MN Rule 4658.0800 S Staff assistance	Subp. 3 Infection Control;	21385		
	Personnel must be as infection control prograthe residents and nur	ance with infection control. ssigned to assist with the ram, based on the needs of sing home, to implement edures of the infection			
	by: Based on observation review the facility faile control priactice for reresident ice packs an residents (R14) review soiled resident linen versidents include:	t is not met as evidenced  n, interview and document ed to implement infection esident food with usable d handwahsing for 1 of 3 wed for pressure ulcers; and was placed on the floor.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	SURVEY
744512741	or definition	IDENTIFICATION NO.	A. BUILDING: _		33,111	
		00593	B. WING		04	03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST ELIGIL	IS HEALTH CENTER		ND AVENUE			
		DULUTH,	MN 55807	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21385	Continued From page	9	21385			
	On 4/2/14, at 7:22 a.r making R14's bed. Nanightgown and a blue she had completed me the blue pad and place bed. When questione put soiled linen into a unable to find one. Nashould go into a lined On 4/2/14, at 7:30 a.r was interviewed and sinto a linen bag.  The facility policy and linen dated 4/12, directly placed directly into a Proper handwashing followed during a preson R14.  On 4/2/14, at 6:46 a.r licensed practical nur from the bed to the to LPN-B washed her had and arranged the dresdiscarded her gloves, removed the soiled dithe soiled gloves, did donned clean gloves. cleanse the pressure then placed a clean displaced and some complex of the soiled a clean displaced a clean displaced a clean displaced and some complex of the soiled a clean displaced a	m. NA-C was observed to be A-C dropped a soiled pad onto the floor. When taking the bed, NA-C folded ted it on the foot of R14's d, NA-C stated she usually linen bag, but she was A-C verified soiled lined bag.  m. registered nurse (RN)-C stated soiled lined should go  I procedure on laundry and cted all soiled linen must be covered laundry bag.  procedures were not source dressing change  m. the administrator and se (LPN)-B transferred R14 idlet, then back into bed. ands, donned clean gloves, ssing supplies. LPN-B then donned clean gloves, and ressing. LPN-B discarded not wash her hands, then				
	7:03 a.m. LPN-B state	ed she should have washed love changes when going				
	On 4/3/14, at 2:44 p.r	n. RN-B was interviewed,				

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_	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00593	B. WING		04/03/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
ST ELIGIU	IS HEALTH CENTER	7700 GRA DULUTH,	ND AVENUE MN 55807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21385	and stated hands sho glove changes when to a clean dressing.  The facility policy and dressings dated 10/10 hands thoroughly, put remove soiled dressir thoroughly, put on cle wound.  During observation of 4/3/14, at 10:25 a.m. nurse (LPN-B) a plass noted to be stored wit freezer of the second LPN-B verified at that were for resident use RN-A was interviewed ice packs shouldn't be SUGGESTED METH. The director of nursin develop, review and/oprocedures to ensure and standards are ma appropriate.  The DON or designed appropriate staff on the	procedure on dry/clean D, directed to wash and dry to on clean gloves and an gloves to cleanse the dressing on with a licensed practical stic container of oranges was the reusable ice packs in the floor snack refrigerator. It ime that the ice packs (treatments). At 12:30 p.m. It and indicated that resident to in the [snack] refrigerator.  OD OF CORRECTION:  If (DON) or designee could be revise policies and infection control procedures aintained by all staff as the policies/procedures, and ring systems to ensure corrections.	21385		
21390		Subp. 4 A-I Infection Control d procedures. The infection include policies and	21390		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		l \ /	(3) DATE SURVEY COMPLETED	
		00593	B. WING		04	1/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
ST ELIGIL	JS HEALTH CENTER		AND AVENUE				
0/4) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES	I, MN 55807	PROVIDER'S PLAN OF	COPPECTION	(V5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21390	Continued From page	e 11	21390				
	procedures which procedures which procedures to identify residents; B. a system for dontrol of outbreaks of C. isolation and preduce risk of transm D. in-service eduprevention and control of outbreaks of transm D. in-service eduprevention and control of the control of transm D. in-service eduprevention and control of the control of transm D. in-service eduprevention and transmunization program defined in part 4658. procedures of resider the prevention and transmunization program defined in part 4658. G. a system for reflect the products which affect disinfectants, antiseppincontinence products which affect disinfectants, antiseppincontinence products I. methods for macurrent standards of procedures the facility failed the collection of the	ovide for the following: ased on systematic data assocomial infections in etection, investigation, and of infectious diseases; orecautions systems to ission of infectious agents; cation in infection ol; Ith program including an m, a tuberculosis program as 0810, and policies and nt care practices to assist in eatment of infections; ent and implementation of cies and infection control tuberculosis program as 0815; eviewing antibiotic use; eview and evaluation of infection control, such as tics, gloves, and aintaining awareness of oractice in infection control.  It is not met as evidenced in,interview and document and to identify,document and					
	Review of the Daily in revealed the facility la						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00593	B. WING		04	/03/2014
	ROVIDER OR SUPPLIER  JS HEALTH CENTER	7700 GR	DDRESS, CITY, STATE AND AVENUE I, MN 55807	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21390	down daily on the log number, site of the interest the resident was on.  Examples include, R number appeared on -3/31/14. The only off R142 was Doxycline R6's was listed on the 3/31/14 as lungs-Leve The log lacked date of symptoms, culture reinfections were health or community associate not available to track infections. In addition identify if cultures were appropriate antibiotic.  Interview with the direct registered nurse man Administrator on 4/3/2 this was the system the infections.  DON verified there was method for tracking results of the system of the director of nursing develop, review and/2/2 procedures to ensure	month of March 2014 nurse managers would write a residents name, room fection and what antibiotic  142's name and room the log from 3/19/14 ner information listed for (antibiotic).  de daily log for 3/30/14- aquin (antibiotic) 3/29-4/4  of unset, signs and ports, diagnosis and if the n care associated infections ated. The information was and trend resident , there was no system to re ordered to determine c usage.  ector of nursing (DON) , agers (RN-A & RN-D) and (13 at 1:00 p.m. verified that they used to track and trend  as no policy to direct a esident infections.  OD OF CORRECTION: g (DON) or designee could or revise policies and an effective system for rending, and monitoring of	21390			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
		00593	B. WING		04/03	3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		7700 GRAN	ID AVENUE			
ST ELIGIU	IS HEALTH CENTER	DULUTH, N	IN 55807			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21390	Continued From page	e 13	21390			
	The DON or designed appropriate staff on the	e could educate all ne policies/procedures, and ring systems to ensure  CORRECTION:				
21535	MN Rule4658.1315 S Drug Usage; General	subp.1 ABCD Unnecessary	21535			
	must be free from uniunnecessary drug is a A. in excessive ditherapy; B. for excessive of C. without adequed D. in the presence which indicate the document of the drug part 4658.1310, the rewith provisions in the Code of Federal Regulations Manual, Coperations Manual, Coperations Manual, Coperations Manual, Coperations of Health Health Care Financin This standard is incoravailable through the	duration; ate indications for its use; or se of adverse consequences se should be reduced or gregimen review required in nursing home must comply Interpretive Guidelines for ulations, title 42, section ppendix P of the State Guidance to Surveyors for lities, published by the and Human Services, g Administration, April 1992. porated by reference. It is Minitex interlibrary loan Law Library. It is not				
	by:	t is not met as evidenced				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		00593	B. WING		04/03/2	2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST ELIGIL	IS HEALTH CENTER		ND AVENUE			
	QUILLEN/ QT	DULUTH,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETE DATE
21535	Continued From page	e 14	21535			
	blood glucose checks by the physician to m an oral blood glucose	ed to consistently complete (Accuchecks) as ordered onitor the effectiveness of lowering medication for 1 of ose medications were				
	Findings include:					
	The annual Minimum 3/13/14, indicated R2 diabetes.	Data Set (MDS) dated 9 had a diagnosis of				
	dated 3/21/13, directed Accuchecks twice a dand once two hours a order further directed R29's blood glucose times in a row. The P3/1/14, to 4/1/14, direglipizide (an oral bloomedication) 7.5 millig starting 5/28/13. The Administration History	ral Form (physician's order) ed staff to complete an lay - once in the morning, fiter the evening meal. The staff to call the physician if was greater than 200 two hysician Order Report for cted staff to administer d glucose lowering rams (mg) twice a day Electronic Medication y for March and April 2014, eceive the medication twice				
	room in bed, and at 9 wheelchair. No signs	n. R29 was observed in the :14 a.m. when up in the or symptoms of possible cose levels were observed.				
	4/2/14, were as follow January 2014 - there Accuchecks complete and 1/24. There was January greater than					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00593	B. WING		04/03	3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST ELIGIL	IS HEALTH CENTER	7700 GRAN DULUTH, N	ID AVENUE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	COMPLETE DATE
21535	Continued From page	e 15	21535			
	was completed as ord	dered.				
	2/16, 2/17, 2/18, 2/19 Accucheck on 2/21. T level greater than 200 however, the facility w determine if there wer in a row greater than Accucheck on 2/28, h March 2014 - there w completed on 3/6, 3/7 no evening Accuchec 3/29. There was an A 200 (220) the evening would have been una were two blood glucos than 200 as the morn not been completed. Accucheck level grea	ed on 2/4, 2/6, 2/7, 2/9, 2/13, 2/20, 2/28, and no evening There was one Accucheck (223) the evening of 2/28; would have been unable to re two blood glucose levels 200 as the morning and not been completed.  ere no morning Accuchecks (3, 3/11, 3/17, 3/23, 3/24, and ks completed on 3/24, and ccucheck level greater than g of 3/5; however, the facility ble to determine if there se levels in a row greater ing Accucheck on 3/6, had There was also an ter than 200 (266) the blood glucose monitoring at				
	completed on 4/1. The	s no morning Accucheck e remainder of the ks were all under 200.				
		.m. the registered nurse irmed the lack of				
	The director of nursin review and/or revise pensure medications a monitored for effective	eness for ongoing use as ian. The DON or designee				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00593	B. WING		04/03/2014
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	04/03/2014
31 ELIGIC	3 HEALTH CENTER	DULUTH,	MN 55807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21535	Continued From page	e 16	21535		
	policies/procedures, a monitoring systems to compliance.				
	TIME PERIOD FOR ( Twenty-One (21) Day				
21685	MN Rule 4658.1415 S Housekeeping, Opera	•	21685		
	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.				
	by: Based on observation failed to ensure that 1 R5, R107, R73, R102 R40) were maintained manner related to wa	t is not met as evidenced n and interview the facility 0 of 40 resident rooms (R8, 2, R70, R116, R22, R20, d and repaired in an sanitary lls, flooring and odors. In refrigerator in the kitchen			
	Findings include;				
		ental tour with the facilities es director (ESD) on 4/3/14 wing was noted:			
	right side of the hallw The linoleum on the b	gouges in the wall on the ay when entering the room. bathroom floor had gouges are entry. The room had a			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOLESING.			
		00593	B. WING		04/0	3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST ELIGIL	IS HEALTH CENTER	7700 GRAN DULUTH, N	ND AVENUE			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N .	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
21685	Continued From page	e 17	21685			
		SD indicated the bathroom aced. ESD further stated, urce 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.					
	toilet. The heat regist metal approximately t verified the findings a R70's bathroom shou	rust under the suspended er had an loose piece of two by four inches long. ESD nd indicated the flooring in ld be replaced and that on the list to be replaced.				
		atches and black marks s. ESD verified the findings.				
	behind the head of th was caused by the he being pushed against	ral areas of missing plaster e bed. ESD indicated that ead of the resident's old bed the wall by staff. ESD d received a new bed two				
	sink. ESD indicated s	had a white stain below the he was not sure what it was. it possible could be a paint				
	R40's room had paint baseboard heater at t bathroom door frame	he foot of the bed and the				
	A policy was requeste maintenance for reside provided.	ed regarding routine lent rooms and was not				
	On 3/31/14, at 12 noo	on during tour of the kitchen				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00593	B. WING		04/03/2014
	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21685	standing refrigerator of metal wire shelves that shelves were approximand a half. The refriguleft overs, open packatcheeses, Mayonnaises.  Per interview with CS she said this refrigerat facility used on a daily tomatoes and lettuce, with. The CSD states cleaning of the shelve indicated the cleaning. The CSD stated that it that the selves were considered to form the constant of th	ice director (CSD) a small was observed to have three at were totally rusted. The mately two feet by a foot erator contained yogurt and ages of sandwich meat, e, other compliments, .  D on 3/31/14, at 12:00 noon for holds foods that the y basis, like leftovers, things to make sandwiches at that they do a weekly es. The schedule for April g was documented weekly. It would be hard to ensure clean because of the rust.  OD OF CORRECTION:  If (DON) or designee could mental services staff to be program to ensure odors, and walls are maintain a safe, clean, the DON or designee ropriate staff on the evelop monitoring systems impliance.	21685		

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