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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RQMT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00593

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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 :
Chris Campbell, HFE NEII 05/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/21/2015 (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
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/23/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245483

May 21, 2015

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

Dear Ms. Krattenmaker:

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

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

Effective May 5, 2015 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 18, 2015

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

RE: Project Number S5483024

Dear Ms. Krattenmaker:

On April 7, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 26, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 12, 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 March 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 5, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 26, 2015, effective May 5, 2015 and therefore remedies outlined in our letter to you dated April 7, 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 related to this eNotice.

Sincerely,

Mark Meath

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245483	A. Building B. Wing	5/12/2015

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0170** Reg. # **483.10(i)(1)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **05/05/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/05/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** CC/mm	**Date:** 05/18/2015	**Signature of Surveyor:** 13922	**Date:** 05/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/26/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RQMT

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(L3) **ST ELIGIUS HEALTH CENTER**
(L4) **7700 GRAND AVENUE**
(L5) **DULUTH, MN** (L6) **55807**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/26/2015** (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)
09/30

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From (a) :
To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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 :
Teresa Ament, HFE NEII — 04/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/22/2015 (L20)

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

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_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :
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05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/23/2015 Co. Reposted 04/24/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

April 7, 2015

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

RE: Project Number S5483024

Dear Ms. Krattenmaker:

On March 26, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 5, 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 June 26, 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 September 26, 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.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5483s15

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
	245483	A. BUILDING _____ B. WING _____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. 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 March 23-26, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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	F 000		

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

Electronically Signed | 04/16/2015

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
	245483	A. BUILDING _____ B. WING _____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	F 000		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently deliver mail on Saturday. This had the potential to effect all 60 of 60 residents in the facility. Findings include: R79's quarterly Minimum Data Set (MDS) dated 2/2/15, indicated she was cognitively intact. R79's cognition care plan dated 1/1/15, indicated she was alert and oriented to person, place, time and event. The care plan further indicated she was independent in her decision making skills.	F 170	F170 It is the policy of St. Eligius Health Center to ensure residents have the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. The facility will deliver mail to R79 and R1 as well as all other residents each day it is delivered to the facility by the United States Postal Service. All staff will be educated on this process during department meetings by May 15, 2015. An audit form has been developed to	5/5/15

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	245483	A. BUILDING _____ B. WING _____	03/26/2015

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

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F 170	Continued From page 2 On 3/25/15, at approximately 2:15 p.m. R79 stated that not getting mail on Saturday is her "pet peeve." R79 stated that mail comes to the facility on Saturday but does not get delivered to residents. R79 stated that "once in a great while" it will get delivered to residents. One time she was expecting an invitation and asked a staff person about getting the mail. The staff person told R79 that she didn't have time to sort the mail, as she was working on the facility rummage sale. R79 did not know who the staff person was. R79 stated that the incident made her feel that the rummage sale was more important than her. She stated there was an invitation in there that she did not get until Monday. R79 stated, "I didn't go because I didn't get it until Monday." R1's quarterly MDS dated 3/9/15, indicated R1 had was cognitively intact. R1's cognition care plan indicated she was alert and oriented to person, place, time and event. Her long and short term memory were assessed to be intact and she was independent in her decision making skills. On 3/26/15, at 8:46 a.m. R1 stated that mail is delivered Monday through Friday and that residents don't get mail on weekends. On 3/26/15, at 9:54 a.m. the activities director (AD)-A stated that activities staff deliver resident mail, except on weekends. AD-D stated activities staff don't have access to the mail on weekends. She continued, "I believe the nursing staff delivers on weekends." On 03/26/15, at 1:33 p.m. the director of nursing	F 170	ensure prompt delivery each day of the week. This audit will be conducted weekly X 4 weeks, every other week X 1 month, and monthly X 3. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-5-15	

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F 170	Continued From page 3 (DON) stated activities staff generally deliver the mail on weekends. The DON stated if activities staff are not at the facility on Saturday then it goes on the desk. The DON thought a volunteer delivered the mail if they were at the facility. A policy was provided by the facility that stated nursing staff will sort the mail on Saturdays and mail is delivered by nursing staff or service workers.	F 170		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure privacy was maintained for 1 of 1 residents (R1) who was observed during a blood glucose monitoring procedure. Findings include: On 3/24/15, at 4:30 p.m. R1 was in the hallway receiving her medication from licensed practical nurse (LPN)-A. R1 was about to leave when the LPN stated, "wait, I need to get your blood sugar." There were two other residents in the hall near the medication cart. The LPN then cleansed R1's finger with an alcohol wipe, poked R1's finger, obtained the blood sample and told R1 her blood sugar was 195. R1 was not asked for permission to complete the procedure in the hall where	F 241	F241 It is the policy of St. Eligius Health Center to promote care for residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. The facility will ensure staff provide R1 and all other residents□ privacy for all procedures. All nursing staff will be educated on this process during department meetings by May 15, 2015. An audit tool has been developed to ensure compliance and will be conducted weekly X 4, biweekly X 1 month, and monthly X 3 months. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency.	5/5/15

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F 241	Continued From page 4 privacy could be provided. R1 was returned to her room where she received her insulin. LPN-A stated she takes R1 back to her room to give insulin. LPN-A verified blood sugar checks should not be done in the hall but was hurried, and added she preferred to do them in the resident's room. On 3/25/14, at 1:00 p.m. registered nurse (RN)-A stated blood glucose checks should be done in a private area, not in the hall.	F 241	Completion Date: 5-5-15	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess, identify and provide interventions to prevent the development of pressure ulcers for 2 of 3 residents (R80, R73) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel)	F 314	F314 It is the policy of St. Eligius Health Center to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual□s clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from	5/5/15

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F 314	Continued From page 5 Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage III: Full thickness skin loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Stage III pressure ulcer varies by anatomical location. Bone/tendon is not visible or directly palpable. Stage IV: Full thickness tissue loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint). R80 was admitted to the facility on 12/2/14. R80's face sheet identified diagnoses that included congestive heart failure and chronic kidney disease. R80's admission Minimum Data Set (MDS) dated 12/8/14, indicated R80 was cognitively intact, required extensive assistance of two staff for bed mobility, toileting and personal hygiene, and extensive assistance of one staff for dressing. The MDS further identified R80 was at risk for pressure ulcers, and had a Stage II pressure ulcer that was present on admission.	F 314	developing. R80 has had a skin assessment with measurements of her wound and will continue to have weekly measurements taken. Further intervention recommendations are discussed with the IDT with orders provided by medical providers. She will continue on hourly repositioning, the use of pressure reduction cushion in w/c and air flow pressure reduction mattress in bed. All other residents will have admission skin assessments that detail areas outside of normal limits with measurements and staging as applicable. Residents will have a tissue tolerance completed to determine an individualized repositioning schedule. An audit has been developed to ensure completion of skin assessments, and weekly wound assessments with measurements. This will be conducted weekly X 4, biweekly for 1 month, and monthly for 3 months. All nursing staff will be educated on this process during department meetings by May 15, 2015. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-5-15	

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F 314	Continued From page 6 R80's Admission Skin Assessment dated 12/2/14, indicated R80 was at moderate risk for skin breakdown, and had no redness noted to coccyx. The assessment further identified R82 had a 2.5 centimeter (cm) "slit" on the coccyx area. The area was not staged. R80 was placed on hourly repositioning, and the facility would continue to monitor. On 12/3/14, the progress notes identified R80 had a reddened area above the coccyx, and had pain in that area measuring 7 out of 10 (10 would be the worst pain). R80 remained on hourly repositioning. On 12/4/14, the facility added an air flow pressure reduction mattress to the bed, and a seat cushion for the wheelchair. On 12/8/14, the progress notes identified an open area to the coccyx measuring 2.1 cm x 1.5 cm (area was not staged). On 12/23/14, the progress notes identified the open area as a Stage II pressure ulcer measuring 1.5 cm x 2.0 cm x 0.2 cm. The progress notes identified the worsening of the pressure ulcer, and on 1/6/15, the pressure ulcer was identified as a Stage III pressure ulcer. R80's pressure ulcer continued to deteriorate, with progress notes identifying measurements of 2.5 cm x 4.4 cm x 2.4 cm on 2/7/15. On 2/27/15, the progress notes indicated the pressure ulcer was 5.6 cm x 4.4 cm x 2 cm. On 3/23/15, the pressure ulcer measured 2.5 cm x 3.5 cm, with 1 cm of tunneling at 12 o'clock, and 0.5 cm of tunneling at 5 o'clock. On 3/24/15, at 4:10 p.m. R80 was observed in her bed, lying on her back. R80's bed had an air flow pressure reduction mattress, and her wheelchair had a pressure reduction cushion.	F 314		

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F 314	Continued From page 7 On 3/26/15, at 1:58 p.m. registered nurse (RN)-A was interviewed and stated she would have expected the staff to do an initial skin assessment. If a pressure ulcer was identified, staff should put the resident on an hourly repositioning program, and discuss the pressure ulcer weekly at the skin team meeting. RN-A would also expect documentation and staging be done on a weekly basis. RN-A stated it was not done for R80. R73 was admitted to the facility on 10/6/15, with diagnoses that included acute respiratory failure, anemia and hypertension. R73's admission MDS dated 10/12/14, identified R73 required extensive assistance with bed mobility and transfers. The MDS further indicated R73 had a Stage 1 pressure ulcer, and was at risk for the development of a pressure ulcer. During the closed record review, R73's progress notes dated 10/6/14, indicated R73 was at risk for skin breakdown, and had redness on the coccyx. On 10/7/14, the progress notes indicated R73 had an open area to the right buttock that appeared to be pressure or shear. The pressure ulcer was not measured or staged. On 10/19/14, the progress notes indicated R73 was at medium risk for skin breakdown, and further described R73's coccyx area to be slightly red, with several small round spots just above the coccyx area. The pressure ulcer was not measured or staged. On 12/2/14, the progress notes indicated the area to the right buttock was resolved. Weekly monitoring of the pressure ulcer had not been completed. R73's care plan dated 10/24/14, indicated R73's skin was intact, with areas of concern as follows:	F 314		

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F 314	Continued From page 8 coccyx noted to be slightly reddened. The care plan further identified R73 had a pressure reduction mattress on the bed, and a pressure reduction cushion in the wheelchair, and staff was to reposition every two hours. On 3/25/15, at 1:48 p.m. RN-D was interviewed and stated she coded the pressure ulcer as a Stage I on the MDS because it was described in the progress notes as a Stage I pressure ulcer. On 3/25/15, at 12:33 p.m. RN-C was interviewed and stated she would expect staff to monitor a pressure ulcer daily, document on the pressure ulcer, and assess and determine the cause of the pressure ulcer. RN-C stated she was unable to determine why R73's pressure ulcer was not assessed and documented on consistently. The facility policy and procedure on Skin Risk Assessment undated, directs staff to complete a skin inspection and Braden Scale (used to determine if a resident is at risk for the development of pressure ulcers) within 8 hours of admission. If a pressure ulcer is observed, the facility is to review all skin conditions weekly with the skin integrity/wound team.	F 314		
F 431 SS=D	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		5/5/15

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F 431	Continued From page 9 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 medication labels were accurate for 3 of 4 residents (R31, R110, R1) who were reviewed for medication administration. Findings include: R31 was observed during a medication pass on 3/23/15, at 7:53 a.m.. The registered nurse (RN)-B administered 3 units (u) of Lantus insulin	F 431	F431 It is the policy of St. Eligius Health Center to have drugs and biologicals used in the facility labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. R31□s Lantus insulin has been relabeled. R10□s medications have been relabeled. R1□s Novolog has been relabeled. An	

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F 431	Continued From page 10 to R31. The medication label directed staff to administer 4 u at bedtime. The electronic medication administration record (EMAR) was reviewed with RN-B. The RN verified the medication label did not match the EMAR. The RN stated, "I'm guessing there are separate insulin pens for the morning and bedtime doses." The RN looked through the medication cart and did not find another insulin pen for R31. R31's Physician Order Report signed on 2/19/15, directed staff to give Lantus insulin 3 u in the morning. The orders did not include a bedtime dose of insulin. R110 was observed during a medication pass on 3/24/15, at 4:10 p.m.. Licensed practical nurse (LPN)-A administered all medications via a gastric feeding tube (PEG). The medication labels directed staff to administer as follows: - satalol 80 milligrams (mg) twice a day - warfarin five mg by mouth on Monday, Tuesday, Wednesday, Saturday and Sunday - Prevacid 30 mg via g-tube twice a day The EMAR directed the warfarin to be given orally, the satalol and the Prevacid via gastric tube. In addition, all of R110's medication cards in the medication cart were reviewed with LPN-A. The following medication directed staff to give orally: Four cards of diltiazem 90 mg Two cards of risperdone 0.25 mg One card of simvastatin 40 mg One card of warfarin 2.5 mg Two cards of warfarin 5 mg One card of digoxin 0.125 mg One card of Lasix 20 mg	F 431	audit was conducted on 4/17/15 for all medication storage to ensure medication orders and labels are congruent. An audit has been developed to ensure continued proper medication labels and orders. The audit will be conducted weekly X 4, biweekly for 1 month, and monthly for 1 month. All nursing staff will be educated on this process during department meetings by May 15, 2015. Results will be provided to QA Committee (including the Medical Director) to determine further audit necessity and frequency. Completion Date: 5-5-15	

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F 431	Continued From page 11 Two cards of satalol 80 mg The EMAR and the Physician Order Report signed 3/11/15, also directed nothing by mouth (NPO) all nutrition and medications via PEG tube. R1 was observed during a medication pass on 3/24/15, at 4:30 p.m.. LPN-A administered 6 u of Novolog insulin to R1. The medication label directed staff to administer 6 u at breakfast and lunch and 4 u at supper. The EMAR was reviewed with LPN-A and she verified the medication label did not match the EMAR. The LPN stated if she noticed a medication label did not match the EMAR she would call the pharmacy and place a sticker on the medication stating the directions had changed. R1's current Physician Order Report signed on 2/3/15, directed staff to administer Novolog insulin 6 u three times a day at 8:00 a.m., 12:00 p.m. and 5:00 p.m. On 3/25/14, at 1:00 p.m. RN-A stated the medication label should match the EMAR and the physician's order. RN-A would expect staff to update the pharmacy when an order is changed and place a sticker on the medication indicating the directions had changed. In addition, RN-A stated if a resident was NPO and received all of the medications via a gastric tube the medication label should include the correct route of administration. The facility's Labeling of Medication Containers policy revised 4/07, indicated any medication packaging or containers that were inadequately or improperly labeled where to be returned to the pharmacy.	F 431		

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Eligius Health Center was found 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. St. Eligius Health Center is a 2-story building with a fulll basement. The building was constructed at 2 different times. The original building was constructed in 1971 with an addition in 2005. Both buildings are type II (111) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building, the 2005 building is support services only. The building is fully sprinkler protected, by a complete automatic fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 70 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	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.