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

ID: PDMN
Facility ID: 00040

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245599**
2. STATE VENDOR OR MEDICAID NO. (L2) **356540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE COMMUNITY HOME**
(L4) **700 THIRD AVENUE NORTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA
02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF
03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC
04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **53** (L18)

13. Total Certified Beds **53** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
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
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/18/2015** (L33)

DETERMINATION APPROVAL

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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	(Y2) Multiple Construction	(Y3) Date of Revisit
245599	A. Building B. Wing	6/26/2015

Name of Facility	Street Address, City, State, Zip Code
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**06/16/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**06/16/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**06/16/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/kfd	06/26/2015	03048	06/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/7/2015			

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

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Facility ID: 00040

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(L4) **700 THIRD AVENUE NORTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/07/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/30**

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 06/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/18/2015 (L20)

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

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04-Other Reason for Withdrawal

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05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

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29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 06/18/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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;**
>
> **<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:

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

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

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING ______ B. WING ______	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care related to oral care for 1 of 1 resident (R34) reviewed for activities of daily living (ADL's). Findings include: Review of R34's care plan, last revised on 3/31/15 indicated R34 was independent with oral care after set-up with staff to assist prn (as needed). The care plan further identified a potential for alteration in dental status related to (r/t) carious (decayed) teeth and history of	F 282	On 5/6/2015 RN contacted dental clinic via telephone to notify that resident is out of proxy brushes. Dental clinic stated that they would send more for R 34 in the mail. Proxy brushes were received in the mail on 5/8/15 from the dental clinic. The Director of Nursing will review the policies and procedures related to ensuring the care plan for each resident is followed. All nursing staff will be re-educated on care giver sheets and the plan of care for individual residents. The charge nurses will do spot check audits to ensure the	6/16/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING ______ B. WING ______	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST** **SLEEPY EYE, MN 56085**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 extractions. The interventions included to assist/provide oral hygiene. The care plan also indicated R34 had weakness in right leg, inability to use right arm, and expressive aphasia (loss of the ability to produce language, spoken or written), d/t history of CVA (cerebrovascular accident/stroke) in May 2012. R34's NA assignment sheet, dated 5/5/15 indicated: Per dentist, brush teeth 2 x/day (two times per day) concentrating on gumline. Use proxi brush (a small brush that resembles a mini pipe cleaner or mini Christmas tree) to clean in between teeth. AM, PM. On 5/06/15, at 7:17 a.m. nursing assistant (NA)-A was observed assisting R34 with morning cares including oral care. Prior to brushing teeth, NA-A positioned R34 (who was sitting in his wheelchair) in front of the bathroom sink, turned on the water, and applied toothpaste to R34's regular toothbrush. NA-A stated R34 liked to brush his own teeth and she would re-approach him later and ask if he required further assistance with the teeth located in the back of the mouth and along the gumline. NA-A asked R34 if he needed help. R34 shook his head from side to side, indicating "No". NA-A then exited R34's room indicating she'd be back to check on him. R34 was observed to brush his teeth independently using his left hand only due to (d/t) history (hx) of a stroke affecting the resident's right side. Upon completion, R34 rinsed off his toothbrush, rinsed his mouth with water, and turned off the water. R34 then proceeded to shave his face independently with an electric razor. When finished shaving, R34 was observed to exit his room at 7:44 a.m.. NA-A did not return	F 282	plan of care is being followed. The charge nurse will provide education to the nursing assistants when the plan of care changes. The Staff Development RN, as designated by Director of Nursing will complete routine audits to determine nursing assistant competency. The Director of Nursing will oversee for overall compliance to ensure that the plan of care is being followed for each resident. Any concerns will be addressed at the weekly interdisciplinary team (IDT) meeting. Any unresolved concerns from IDT meeting will be discussed with the quality assurance team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING ______ B. WING ______	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 during this observation to check whether further assistance was required. R34's dental progress notes dated 12/18/14, indicated R34's tissues were inflamed throughout and stressed brushing 2 x/day, concentrating on gumline and using proxi brush to clean in between teeth. When interviewed on 5/06/15, at 1:38 p.m. NA-A confirmed R34 had left his room for breakfast before she was able to offer assistance with tooth brushing. NA-A stated she did check with R34 after he had finished breakfast but he denied the need for further assistance. NA-A stated staff always offer to help with tooth brushing but R34 seldom allows staff assistance. NA-A confirmed that to her knowledge, R34 always uses a regular toothbrush and was unsure what a proxi brush was as indicated on the NA assignment sheet. NA-A indicated she usually works as a restorative aide, but will help at times, help in the role of the NA when needed, as she was doing that day. NA-A further indicated that when she works as a NA, she is usually assigned the 200 wing, where R34 was located. When interviewed on 5/07/15, at 1:58 p.m. NA-B stated she worked 4 days per week on the morning shift with residents located on the 200 and 300 wings as her primary assignments for the past year. NA-B stated R34 preferred to brush his own teeth after staff set up and utilized a regular toothbrush and toothpaste. NA-B further indicated being unaware of any specialized equipment that was to be given to R34 for tooth brushing and/or cleaning in between teeth.	F 282		

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F 282	Continued From page 3 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. 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.	F 282		
F 311 SS=D	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		6/16/15

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DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085**

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F 311	Continued From page 4 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). Findings include: When interviewed on 5/5/15, at 10:27 a.m. family member (FM)-A stated feeling unsure whether R34 received the required assistance with oral care. FM-A indicated R34 had issues with increased plaque build-up per the dentist and with recent dental appointments this had continued to be a problem. On 5/06/15, at 7:17 a.m. nursing assistant (NA)-A was observed assisting R34 with morning cares including oral care. Prior to brushing teeth, NA-A positioned R34 (who was sitting in his wheelchair) in front of the bathroom sink, turned on the water, and applied toothpaste to R34's regular toothbrush. NA-A stated R34 liked to brush his own teeth and she would re-approach him later and ask if he required further assistance with the teeth located in the back of the mouth and along the gumline. NA-A asked R34 if he needed help. R34 shook his head from side to side, indicating "No". NA-A then exited R34's room indicating she'd be back to check on him. R34 was observed to brush his teeth independently using his left hand only due to (d/t) history (hx) of a stroke affecting the resident's right side. Upon completion, R34 rinsed off his toothbrush, rinsed his mouth with water, and turned off the water. R34 then proceeded to shave his face independently with an electric razor. When finished shaving, R34 was observed	F 311	On 5/6/2015 RN contacted dental clinic via telephone to notify that resident is out of proxy brushes. Dental clinic stated that they would send more for R 34 in the mail. Proxy brushes were received in the mail on 5/8/15 from the dental clinic. The Director of Nursing will review the policies and procedures related to ensuring the care plan for each resident is followed. All nursing staff will be re- educated that supplies must be available in order to provide the care accordingly for each individual resident. The charge nurses will do spot check audits to ensure the plan of care is being followed and to ensure the proper supplies are available. The charge nurse will provide education to the nursing assistants when the plan of care changes. The Staff Development RN, as designated by Director of Nursing will complete routine audits to determine nursing assistant competency. The Director of Nursing will oversee for overall compliance to ensure that the plan of care is being followed for each resident and that necessary supplies are readily available. Any concerns will be addressed with the quality assurance team.	

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F 311	Continued From page 5	F 311		

to exit his room at 7:44 a.m.. NA-A did not return during this observation to check whether further assistance was required.

Review of R34's care plan, last revised on 3/31/15 indicated R34 was independent with oral care after set-up with staff to assist prn (as needed). The care plan further identified a potential for alteration in dental status related to (r/t) carious (decayed) teeth and history of extractions. The interventions included to assist/provide oral hygiene. The care plan also indicated R34 had weakness in right leg, inability to use right arm, and expressive aphasia (loss of the ability to produce language, spoken or written), d/t history of CVA (cerebrovascular accident/stroke) in May 2012.

R34's NA assignment sheet, dated 5/5/15 indicated: Per dentist, brush teeth 2 x/day (two times per day) concentrating on gumline. Use proxi brush (a small brush that resembles a mini pipe cleaner or mini Christmas tree) to clean in between teeth. AM, PM.

R34's dental progress notes, dated 12/18/14 indicated R34's tissues were inflamed throughout and stressed brushing 2 x/day concentrating on gumline and using proxi brush to clean in between teeth. Documentation also indicated 3 areas of decay were noted. A subsequent dental progress note dated 1/19/15, indicated R34 received treatment/fillings for the decayed areas.

Nurses notes dated 4/9/15, indicated that R34 requested an appointment due to complaints of upper tooth pain and reddened gums and nursing had updated the attending physician regarding this issue.

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F 311	Continued From page 6	F 311		

When interviewed on 5/06/15, at 1:38 p.m. NA-A confirmed R34 had left his room for breakfast before she was able to offer assistance with tooth brushing. NA-A stated she did check with R34 after he had finished breakfast but he denied the need for further assistance. NA-A stated staff always offer to help with tooth brushing but R34 seldom allows staff assistance. NA-A confirmed that to her knowledge, R34 always uses a regular toothbrush and was unsure what a proxi brush was as indicated on the NA assignment sheet. NA-A could not say whether R34 had ever used any other device than his regular toothbrush to clean in between his teeth. NA-A indicated she usually works as a restorative aide, but will help at times in the role of the NA when needed, as she was doing that day (5/6). NA-A further indicated that when she works as a NA, she is usually assigned the 200 wing, the location of R34.

When interviewed on 5/07/15, at 1:55 p.m. trained medication aide (TMA)-A stated she did not usually work with R34 but to talk to NA-A as she worked with him often.

When interviewed on 5/07/15, at 1:58 p.m. NA-B stated she worked 4 days per week on the AM shift with 200 and 300 wings as her primary assignments for the past year. NA-B stated R34 preferred to brush his own teeth after staff set up and utilized a regular toothbrush and toothpaste. NA-B further indicated being unaware of any specialized equipment that was to be given to R34 for tooth brushing and/or cleaning in between teeth.

When interviewed on 5/06/15, at 2:09 p.m.

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F 311	Continued From page 7 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. 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, after the recommendation for use. The DON stated R34 must have used all of the proxi brushes and so 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.	F 311		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		6/16/15

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F 431	Continued From page 8 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were labeled according to accepted professional principles for 13 of 16 residents (R1, R3, R9, R17, R20, R28, R32, R33, R38, R41, R43, R46 & R57) in the facility who received ear drops, eye drops and insulin medications. In addition, the facility failed to ensure controlled substances were reconciled on a daily basis to minimize the time between actual loss or diversion and the detection and determination of the extent of loss or diversion.	F 431	Director of Nursing and RN Charge Nurse will ensure all residents affected will have proper medication labels on medication. All licensed nurses and TMAs were educated on proper medication labeling according to accepted professional principles at the meeting held on 5/21/15. Each prescription label must include the date dispensed, instructions for use, Rx number, name of resident and the physician¿s name. Nursing staff are expected to make sure that all	

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F 431	Continued From page 9 Findings include: During observation of the medication storage on the medication carts on 5/6/15, at 2:12 p.m. it was noted that multiple eye drops, ear drops and insulin's bottles were not kept in the original labeled boxes with the original prescription. The individual bottles were labeled with a smaller yellow strip which only included the name of the resident and the drug. The following medications lacked a prescription label which included the date dispensed, instructions for use and prescription (Rx) number: (1) R3, R17, R32, R33, R38 & R57- bottles of Artificial tears eye drops; (2) R9, R28 & R41- bottles of Systane eyes drops; (3) R46- bottles of Refresh and Genteal eye drops; (4) R1- bottle of ear drops; (5) R20- bottles of Comtan & Lumigan eye drops; (6) R43 & R20- Lantus and Novolog insulin vials; and (7) Unlabeled Humalog Quick pen- which the director of nurses (DON) identified belonged to R57. The facility narcotics medication documents lacked evidence of a daily reconciliation by staff of the controlled substances locked in the cupboard and which were available for resident use (including emergency stock supply). Review of the Controlled II Medication Count record indicated that staff reconciliation did not occur daily for 10 days in April, 10 days in March, 2 days in February and 7 days in January for year 2015. Review of the documentation dated 2014 identified incomplete counts for 18 days in December, 5 days in November, 10 days in	F 431	medications have a proper label. If eye drops, insulins or other medications do not have a full label attached to the bottle, then the staff must maintain the box or full label with the medication to meet the requirements. The Policy: Pharmaceutical Control and Accountability was revised to indicate proper medication labeling and will be reviewed by Consulting Pharmacist. Director of Nursing will do audits of medications in the cart and medication room to ensure proper labeling. Consulting pharmacist will continue to inspect the medication carts and medication room on a quarterly basis to ensure compliance. Any concerns will be addressed with the quality assurance team. All nursing staff has received education in accordance with State and Federal laws, that the facility must store drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The policy: Pharmaceutical Control and Accountability has been revised to ensure that controlled medications are reconciled accurately. Controlled medications must be reconciled at least once every 24 hours. The Director of Nursing revised the log to reflect that each unit controlled medications as well as emergency controlled medications are reconciled daily. The Charge Nurse will monitor log daily to ensure compliance of reconciliation of controlled medications. The Director of Nursing will oversee for	

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F 431	Continued From page 10 October, 6 days in September, 16 days in August, 10 days in July, 8 days in June and 7 days in May. Further review of the documentation on the reconciliation form indicated that only one staff reconciled the daily controlled II medication count. When interviewed on 5/6/15, at 2:12 p.m. licensed practical nurse (LPN)-A reported the eye drops and insulin medications were delivered in a labeled box but the medications are removed from the boxes prior to use and the original medication boxes are then discarded. LPN-A indicated the narcotics located in the emergency cupboard are not routinely counted as part of the daily narcotic count since they are located separately from the narcotic medications available for as needed (PRN) daily use. Medications noted in the emergency kit included: Roxanol (a concentrated liquid morphine) and hydrocodone (an opioid pain medication); both classified as schedule II controlled substances (drugs with a high potential for abuse and/or diversion). During a telephone interview on 5/7/15, at 9:00 a.m. the registered pharmacist (RPh) from Randy's Family Drug reported the smaller medication bottles, i.e. eye drops and insulin are labeled according to accepted standard of practice on the original box. RPh indicated a yellow mini label is placed on the bottle or vial which included the resident's name, name of the medication, date and Rx number. The RPh indicated the expectation would be to maintain the vials/bottles of medication with the original labeled box. She had been unaware the practice had been to discard the labeled box prior to resident administration and to use only the mini label as the acceptable label.	F 431	compliance for medication reconciliation of controlled medications. Any concerns will be addressed with the quality assurance team.	

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F 431	Continued From page 11 During a telephone interview on 5/7/15, at 9:25 a.m. the consultant pharmacist (RPh)-C indicated a complete label was required with each prescription medication. RPh-C stated best practice required the label to be attached to the medication bottle/vial so the manufacturing label with the expiration date is not obstructed. RPh-C stated he was unaware medications were removed from the box with the original label and further verified that narcotics required no less than daily reconciliation. When interviewed on 5/7/15, at 10:00 a.m. the DON indicated that narcotics are reconciled twice daily, usually on evening and night shifts. When the narcotic reconciliation documentation was reviewed, multiple days in April were not initialed as completed and she indicated the staff expectation was to document the completion of this reconciliation. The DON further indicated the narcotics located in the emergency cupboard are locked and should also be counted daily. A medication reconciliation policy/procedure was requested but not provided. Review of the procedure titled Specific Medication Administration Procedures indicated that the medication label would be read three times: 1) prior to removing the medication package/container from the cart/drawer; 2) prior to removing the medication from the package/container; 3) as the package/container is returned to the cart/drawer. Compare label to MAR (medication administration record).	F 431		

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

F5599024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/06/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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. 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	K 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Rooms. The facility has a capacity of 53 beds and had a census of 45 at time of the survey.	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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00040	A. BUILDING: ____ B. WING ____	05/07/2015

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DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 5/4, 5/5, 5/6 and 5/7/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the plan of care related to oral care for 1 of 1 resident (R34) reviewed for activities of daily living (ADL's). Findings include: Review of R34's care plan, last revised on 3/31/15 indicated R34 was independent with oral care after set-up with staff to assist prn (as needed). The care plan further identified a potential for alteration in dental status related to (r/t) carious (decayed) teeth and history of extractions. The interventions included to assist/provide oral hygiene. The care plan also indicated R34 had weakness in right leg, inability to use right arm, and expressive aphasia (loss of the ability to produce language, spoken or written), d/t history of CVA (cerebrovascular accident/stroke) in May 2012. R34's NA assignment sheet, dated 5/5/15	2 565	Corrected	6/16/15

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2 565	Continued From page 3	2 565		

indicated: Per dentist, brush teeth 2 x/day (two times per day) concentrating on gumline. Use proxi brush (a small brush that resembles a mini pipe cleaner or mini Christmas tree) to clean in between teeth. AM, PM.

On 5/06/15, at 7:17 a.m. nursing assistant (NA)-A was observed assisting R34 with morning cares including oral care. Prior to brushing teeth, NA-A positioned R34 (who was sitting in his wheelchair) in front of the bathroom sink, turned on the water, and applied toothpaste to R34's regular toothbrush. NA-A stated R34 liked to brush his own teeth and she would re-approach him later and ask if he required further assistance with the teeth located in the back of the mouth and along the gumline. NA-A asked R34 if he needed help. R34 shook his head from side to side, indicating "No". NA-A then exited R34's room indicating she'd be back to check on him.

R34 was observed to brush his teeth independently using his left hand only due to (d/t) history (hx) of a stroke affecting the resident's right side. Upon completion, R34 rinsed off his toothbrush, rinsed his mouth with water, and turned off the water. R34 then proceeded to shave his face independently with an electric razor. When finished shaving, R34 was observed to exit his room at 7:44 a.m.. NA-A did not return during this observation to check whether further assistance was required.

R34's dental progress notes, dated 12/18/14 indicated R34's tissues were inflamed throughout and stressed brushing 2 x/day concentrating on gumline and using proxi brush to clean in between teeth.

When interviewed on 5/06/15, at 1:38 p.m. NA-A

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2 565	Continued From page 4	2 565		

confirmed R34 had left his room for breakfast before she was able to offer assistance with tooth brushing. NA-A stated she did check with R34 after he had finished breakfast but he denied the need for further assistance. NA-A stated staff always offer to help with tooth brushing but R34 seldom allows staff assistance. NA-A confirmed that to her knowledge, R34 always uses a regular toothbrush and was unsure what a proxi brush was as indicated on the NA assignment sheet. NA-A indicated she usually works as a restorative aide, but will help at times, helps in the role of the NA when needed as she was doing that day. NA-A further indicated that when she works as a NA, she is usually assigned the 200 wing, where R34 was located.

When interviewed on 5/07/15, at 1:58 p.m. NA-B stated she worked 4 days per week on the AM shift with 200 and 300 wings as her primary assignments for the past year. NA-B stated R34 preferred to brush his own teeth after staff set up and utilized a regular toothbrush and toothpaste. NA-B further indicated being unaware of any specialized equipment that was to be given to R34 for tooth brushing and/or cleaning in between teeth.

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 unaware whether R34 used any other type of tooth brush for oral care.

When interviewed on 5/07/15, at 9:36 a.m. the director of nursing (DON) stated the dental office

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2 565	Continued From page 5 had sent a proxi brush with R34 after a dental appointment on 12/18/14, after the recommendation for use. The DON stated R34 must have used all of the proxi brushes and so 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this	2 915		6/16/15

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2 915	Continued From page 6 part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and 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). Findings include: When interviewed on 5/5/15, at 10:27 a.m. family member (FM)-A stated feeling unsure whether R34 received the required assistance with oral care. FM-A indicated R34 had issues with increased plaque build-up per the dentist and with recent dental appointments this had continued to be a problem. On 5/06/15, at 7:17 a.m. nursing assistant (NA)-A was observed assisting R34 with morning cares including oral care. Prior to brushing teeth, NA-A positioned R34 (who was sitting in his wheelchair) in front of the bathroom sink, turned on the water, and applied toothpaste to R34's regular toothbrush. NA-A stated R34 liked to brush his own teeth and she would re-approach him later and ask if he required further assistance with the	2 915	Corrected	

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2 915	Continued From page 7	2 915		

teeth located in the back of the mouth and along the gumline. NA-A asked R34 if he needed help. R34 shook his head from side to side, indicating "No". NA-A then exited R34's room indicating she'd be back to check on him.

R34 was observed to brush his teeth independently using his left hand only due to (d/t) history (hx) of a stroke affecting the resident's right side. Upon completion, R34 rinsed off his toothbrush, rinsed his mouth with water, and turned off the water. R34 then proceeded to shave his face independently with an electric razor. When finished shaving, R34 was observed to exit his room at 7:44 a.m.. NA-A did not return during this observation to check whether further assistance was required.

Review of R34's care plan, last revised on 3/31/15 indicated R34 was independent with oral care after set-up with staff to assist prn (as needed). The care plan further identified a potential for alteration in dental status related to (r/t) carious (decayed) teeth and history of extractions. The interventions included to assist/provide oral hygiene. The care plan also indicated R34 had weakness in right leg, inability to use right arm, and expressive aphasia (loss of the ability to produce language, spoken or written), d/t history of CVA (cerebrovascular accident/stroke) in May 2012.

R34's NA assignment sheet, dated 5/5/15 indicated: Per dentist, brush teeth 2 x/day (two times per day) concentrating on gumline. Use proxi brush (a small brush that resembles a mini pipe cleaner or mini Christmas tree) to clean in between teeth. AM, PM.

R34's dental progress notes, dated 12/18/14

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2 915	Continued From page 8	2 915		

indicated R34's tissues were inflamed throughout and stressed brushing 2 x/day concentrating on gumline and using proxi brush to clean in between teeth. Documentation also indicated 3 areas of decay were noted. A subsequent dental progress note dated 1/19/15, indicated R34 received treatment/fillings for the decayed areas.

Nurses notes dated 4/9/15, indicated that R34 requested an appointment due to complaints of upper tooth pain and reddened gums and nursing had updated the attending physician regarding this issue.

When interviewed on 5/06/15, at 1:38 p.m. NA-A confirmed R34 had left his room for breakfast before she was able to offer assistance with tooth brushing. NA-A stated she did check with R34 after he had finished breakfast but he denied the need for further assistance. NA-A stated staff always offer to help with tooth brushing but R34 seldom allows staff assistance. NA-A confirmed that to her knowledge, R34 always uses a regular toothbrush and was unsure what a proxi brush was as indicated on the NA assignment sheet. NA-A could not say whether R34 had ever used any other device than his regular toothbrush to clean in between his teeth. NA-A indicated she usually works as a restorative aide, but will help at times in the role of the NA when needed, as she was doing that day (5/6). NA-A further indicated that when she works as a NA, she is usually assigned the 200 wing, the location of R34.

When interviewed on 5/07/15, at 1:55 p.m. trained medication aide (TMA)-A stated she did not usually work with R34 but to talk to NA-A as she worked with him often.

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2 915	Continued From page 9	2 915		

When interviewed on 5/07/15, at 1:58 p.m. NA-B stated she worked 4 days per week on the AM shift with 200 and 300 wings as her primary assignments for the past year. NA-B stated R34 preferred to brush his own teeth after staff set up and utilized a regular toothbrush and toothpaste. NA-B further indicated being unaware of any specialized equipment that was to be given to R34 for tooth brushing and/or cleaning in between teeth.

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.

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, after the recommendation for use. The DON stated R34 must have used all of the proxi brushes and so 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.

SUGGESTED METHOD OF CORRECTION:

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2 915	Continued From page 10 The DON could audit oral cares for completion and refer to the quality assurance committee for follow up. The DON could review/revise policies and procedres related to oral care and provide additional training to staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were labeled according to accepted professional principles for 13 of 16 residents (R1, R3, R9, R17, R20, R28, R32, R33, R38, R41, R43, R46 & R57) in the facility who received ear drops, eye drops and insulin medications. In addition, the facility failed to ensure controlled substances were reconciled on a daily basis to minimize the time between actual loss or diversion and the detection and determination of the extent of loss or diversion. Findings include: During observation of the medication storage on the medication carts on 5/6/15, at 2:12 p.m. it was noted that multiple eye drops, ear drops and insulin's bottles were not kept in the original labeled boxes with the original prescription. The individual bottles were labeled with a smaller yellow strip which only included the name of the resident and the drug.	21620	Corrected	6/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00040	A. BUILDING: ______ B. WING ______	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	**700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085**

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21620	Continued From page 11 The following medications lacked a prescription label which included the date dispensed, instructions for use and prescription (Rx) number: (1) R3, R17, R32, R33, R38 & R57- bottles of Artificial tears eye drops; (2) R9, R28 & R41- bottles of Systane eyes drops; (3) R46- bottles of Refresh and Genteal eye drops; (4) R1- bottle of ear drops; (5) R20- bottles of Comtan & Lumigan eye drops; (6) R43 & R20- Lantus and Novolog insulin vials; and (7) Unlabeled Humalog Quick pen- which the director of nurses (DON) identified belonged to R57. The facility narcotics medication documents lacked evidence of a daily reconciliation by staff of the controlled substances locked in the cupboard and which were available for resident use (including emergency stock supply). Review of the Controlled II Medication Count record indicated that staff reconciliation did not occur daily for 10 days in April, 10 days in March, 2 days in February and 7 days in January for year 2015. Review of the documentation dated 2014 identified incomplete counts for 18 days in December, 5 days in November, 10 days in October, 6 days in September, 16 days in August, 10 days in July, 8 days in June and 7 days in May. Further review of the documentation on the reconciliation form indicated that only one staff reconciled the daily controlled II medication count. When interviewed on 5/6/15, at 2:12 p.m. licensed practical nurse (LPN)-A reported the eye drops and insulin medications were delivered in a labeled box but the medications are removed from the boxes prior to use and the original	21620		

Minnesota Department of Health

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	00040	A. BUILDING: ______ B. WING ______	05/07/2015

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21620	Continued From page 12 medication boxes are then discarded. LPN-A indicated the narcotics located in the emergency cupboard are not routinely counted as part of the daily narcotic count since they are located separately from the narcotic medications available for as needed (PRN) daily use. Medications noted in the emergency kit included: Roxanol (a concentrated liquid morphine) and hydrocodone (an opioid pain medication); both classified as schedule II controlled substances (drugs with a high potential for abuse and/or diversion). During a telephone interview on 5/7/15, at 9:00 a.m. the registered pharmacist (RPh) from Randy's Family Drug reported the smaller medication bottles, i.e. eye drops and insulin are labeled according to accepted standard of practice on the original box. RPh indicated a yellow mini label is placed on the bottle or vial which included the resident's name, name of the medication, date and Rx number. The RPh indicated the expectation would be to maintain the vials/bottles of medication with the original labeled box. She had been unaware the practice had been to discard the labeled box prior to resident administration and only use the mini label as the acceptable drug label. During a telephone interview on 5/7/15, at 9:25 a.m. the consultant pharmacist (RPh)-C indicated a complete label was required with each prescription medication. RPh-C stated best practice required the label to be attached to the medication bottle/vial so the manufacturing label with the expiration date is not obstructed. RPh-C stated he was unaware medications were removed from the box with the original label and further verified that narcotics required no less than daily reconciliation. When interviewed on 5/7/15, at 10:00 a.m. the	21620		

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21620	Continued From page 13	21620		

DON indicated that narcotics are reconciled twice daily, usually on evening and night shifts. When the narcotic reconciliation documentation was reviewed, multiple days in April were not initialed as completed and she indicated the staff expectation was to document the completion of this reconciliation. The DON further indicated the narcotics located in the emergency cupboard are locked and should also be counted daily. A medication reconciliation policy/procedure was requested but not provided.

Review of the procedure titled Specific Medication Administration Procedures indicated that the medication label would be read three times: 1) prior to removing the medication package/container from the cart/drawer; 2) prior to removing the medication from the package/container; 3) as the package/container is returned to the cart/drawer. Compare label to MAR (medication administration record).

SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education to staff related to medication labeling requirements. The director of nursing could revise/review policies and procedures related to medication labels with the consultant pharmacist and conduct periodic audits of staff to monitor for compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.