DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PDMN PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00040 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) DIVINE PROVIDENCE COMMUNITY HOME (L1) 245599 1. Initial 2. Recertification (L4) 700 THIRD AVENUE NORTHWEST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) **56085** 356540800 (L2)(L5) SLEEPY EYE, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 02 7. PROVIDER/SUPPLIER CATEGORY (L7)8. Full Survey After Complaint (1.9)13 PTIP 01 Hospital **05 HHA** 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 06/26/2015 (L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 06/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 53 (L18) _1. Acceptable POC 8. Patient Room Size ___ 9. Beds/Room 5. Life Safety Code Not in Compliance with Program 53 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)* Code: Α 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)53 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: 06/26/2015 Kathryn Serie, Unit Supervisor Kamala Fiske-Downing, Enforcement Specialist 06/26/2015 (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: ____ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 10/01/1991 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (1.24)(1.41)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44)

(L27)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

B. Rescind Suspension Date:

(L28)

(L32)

(L45)

30. REMARKS

DETERMINATION APPROVAL

(1.31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

03001

06/18/2015



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245599

June 26, 2015

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

Dear Ms. Groebner:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 16, 2015 the above facility is certified for:

53 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 53 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 26, 2015

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

RE: Project Number S5599025

Dear Ms. Groebner:

On June 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 7, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 7, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 7, 2015, effective June 16, 2015 and therefore remedies outlined in our letter to you dated June 8, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 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 245599	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/26/2015			
Name of Facility		Street Address, City, State, Zip Code				
DIVINE PROVIDENCE COMMUNITY HOME		700 THIRD AVENUE NORTHWEST				

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			C	Correction					Correction
ID Prefix	F0282	Completed 06/16/2015		F0311		Completed 06/16/2015		ID Prefix	F0431		Completed 06/16/2015
	483.20(k)(3)(ii)			483.25(a)(2)				Reg. #	483.60(b), (d),	(e)	
LSC			LSC					LSC			_
		Correction			C	Correction					Correction
		Completed			C	Completed					Completed
Reg. # LSC			Reg. #					Reg. # LSC			_
		Correction			C	Correction					Correction
ID Prefix		Completed				Completed		ID Profix			Completed
Reg. #											<u> </u>
			LSC					LSC			<u>—</u> ;
		Correction				Correction					Correction
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LSC			LSC					LSC			_
		Correction			_	Correction					Correction
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Reg. #			Reg. #					Reg. #			<u>—</u>
								100			
Reviewed E	By Rev	iewed By	Date:	Signature	e of Surv	eyor:				Date:	
State Agen	cy KS/	kfd	06/26/20	15		0.	3048				06/26/2015
	By Rev	iewed By	Date:	Signature	e of Surv	eyor:				Date:	
CMS RO											
Followup t	o Survey Comple			Check for an					Summary of the Facility?	VEO	No
	5/7/2015							. ,		YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

IITTAL ID: PDMN
GENCY Facility ID: 00040

(L5) SLEEPY EY 7. PROVIDER/SU	E, MN		•	3. Termination	2. Recertification 4. CHOW
01 Hospital	PPLIER CATEGO	ORY 09 ESRD	(L6) 56085 <u>02</u> (L7) 13 PTIP 22 CLIA	5. Validation 7. On-Site Visit 8. Full Survey Af	6. Complaint 9. Other ser Complaint
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 ENI	DING DATE: (L35)
A. In Compliar Program Re Compliance	nce With equirements e Based On: cceptable POC upliance with Progr	ram	2. Technical Personnel 3. 24 Hour RN	6. Scope of S7. Medical E8. Patient Ro	Services Limit Director om Size
ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
COMPLETED B	BY HCFA RE	GIONAL	Kamala Fiske-Downing. OFFICE OR SINGLE S 21. 1. Statement of Fina 2. Ownership/Control	Enforcement Special Solvency (HCFA-2 of Interest Disclosure Str	(L20)
MENT 24 G DATE EVE SANCTIONS In of Admissions: uspension Date:			VOLUNTARY 000 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	INVOLU 05-Fail t 06-Fail t 07-Provi	der Status Change
03001		(L31) DATE (L33)			
	03 SNF/NF/Distinct 04 SNF 10.THE FACILITY A. In Complian Program R. Complianc	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP 10.THE FACILITY IS CERTIFIED A A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC X B. Not in Compliance with Prog Requirements and/or Applie ICF IID (L42) (L43) ABLE SHOW LTC CANCELLATION II Date: 06/15/2015 COMPLETED BY HCFA RE 20. COMPLIANCE WITH RIGHTS ACT: MENT 24. LTC AGREEM FIGHTS ACT: MENT 24. LTC AGREEM G DATE ENDING DATE (L25) VE SANCTIONS IN of Admissions: (L44) uspension Date: (L45) D. INTERMEDIARY/CARRIER NO. 03001	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 04 SNF 08 OPT/SP 12 RHC 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On:	02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On:	OH Hospital OH HOSPITA 19 NF 13 PTIP 22 CLIA 12 SINFAPEDIA 16 PTIF 10 NF 14 CORF 13 SNFAPEDIA 16 PTIF 15 ASC 06/30 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements 2. Technical Personnel 6. Scope of S. 2. 4 Hour RN 7. Medical Exception 7. 1 Page of the Safety Code 9. Beds/Roo 2. Life Safety Code 2. Life Safety Code 9. Beds/Roo 2. Life Safety Code 9. Beds/Roo 2. Life Safety Code 9. Beds/Roo 2. Life Safety Code 2. Life Safety Code 2. Life Safety Code 2. Life Safety Code 2.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 8, 2015

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

RE: Project Number S5599025

Dear Ms. Groebner:

On May 7, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 16, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

Divine Providence Community Home June 8, 2015 Page 4

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 7, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 7, 2015 (six months after the

Divine Providence Community Home June 8, 2015 Page 5

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program

Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

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

PRINTED: 06/18/2015 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245599	B. WING			05/	07/2015
	PROVIDER OR SUPPLIER	JNITY HOME		700 THIRE	DDRESS, CITY, STATE, ZIP CODE D AVENUE NORTHWEST EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT		F 0	00			
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are cour signature is not required irrst page of the CMS-2567 nic submission of the POC will cion of compliance.					
F 282 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 2	82			6/16/15
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of					
	by: Based on observatoreview the facility farelated to oral care reviewed for activitive Findings include: Review of R34's ca 3/31/15 indicated Recare after set-up with needed). The care potential for alteration	ion, interview and document illed to follow the plan of care for 1 of 1 resident (R34) es of daily living (ADL's). re plan, last revised on 34 was independent with oral th staff to assist prn (as plan further identified a on in dental status related to ed) teeth and history of		via tel of pro they v Proxy on 5/8 Direct and p care p nursir giver s individ	/6/2015 RN contacted dental lephone to notify that resident by brushes. Dental clinic state would send more for R 34 in the brushes were received in the 3/15 from the dental clinic. The tor of Nursing will review the procedures related to ensuring blan for each resident is following staff will be re-educated or sheets and the plan of care for the charge in the spot check audits to ensure	is out ed that he mail. e mail e policies g the wed. All a care or urses	
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

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

TITLE

Electronically Signed

06/15/2015

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

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245599	B. WING			05/0	7/2015
	PROVIDER OR SUPPLIER PROVIDENCE COMM			70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 THIRD AVENUE NORTHWEST LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	extractions. The increase assist/provide oral indicated R34 had to use right arm, at the ability to produce written), d/t history accident/stroke) in R34's NA assignmindicated: Per detitimes per day) corproxi brush (a smapipe cleaner or midetween teeth. All On 5/06/15, at 7:1 was observed assincluding oral care positioned R34 (win front of the bath and applied toothy toothbrush. NA-A own teeth and she and ask if he requite the located in the gumline. NA-R34 shook his health of the back to consider the she'd be back to consider the she'd be back to consider the water shave his face increaser. When finis	nterventions included to hygiene. The care plan also weakness in right leg, inability and expressive aphasia (loss of ice language, spoken or of CVA (cerebrovascular May 2012. The ent sheet, dated 5/5/15 mist, brush teeth 2 x/day (two incentrating on gumline. Use all brush that resembles a mini in Christmas tree) to clean in M, PM. 7 a.m. nursing assistant (NA)-A isting R34 with morning cares e. Prior to brushing teeth, NA-A ho was sitting in his wheelchair) troom sink, turned on the water, be aste to R34's regular stated R34 liked to brush his e would re-approach him later ired further assistance with the e back of the mouth and along A asked R34 if he needed help. and from side to side, indicating exited R34's room indicating exited R34's room indicating	F 2	282	plan of care is being followed. The nurse will provide education to the assistants when the plan of care charter the Staff Development RN, as desby Director of Nursing will complete routine audits to determine nursing assistant competency. The Director Nursing will oversee for overall compliance to ensure that the plan is being followed for each resident. concerns will be addressed at the vinterdisciplinary team (IDT) meeting unresolved concerns from IDT meet will be discussed with the quality assurance team.	nursing nanges. ignated r of of care Any veekly g. Any	

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

-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED		
		245599	B. WING			05/0	07/2015
	PROVIDER OR SUPPLIER	JNITY HOME		700	REET ADDRESS, CITY, STATE, ZIP CODE THIRD AVENUE NORTHWEST EEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	during this observar assistance was required R34's dental progres indicated R34's tiss and stressed brush gumline and using between teeth. When interviewed a confirmed R34 had before she was ablebrushing. NA-A states after he had finisheneed for further assalways offer to help seldom allows staff that to her knowled toothbrush and was was as indicated on NA-A indicated she aide, but will help a NA when needed, a NA-A further indicated NA, she is usually a R34 was located. When interviewed a stated she worked morning shift with rand 300 wings as help the past year. NA-I brush his own teeth a regular toothbrus further indicated be specialized equipm	tion to check whether further uired. ess notes dated 12/18/14, ues were inflamed throughout ing 2 x/day, concentrating on proxi brush to clean in on 5/06/15, at 1:38 p.m. NA-A left his room for breakfast e to offer assistance with tooth ed she did check with R34 d breakfast but he denied the sistance. NA-A stated staff with tooth brushing but R34 assistance. NA-A confirmed ge, R34 always uses a regular sunsure what a proxi brush in the NA assignment sheet. usually works as a restorative t times, help in the role of the is she was doing that day. Ited that when she works as a assigned the 200 wing, where	F 2	82			

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

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 THIRD AVENUE NORTHWEST				A. BUILDII	NG	00	ATE SURVEY OMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 THIRD AVENUE NORTHWEST			245599	B. WING _		05/0	07/2015	
DIVINE PROVIDENCE COMMUNITY HOME SLEEPY EYE, MN 56085			JNITY HOME		700 THIRD AVENUE NORTHWEST			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY DEPOVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE	
When interviewed on 5/06/15, at 2:09 p.m. registered nurse (RN)-A was unaware of the appearance of the proxi brush but searched R34's room to find the device. RN-A was only able to locate a regular toothbrush. RN-A stated R34 may have discarded the proxi brush. When RN-A questioned LPN-A about the use of the proxi brush, LPN-A was unaware whether R34 used any other type of tooth brush for oral care except a regular tooth brush for oral care except a regular tooth brush. When interviewed on 5/07/15, at 9:36 a.m. the director of nursing (DON) stated the dental office had sent a proxi brush with R34 after a dental appointment on 12/18/14, upon their recommendation. The DON stated R34 must have used all of the proxi brushes and subsequently, the dental office had been contacted now so that additional brushes would be available. The DON stated it would have been the NA's responsibility to communicate with the nursing staff when R34 no longer had them available. During a subsequent interview at 1:15 p.m., the DON confirmed she was unaware how long R34 had been without the proxi brush recommended by the dentist, and was also unaware whether the dental office had supplied more since the appointment on 12/18/14. 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 311 SS=D	When interviewed oregistered nurse (Rappearance of the pR34's room to find table to locate a registered nurse (Richards room to find table to locate a registered nurse and proximal pr	N)-A was unaware of the proxi brush but searched the device. RN-A was only ular toothbrush. RN-A stated arded the proxi brush. When PN-A about the use of the was unaware whether R34 of tooth brush for oral care oth brush. On 5/07/15, at 9:36 a.m. the DON) stated the dental office ush with R34 after a dental 18/14, upon their The DON stated R34 must proxi brushes and lental office had been that additional brushes would DON stated it would have been lity to communicate with the R34 no longer had them subsequent interview at 1:15 irrmed she was unaware how without the proxi brush the dential, and was also the dential office had supplied ointment on 12/18/14. TMENT/SERVICES TO IN ADLS the appropriate treatment and the or improve his or her abilities aph (a)(1) of this section.				6/16/15	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245599	B. WING			05/0	07/2015
	PROVIDER OR SUPPLIER PROVIDENCE COMM			70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 THIRD AVENUE NORTHWEST 6LEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	review the facility recommended or available for 1 of activities of daily life. Findings include: When interviewed member (FM)-A s R34 received the care. FM-A indicaincreased plaque recent dental apple a problem. On 5/06/15, at 7:1 was observed assincluding oral care positioned R34 (win front of the bath and applied tooth toothbrush. NA-A own teeth and she and ask if he requite the located in the gumline. NA-R34 shook his her "No". NA-A then eashe'd be back to consider the she'd be back to consider the side. Upon contoothbrush, rinsecturned off the water shave his face inconsidered the state of the same shave his face inconsidered the same shape in the same shape shape in the same shape sha	ation, interview, and document failed to ensure the all hygiene supplies were made I resident (R34) reviewed for ving (ADL's). I on 5/5/15, at 10:27 a.m. family tated feeling unsure whether required assistance with oral atted R34 had issues with build-up per the dentist and with bintments this had continued to 7 a.m. nursing assistant (NA)-A disting R34 with morning cares as Prior to brushing teeth, NA-A who was sitting in his wheelchair) aroom sink, turned on the water, be asset to R34's regular stated R34 liked to brush his a would re-approach him later irred further assistance with the e back of the mouth and along A asked R34 if he needed help. ad from side to side, indicating exited R34's room indicating	F3	311	On 5/6/2015 RN contacted dental via telephone to notify that resident of proxy brushes. Dental clinic state they would send more for R 34 in the Proxy brushes were received in the on 5/8/15 from the dental clinic. The Director of Nursing will review the pand procedures related to ensuring care plan for each resident is follow nursing staff will be re-educated the supplies must be available in order provide the care accordingly for each individual resident. The charge nurwill do spot check audits to ensure plan of care is being followed and the ensure the proper supplies are avanged the nursing assistants when the placare changes. The Staff Developmen RN, as designated by Director of Navill complete routine audits to detenursing assistant competency. The Director of Nursing will oversee for compliance to ensure that the plan is being followed for each resident that necessary supplies are readily available. Any concerns will be add with the quality assurance team.	is out ed that he mail. e mail e colicies y the wed. All hat to ch rses the o hilable. eation to an of ent cursing rmine overall of care and	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY PLETED
		245599	B. WING		 	05/0	07/2015
	PROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 100 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	to exit his room at during this observa assistance was red. Review of R34's care after set-up was needed). The care potential for alterative (r/t) carious (decay extractions. The interest assist/provide oral indicated R34 had to use right arm, at the ability to produwritten), d/t history accident/stroke) in R34's NA assignmindicated: Per der times per day) comproxi brush (a smapipe cleaner or min between teeth. AN R34's dental progrindicated R34's tis and stressed brusing gumline and using between teeth. Do areas of decay we progress note date requested an appour upper tooth pain an area.	7:44 a.m NA-A did not return ation to check whether further quired. are plan, last revised on R34 was independent with oral vith staff to assist prn (as e plan further identified a tion in dental status related to ved) teeth and history of nterventions included to hygiene. The care plan also weakness in right leg, inability nd expressive aphasia (loss of ce language, spoken or of CVA (cerebrovascular May 2012. ent sheet, dated 5/5/15 ntist, brush teeth 2 x/day (two incentrating on gumline. Use all brush that resembles a mini in Christmas tree) to clean in	F3	311			

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

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTI	` '	(X3) DATE SURVEY COMPLETED		
		245599	B. WING			05/	07/2015	
	PROVIDER OR SUPPLIER	JNITY HOME		700 THIRD	DDRESS, CITY, STATE, ZIP CODE D AVENUE NORTHWEST EYE, MN 56085	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI EACH CORRECTIVE ACTION SHOU OSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 311	confirmed R34 had before she was ablibrushing. NA-A stat after he had finishe need for further assalways offer to help seldom allows staff that to her knowled toothbrush and was was as indicated or NA-A could not say any other device the clean in between hi usually works as a at times in the role she was doing that indicated that when usually assigned the R34. When interviewed of trained medication not usually work with she worked with hir when interviewed of stated she worked shift with 200 and 3 assignments for the preferred to brush hand utilized a regula NA-B further indical specialized equipm R34 for tooth brush between teeth.	on 5/06/15, at 1:38 p.m. NA-A left his room for breakfast e to offer assistance with tooth ted she did check with R34 d breakfast but he denied the sistance. NA-A stated staff with tooth brushing but R34 assistance. NA-A confirmed ge, R34 always uses a regular sunsure what a proxi brush the NA assignment sheet. Whether R34 had ever used an his regular toothbrush to steeth. NA-A indicated she restorative aide, but will help of the NA when needed, as day (5/6). NA-A further she works as a NA, she is e 200 wing, the location of	F3	:11				

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMP		E SURVEY PLETED	
		245599	B. WING _		05/	07/2015
	PROVIDER OR SUPPLIER	UNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085	•	
(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 APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 311 F 431 SS=E	appearance of the R34's room to find able to locate a reg R34 may have disc RN-A questioned I proxi brush, LPN-A used any other type. When interviewed director of nursing had sent a proxi brappointment on 12 recommendation for must have used all the dental office had additional brushes stated it would have to communicate with no longer had then subsequent intervieconfirmed she was been without the puthe dentist, and was dental office had stappointment on 12 483.60(b), (d), (e) LABEL/STORE DETENTION The facility must enable a licensed pharma of records of receip controlled drugs in accurate reconciliar records are in order	RN)-A was unaware of the proxi brush but searched the device. RN-A was only gular toothbrush. RN-A stated carded the proxi brush. When LPN-A about the use of the was unaware whether R34 e of tooth brush for oral care. on 5/07/15, at 9:36 a.m. the (DON) stated the dental office ush with R34 after a dental /18/14, after the or use. The DON stated R34 of the proxi brushes and so ad been contacted now so that would be available. The DON e been the NA's responsibility th the nursing staff when R34 in available. During a lew at 1:15 p.m., the DON is unaware how long R34 had roxi brush recommended by its also unaware whether the upplied more since the /18/14.	F 31			6/16/15

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		245599	B. WING			05/0	07/2015
	PROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	labeled in accorda professional princi appropriate access instructions, and the applicable. In accordance with facility must store locked compartme controls, and permanently affixed controlled drugs list Comprehensive D Control Act of 1970 abuse, except whe package drug disti	cals used in the facility must be not with currently accepted ples, and include the sory and cautionary ne expiration date when In State and Federal laws, the all drugs and biologicals in ents under proper temperature nit only authorized personnel to be keys. In State and Federal laws, the all drugs and biologicals in ents under proper temperature nit only authorized personnel to be keys. In State and Federal laws, the all drugs and biologicals in ents under proper temperature nit only authorized personnel to be keys. In State and Federal laws, the all drugs and biologicals in ents under proper temperature nit only authorized personnel to be keys.	F 4	131			
	by: Based on observareview the facility for were labeled accordinately for 13 of R17, R20, R28, R37) in the facility drops and insuling facility failed to ensure reconciled or time between actu	ation, interview and document ailed to ensure medications rding to accepted professional for 16 residents (R1, R3, R9, R32, R33, R38, R41, R43, R46 & who received ear drops, eye medications. In addition, the sure controlled substances in a daily basis to minimize the alloss or diversion and the ermination of the extent of loss			Director of Nursing and RN Charge Nurse will ensure all residents affect have proper medication labels on medication. All licensed nurses and were educated on proper medication labeling according to accepted professional principles at the meeti on 5/21/15. Each prescription label include the date dispensed, instruct for use, Rx number, name of reside the physician is name. Nursing star expected to make sure that all	ted will d TMAs on ng held must tions ent and	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY PLETED
	245599	B. WING		05/	07/2015
NAME OF PROVIDER OR SUPPLIER		!	STREET ADDRESS, CITY, STATE, ZIP		
DIVINE PROVIDENCE COMM	LINITY HOME		700 THIRD AVENUE NORTHWEST		
DIVINE I HOVIDENCE COMM	ONTTTTOME		SLEEPY EYE, MN 56085		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
the medication carrented that multiple insulin's bottles we labeled boxes with individual bottles wyellow strip which or resident and the dr The following medilabel which include instructions for use (1) R3, R17, R32, R Artificial tears eye (2) R9, R28 & R41 drops; (3) R46- bottles of drops; (4) R1- bottle of ea (5) R20- bottles of (6) R43 & R20- Lar and (7) Unlabeled Hum director of nurses (R57. The facility narcotic lacked evidence of of the controlled sucupboard and which use (including eme Review of the Controlled that occur daily for 10 d 2 days in February	of the medication storage on its on 5/6/15, at 2:12 p.m. it was eye drops, ear drops and re not kept in the original the original prescription. The ere labeled with a smaller only included the name of the ug. cations lacked a prescription d the date dispensed, and prescription (Rx) number: R33, R38 & R57- bottles of drops; bottles of Systane eyes Refresh and Genteal eye ar drops; Comtan & Lumigan eye drops; hus and Novolog insulin vials; alog Quick pen- which the DON) identified belonged to be medication documents a daily reconciliation by staff abstances locked in the hard were available for resident argency stock supply). It olled II Medication Count at staff reconciliation did not lays in April, 10 days in March, and 7 days in January for year ne documentation dated 2014	F4	medications have a proper drops, insulins or other me not have a full label attache then the staff must maintai label with the medication to requirements. The Policy: Pharmaceutical Control and was revised to indicate prolabeling and will be reviewed Consulting Pharmacist. Di Nursing will do audits of method the cart and medication roop proper labeling. Consulting continue to inspect the method and medication room on a to ensure compliance. Any be addressed with the qualiteam. All nursing staff has receive accordance with State and that the facility must store biologicals in locked comperoper temperature controully authorized personnel to the keys. The policy: Pheontrol and Accountability revised to ensure that continued medications are reconciled at least once extra Director of Nursing revised to ensure that continued medications are daily. The Charge Nurse we daily to ensure compliance reconciliation of controlled	dications do ed to the bottle, n the box or full o meet the d Accountability per medication ed by rector of edications in om to ensure pharmacist will dication carts quarterly basis y concerns will lity assurance ed education in Federal laws, drugs and artments under ls, and permit to have access armaceutical has been rolled I accurately. est be rery 24 hours. vised the log to blled ergency reconciled fill monitor log of	

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

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245599	B. WING			05/0	07/2015
	OVIDER OR SUPPLIER	JNITY HOME		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOUL		BE	(X5) COMPLETION DATE
Construction of the constr	O days in July, 8 d May. Further review econciliation form in econciled the daily When interviewed of censed practical in drops and insulin metabeled box but the rom the boxes prior inedication boxes andicated the narcor cupboard are not ro daily narcotic count deparately from the evailable for as need evaluable for as need drugs with a high p diversion). During a telephone in	ge 10 September, 16 days in August, ays in June and 7 days in w of the documentation on the indicated that only one staff controlled II medication count. on 5/6/15, at 2:12 p.m. urse (LPN)-A reported the eye redications were delivered in a medications are removed or to use and the original are then discarded. LPN-A tics located in the emergency outlinely counted as part of the since they are located narcotic medications added (PRN) daily use. In the emergency kit included: crated liquid morphine) and bioloid pain medication); both alle II controlled substances botential for abuse and/or interview on 5/7/15, at 9:00 pharmacist (RPh) from the greported the smaller i.e. eye drops and insulin are of accepted standard of inal box. RPh indicated a placed on the bottle or vial resident's name, name of the and Rx number. The RPh station would be to maintain medication with the original ad been unaware the practice of the labeled box prior to	F 4	.31	compliance for medication reconcil of controlled medications. Any conceil will be addressed with the quality assurance team.		

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CON	NSTRUCTION		E SURVEY PLETED
		245599	B. WING			05/0	07/2015
	PROVIDER OR SUPPLIER PROVIDENCE COMMU	JNITY HOME		700 TH	T ADDRESS, CITY, STATE, ZIP CODE IIRD AVENUE NORTHWEST PY EYE, MN 56085	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	a.m. the consultant a complete label was prescription medication bottle/vi with the expiration of stated he was unawaremoved from the further verified that than daily reconcilia. When interviewed of DON indicated that daily, usually on evithe narcotic reconcility reconciliation. The process of the process	interview on 5/7/15, at 9:25 pharmacist (RPh)-C indicated as required with each ation. RPh-C stated best he label to be attached to the hal so the manufacturing label date is not obstructed. RPh-C ware medications were hox with the original label and harcotics required no less hation. In 5/7/15, at 10:00 a.m. the harcotics are reconciled twice hening and night shifts. When hilliation documentation was hation documentation was hation document the completion of he DON further indicated the hathe emergency cupboard are hatso be counted daily. A hilliation policy/procedure was horovided. Hedure titled Specific hatration Procedures indicated habel would be read three moving the medication hatford from the cart/drawer; 2) prior	F 4	31			

Printed: 05/08/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 245599 B. WING 05/06/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **DIVINE PROVIDENCE COMMUNITY HOME** 700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 5, 2015.. At the time of this survey, Divine Providence Community Home was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

Divine Providence Community Home is a one-story building with no basement. The building was constructed in 1993, and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected throughout.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all Resident

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

TITLE

(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.

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

Printed: 05/08/2015 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN	(X3) DATE SURVEY COMPLETED			
		245599		B. WING _		05/06/2015		
1	PROVIDER OR SUPPLIER PROVIDENCE COM	MUNITY HOME	700 TH	DDRESS, CITY, STATE, ZIP CODE HIRD AVENUE NORTHWEST EPY EYE, MN 56085				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETI	ION	
K 000	Rooms. The facilit	age 1 y has a capacity of 5: of 45 at time of the su	3 beds urvey.	K 000				



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted June 8, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5599025

Dear Ms. Groebner:

The above facility was surveyed on May 4, 2015 through May 7, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Divine Providence Community Home June 8, 2015 Page 2

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 06/18/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00040 05/07/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 THIRD AVENUE NORTHWEST **DIVINE PROVIDENCE COMMUNITY HOME** SLEEPY EYE. MN 56085 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a

INITIAL COMMENTS:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

notice of assessment for non-compliance.

Minnesota Department of Health

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

Electronically Signed 06/15/15

STATE FORM PDMN11 If continuation sheet 1 of 14

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.			
		00040	B. WING		05/0	7/2015
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
DIVINE P	ROVIDENCE COMMI	INITY HOME	D AVENUE N EYE, MN 56	IORTHWEST 085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	you electronically. is necessary for State necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the dat Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To assigned to Minnesota Department be state and replaces to minnesota Department be assigned to Minnesota Departmen	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. d 5/7/15 surveyors of this visited the above provider and ction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed. The order of Health is documenting. Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection. ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 PDMN11 If continuation sheet 2 of 14 Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00040	B. WII	NG		05/0	7/2015
	PROVIDER OR SUPPLIER	INITY HOME 700	•	NUE N	ORTHWEST 085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 00	0			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS E STATUTES/RULES.					
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 56	5			6/16/15
	Subp. 3. Use. A co	omprehensive plan of care personnel involved in the					
	by: Based on observatireview the facility farelated to oral care	ent is not met as evidence on, interview, and docume tiled to follow the plan of ca for 1 of 1 resident (R34) es of daily living (ADL's).	nt		Corrected		
	Findings include:						
	3/31/15 indicated R care after set-up wir needed). The care potential for alteration (r/t) carious (decaye extractions. The introduced assist/provide oral hindicated R34 had with to use right arm, and the ability to produce	re plan, last revised on 34 was independent with of the staff to assist prn (as plan further identified a on in dental status related ed) teeth and history of terventions included to hygiene. The care plan also weakness in right leg, inabled expressive aphasia (loss the language, spoken or of CVA (cerebrovascular May 2012.	to so ility				
	R34's NA assignme	ent sheet, dated 5/5/15					

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00040	B. WING		05/0	7/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	05/0	1/2013
	PROVIDENCE COMMU	INITY HOME 700 THIRE	AVENUE N	ORTHWEST		
		SLEEPY E	YE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	times per day) conc proxi brush (a smal pipe cleaner or min between teeth. AM On 5/06/15, at 7:17 was observed assis including oral care. positioned R34 (wh in front of the bathra and applied toothpa toothbrush. NA-A so own teeth and she and ask if he requir teeth located in the the gumline. NA-A R34 shook his head "No". NA-A then ex	a.m. nursing assistant (NA)-A sting R34 with morning cares Prior to brushing teeth, NA-A o was sitting in his wheelchair) oom sink, turned on the water, aste to R34's regular tated R34 liked to brush his would re-approach him later ed further assistance with the back of the mouth and along asked R34 if he needed help. If from side to side, indicating kited R34's room indicating				
	history (hx) of a stro- right side. Upon co- toothbrush, rinsed h turned off the water shave his face inde- razor. When finish- to exit his room at 7 during this observa assistance was req R34's dental progre- indicated R34's tiss and stressed brush gumline and using between teeth.	to brush his teeth g his left hand only due to (d/t) bke affecting the resident's impletion, R34 rinsed off his nis mouth with water, and c. R34 then proceeded to pendently with an electric ed shaving, R34 was observed 7:44 a.m NA-A did not return tion to check whether further				

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00040	B. WING		05/0	7/2015
	PROVIDER OR SUPPLIER	INITY HOME 700 THIRE		STATE, ZIP CODE ORTHWEST 085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	confirmed R34 had before she was able brushing. NA-A stat after he had finishe need for further assalways offer to help seldom allows staff that to her knowled toothbrush and was was as indicated or NA-A indicated she aide, but will help at NA when needed at NA-A further indicat NA, she is usually at R34 was located. When interviewed as shift with 200 and 3 assignments for the preferred to brush hand utilized a regulation NA-B further indicat specialized equipm R34 for tooth brush between teeth. When interviewed a registered nurse (Rappearance of the R34's room to find the able to locate a registered nurse) R34 may have discipated brush, LPN-A	left his room for breakfast e to offer assistance with tooth ed she did check with R34 d breakfast but he denied the sistance. NA-A stated staff with tooth brushing but R34 assistance. NA-A confirmed ge, R34 always uses a regular unsure what a proxi brush the NA assignment sheet. usually works as a restorative times, helps in the role of the she was doing that day. The ted that when she works as a assigned the 200 wing, where the past year. NA-B stated R34 his own teeth after staff set up ar toothbrush and toothpaste. The ted being unaware of any ent that was to be given to ing and/or cleaning in the son's brush but searched the device. RN-A was only ular toothbrush. RN-A stated arded the proxi brush. When LPN-A about the use of the unaware whether R34 used oth brush for oral care.	2 565			
		on 5/07/15, at 9:36 a.m. the DON) stated the dental office				

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00040	B. WING		05/0	7/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DIVINE F	PROVIDENCE COMMU	INITAHOME	O AVENUE N EYE, MN 560	ORTHWEST 085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	had sent a proxi broappointment on 12/recommendation for must have used all the dental office had additional brushes of stated it would have to communicate with no longer had them subsequent intervier confirmed she was been without the properties of the dentist, and was dental office had suppointment on 12/review and revise properties and revise properties of staff and develop a staff are providing of plan of care.	ush with R34 after a dental 18/14, after the or use. The DON stated R34 of the proxi brushes and so d been contacted now so that would be available. The DON be been the NA's responsibility the he nursing staff when R34 available. During a sew at 1:15 p.m., the DON unaware how long R34 had oxi brush recommended by a also unaware whether the applied more since the	2 565			
2 915		5 Subp. 6 A Rehab - ADLs	2 915			6/16/15
	comprehensive res home must ensure A. a resident is treatments and sen abilities in activities deterioration is a no	of daily living. Based on the ident assessment, a nursing that: given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this				

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00040	B. WING		05/0	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DIVINE F	PROVIDENCE COMMU	INITAHOME	O AVENUE N EYE, MN 560	ORTHWEST 085		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 915	part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	ss, and groom; d ambulate;	2 915			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the recommended oral hygiene supplies were made available for 1 of 1 resident (R34) reviewed for activities of daily living (ADL's).			Corrected		
	member (FM)-A sta R34 received the re care. FM-A indicate increased plaque b recent dental appoi be a problem.	on 5/5/15, at 10:27 a.m. family ated feeling unsure whether equired assistance with oral ed R34 had issues with uild-up per the dentist and with ntments this had continued to				
	was observed assist including oral care. positioned R34 (whim front of the bathmand applied toothpatoothbrush. NA-As sown teeth and she	a.m. nursing assistant (NA)-A sting R34 with morning cares Prior to brushing teeth, NA-A o was sitting in his wheelchair) oom sink, turned on the water, aste to R34's regular tated R34 liked to brush his would re-approach him later ed further assistance with the				

Minnesota Department of Health

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Minnesota Department of Health

_	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		00040	B. WING		05/	07/2015
	PROVIDER OR SUPPLIER	INITY HOME 700 THIS	DDRESS, CITY, S RD AVENUE N EYE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 915	teeth located in the the gumline. NA-A R34 shook his head "No". NA-A then exshe'd be back to che R34 was observed independently using history (hx) of a stroright side. Upon cotoothbrush, rinsed hurned off the water shave his face inderazor. When finish to exit his room at 7 during this observation assistance was required for alteration (r/t) carious (decaye extractions. The in assist/provide oral lindicated R34 had to use right arm, and the ability to product written), d/t history accident/stroke) in R34's NA assignment indicated: Per dent times per day) concorning between teeth. AM	back of the mouth and along asked R34 if he needed help. If from side to side, indicating sited R34's room indicating sited R34 resident's simpletion, R34 rinsed off his site mouth with water, and radiation. R34 then proceeded to pendently with an electric sed shaving, R34 was observed radiation. NA-A did not return tion to check whether further uired. The plan, last revised on radiation as a plan further identified a son in dental status related to sed teeth and history of terventions included to sed teeth and history of terventions included to sea plan also weakness in right leg, inability of earnessive aphasia (loss of se language, spoken or of CVA (cerebrovascular May 2012. The sheet, dated 5/5/15 sist, brush teeth 2 x/day (two centrating on gumline. Use I brush that resembles a mini i Christmas tree) to clean in	1			

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00040	B. WING		05/0	07/2015
	PROVIDER OR SUPPLIER	INITY HOME 700 THIR		STATE, ZIP CODE IORTHWEST 085		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 915	indicated R34's tiss and stressed brush gumline and using petween teeth. Doc areas of decay were progress note dated received treatment/ Nurses notes dated requested an appoil upper tooth pain an had updated the att this issue. When interviewed a confirmed R34 had before she was able brushing. NA-A stat after he had finishened for further assalways offer to help seldom allows staff that to her knowled toothbrush and was was as indicated or NA-A could not say any other device the clean in between hi usually works as a at times in the role she was doing that indicated that when usually assigned the R34. When interviewed of trained medication of the could medication of the could medicated that when usually assigned the R34.	sues were inflamed throughout ing 2 x/day concentrating on proxi brush to clean in cumentation also indicated 3 e noted. A subsequent dental d 1/19/15, indicated R34 fillings for the decayed areas. A 4/9/15, indicated that R34 intment due to complaints of id reddened gums and nursing tending physician regarding on 5/06/15, at 1:38 p.m. NA-A left his room for breakfast e to offer assistance with tooth ted she did check with R34 d breakfast but he denied the sistance. NA-A stated staff with tooth brushing but R34 assistance. NA-A confirmed ge, R34 always uses a regular to unsure what a proxi brush in the NA assignment sheet. Whether R34 had ever used an his regular toothbrush to steeth. NA-A indicated she restorative aide, but will help of the NA when needed, as day (5/6). NA-A further is she works as a NA, she is e 200 wing, the location of				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00040	B. WING		05/	07/2015	
	PROVIDER OR SUPPLIER	INITY HOME 700 THIS	DDRESS, CITY, STATE, ZIP CODE RD AVENUE NORTHWEST EYE, MN 56085				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 915	When interviewed of stated she worked shift with 200 and 3 assignments for the preferred to brush hand utilized a regulation NA-B further indical specialized equipm R34 for tooth brush between teeth. When interviewed or registered nurse (Rappearance of the R34's room to find able to locate a regulation R34 may have discensible to locate a regulation of the R34's room to find able to locate a regulation of the R34's room t	on 5/07/15, at 1:58 p.m. NA-B 4 days per week on the AM 900 wings as her primary e past year. NA-B stated R34 his own teeth after staff set up ar toothbrush and toothpaste. Ited being unaware of any ent that was to be given to ing and/or cleaning in on 5/06/15, at 2:09 p.m. N)-A was unaware of the proxi brush but searched the device. RN-A was only ular toothbrush. RN-A stated arded the proxi brush. When PN-A about the use of the was unaware whether R34 e of tooth brush for oral care. On 5/07/15, at 9:36 a.m. the (DON) stated the dental office ush with R34 after a dental (18/14, after the or use. The DON stated R34 of the proxi brushes and so d been contacted now so that would be available. The DON e been the NA's responsibility the the nursing staff when R34 available. During a sew at 1:15 p.m., the DON unaware how long R34 had oxi brush recommended by a also unaware whether the upplied more since the					

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00040	B. WING		05/0	7/2015	
	PROVIDER OR SUPPLIER	INITY HOME 700 THII	DDRESS, CITY, STATE, ZIP CODE RD AVENUE NORTHWEST EYE, MN 56085				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 915	The DON could aud and refer to the qua follow up. The DOI and procedres relat additional training to	dit oral cares for completion ality assurance committee for N could review/revise policies ted to oral care and provide	2 915				
21620	Drugs used in the n in accordance with	nursing home must be labeled	21620			6/16/15	
	by: Based on observatireview the facility fawere labeled according principles for 13 of R17, R20, R28, R3. R57) in the facility drops and insulin macility failed to ensure reconciled on time between actual	on, interview and document alled to ensure medications ding to accepted professional 16 residents (R1, R3, R9, 2, R33, R38, R41, R43, R46 & who received ear drops, eye redications. In addition, the ure controlled substances a daily basis to minimize the alloss or diversion and the mination of the extent of loss	k	Corrected			
	the medication cart noted that multiple insulin's bottles wer labeled boxes with individual bottles we	of the medication storage on s on 5/6/15, at 2:12 p.m. it wa eye drops, ear drops and re not kept in the original the original prescription. The ere labeled with a smaller nly included the name of the ug.	S				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00040	B. WING		05/0	7/2015
NAME OF I				STATE, ZIP CODE		.,
DIVINE E	PROVIDENCE COMMU	INITY HOME 700 THIRE	AVENUE N	ORTHWEST		
DIVINE		SLEEPY E	YE, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 11	21620			
21620	The following medic label which included instructions for use (1) R3, R17, R32, F Artificial tears eye (2) R9, R28 & R41-drops; (3) R46- bottles of Idrops; (4) R1- bottle of ea (5) R20- bottles of (6) R43 & R20- Lar and (7) Unlabeled Humdirector of nurses (R57. The facility narcotic lacked evidence of of the controlled sucupboard and which use (including emerical execution of the Controlled sucupboard and which use (including emerical execution of the Controlled sucupboard and which use (including emerical execution of the Controlled sucupboard and which use (including emerical execution of the Controlled sucupboard and which use (including emerical execution of the Controlled incompleted becember, 5 days in 10 days in July, 8 d May. Further review reconciliation form reconciled the daily When interviewed clicensed practical in	cations lacked a prescription of the date dispensed, and prescription (Rx) number: R33, R38 & R57- bottles of drops; bottles of Systane eyes Refresh and Genteal eye ar drops; Comtan & Lumigan eye drops; alog Quick pen- which the DON) identified belonged to a daily reconciliation by staff betances locked in the h were available for resident regency stock supply). Tolled II Medication Count at staff reconciliation did not ays in April, 10 days in March, and 7 days in January for year e documentation dated 2014 to counts for 18 days in in November, 10 days in September, 16 days in August, ays in June and 7 days in w of the documentation on the indicated that only one staff controlled II medication count.	21620			
	labeled box but the	medications were delivered in a medications are removed or to use and the original				

Minnesota Department of Health

STATE FORM PDMN11 If continuation sheet 12 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00040	B. WING		05/0	7/2015	
	PROVIDER OR SUPPLIER	INITY HOME 700 THIS	DDRESS, CITY, STATE, ZIP CODE D AVENUE NORTHWEST EYE, MN 56085				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21620	medication boxes a indicated the narcor cupboard are not ro daily narcotic count separately from the available for as need Medications noted in Roxanol (a concent hydrocodone (an operation of the consultant of	tree then discarded. LPN-A tics located in the emergency outinely counted as part of the since they are located in narcotic medications eded (PRN) daily use. In the emergency kit included: trated liquid morphine) and bioid pain medication); both full out an endication and bioid pain medication; both full out an endication and bioid pain medication; both full out and bioid pain medication; both full out and pain and bioid pain medication; both from the reported the smaller i.e. eye drops and insulin are to accepted standard of inal box. RPh indicated a placed on the bottle or vial resident's name, name of the find Rx number. The RPh findication with the original and been unaware the practice of the labeled box prior to tion and only use the minificable drug label. Interview on 5/7/15, at 9:25 pharmacist (RPh)-C indicated as required with each atton. RPh-C stated best the label to be attached to the all so the manufacturing label date is not obstructed. RPh-C ware medications were box with the original label and narcotics required no less					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00040	B. WING		05/0	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DIVINE I	PROVIDENCE COMMU	INITY HOME	D AVENUE N EYE, MN 560	ORTHWEST 085		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21620	daily, usually on evithe narcotic reconcreviewed, multiple of as completed and sexpectation was to this reconciliation. narcotics located in locked and should a medication reconcil requested but not perform the medication Administ that the medication times: 1) prior to repackage/container to removing the medication and the medication and the medication and the medication are staff related to the calculation and the director of nursication and proceed labels with the consperiodic audits of significant and the medication and proceed labels with the consperiodic audits of significant and the medication and proceed labels with the consperiodic audits of significant and the medication and proceed labels with the consperiodic audits of significant and the medication an	narcotics are reconciled twice ening and night shifts. When iliation documentation was days in April were not initialed she indicated the staff document the completion of The DON further indicated the athe emergency cupboard are also be counted daily. A liation policy/procedure was provided. The document the completion of the emergency cupboard are also be counted daily. A liation policy/procedure was provided. The document the daily is a second daily in the daily indicated also be read three emoving the medication from the cart/drawer; 2) prior	21620			

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