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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RWW8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00675

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245487**

2.STATE VENDOR OR MEDICAID NO.
(L2) **394347000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ELIZABETH MEDICAL CENTER**
(L4) **1200 FIFTH GRANT BOULEVARD WEST**
(L5) **WABASHA, MN** (L6) **55981**

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 **09/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **100** (L18)

13.Total Certified Beds **100** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(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 :
Kyla Einertson, HFE NE II 10/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/05/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/14/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 3, 2014

Mr. Tom Crowley, Administrator
St Elizabeth Medical Center
1200 Fifth Grant Boulevard West
Wabasha, Minnesota 55981

RE: Project Number S5487026

Dear Mr. Crowley:

On September 18, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 October 28, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 28, 2014 the following remedy will be imposed:

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

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.

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 December 18, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting 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 electronic 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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
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
	245487	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate the height of the dining table for 1 of 1 resident (R41) who dining table height was at a level that prevented them from eating in a comfortable manner. Findings include: Observation of R41 in the main dining room on	F 246	R41 Corrective actions: 9/18/14 DON addressed concern with R41 to inquire and observe resident sitting in w/c. Identified limitation in ROM of upper extremities due to armrest height. -Care conference was done 9/17/14 with R41 in attendance, nutrition was addressed and new intervention implemented was built up utensils, in addition to divided plate related to	10/10/14

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

Electronically Signed | 10/10/2014

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F 246	Continued From page 1 9/15/14, at 5:30 p.m. noted she was served a chicken salad croissant on a plate. R41 had difficulty reaching her arms/hands up to the table as she attempted to cut the croissant in half. Her plate was teetering on the edge of the table, but did not fall onto her lap. She was able to pick up one half of the sandwich and consumed most of it. R41 was noted to have a noticeable curve of the spin (kyphotic-posture) and her eyes were at the same level as the top of the table. During another observation of R41 in the dining room on 9/17/14, at 12:10 p.m. identified that R41 again was seated at a table in the dining room where her eyes were at the level of the top of the table and she had to lift her elbows high in the air to get her hand to the food located on the table. Interview with R41 on 9/17/14, at 12:20 p.m. verified that she had difficulty reaching and eating her food and fluids due to the height of the table where she was seated and stated that she would like to eat at a table where she was able to see the food items in the dishes and be able to reach her food and fluids without difficulty. R41 added that the table she was seated at was too high for her to access her food and fluids without spilling. Review of the significant change Minimum Data Set (MDS) dated 9/7/14 verified that R41 had a brief interview of mental status (BIMS) score of 15 which indicated intact cognition. The height of the dining room table where R41 was seated was verified as being too high by the assistant dietary supervisor (ADS)-A on 9/17/14, at 12:30 p.m. The ADS-A added that residents have assigned seating and R41 was seated at the lowest table in the main dining room. The	F 246	resident's vision. R41 stated unable to eat large amounts due to becoming full easily related to stooped over posture. -Occupational therapy consult order obtained 9/18/14 with focus on w/c positioning and adaptive equipment to support nutritional needs. -Trial of stationary chair in main dining room with 2 inch cushion and lower arm rests to improve her range of motion and ability to reach items at table. Trial initiated 9/18/14, resident declined this trial 9/20/14 stating that first feet did not rest completely on the floor which had been identified as potential need for adaptation and secondly that she was not able to easily slide back onto chair resulting in her clothing bunching up. -OT eval completed 9/19 with further treatment and recommendations provided 9/22/14, 9/23/14, 9/24/14, 9/25/14. -R41 had significant change in medical condition on 9/26/14 resulting in change to comfort cares only, R41 passed away 10/4/14. Potential to impact other residents: -Residents at risk for not having their individual needs accommodated will be identified through resident report, interdisciplinary term (IDT) general observation, data collection (weights and changes in weight), care conference/MDS completion. -Discussion of state survey preliminary results verbally shared at IDT morning meeting 9/19/14. -Review of policies and changes in processes to be completed at nursing	

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	245487	A. BUILDING _____ B. WING _____	09/18/2014

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F 246	Continued From page 2 ADS-A stated that this situation had been going on for some time and didn't report it to anyone from nursing, as that was not his area to be concerned about, that area belonged to nursing.	F 246	staff meetings (10/14/14, 10/15/14, 10/21/14, 10/23/14 and 10/28/14) by 10/28/14. -Discussion of state survey preliminary results done at Long Term Care Department Head Meeting 9/25/14. -Review of policies and changes in processes to be reviewed at Long Term Care Department Head Meeting 10/23/14. Policies reviewed and revised (as indicated) by dietician, DON, dietary manager, nurse managers by 10/10/14. -Unintended weight loss -Weights -Significant Change in Resident Condition Assessment Processes changed 10/13/14 -Facility recognizes regular weight monitoring as one effective means to detect potential concerns with a resident's health or well-being. -Residents to be weighed weekly and data entered into electronic health record. If identified variances during specific time periods (7 days, 30 days, 90 days, 180 days)are noted related to weight, an automatic electronic internal message will be sent to designated individuals prompting further investigation of potential reason for weight changes. -Assigned individuals (dietician or designee, RN nurse managers or designee) to provide follow up observation, review of clinical data and resident interview to identify potential causes related to weight changes. Referral to occupational thereapy and/or	

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F 246	Continued From page 3	F 246	speech therapy will be initiated when indicated to promote the well-being of each resident. Review of current resident roster completed 10/7/14 to identify residents that have lost >5% of weight in last 30 days. Identified residents to be reviewed to indentify potential for further interventions by 10/17/14. Monthly audit x3 months to include reviewing current resident roster, identify residents that have lost >5% of weight in last 30 days. Identified residents to be observed and/or interviewed and/or review of medical record and determination made regarding further interventions required. Random audits thereafter to ensure continued compliance.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 371	Corrective action: Steam table pans	10/10/14

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F 371	Continued From page 4 review the facility failed to store steam table pans dry; failed to maintain the large mixer blades in a clean and sanitary manner and failed to identify deep grooves in the green cutting board in an effort to prevent food contamination. This practice had the potential to affect all 75 resident's currently residing in the facility who received foods prepared in the kitchen. Findings include: During a tour of the kitchen on 9/15/14, at 4:33 p.m. with the assistant dietary supervisor (ADS)-A the following was identified: 2 of 5 oblong stacked steam table pans had visible water inside the pans; the large mixer, which had been identified by ADS-A as being clean and ready for use, was noted to have a white substance on the mixer blades, and the green cutting board, identified by ADS-A as used for cutting vegetables, had deep grooves in the cutting board. This cutting board which was identified by ADS-A as clean and ready for use, had visible signs of food debris inside the grooves. The above was verified by ADS-A on 9/15/14, at 5:55 p.m. Review of the policy DISH AND UTENSIL WASHING last revised 3/13, identified the following: Dish and utensil washing shall be performed following proper procedures that insure that intimate eating utensils and food preparation utensils do not become agents for transmission of disease or harmful microorganisms from one individual to another. The policy further identified that dishes shall be air dried and all dishes and utensils are stored in closed cupboards or drawers or turned upside down on shelves.	F 371	noted to have moisture present 9/15/14 were recleaned that day, large mixer/blades were recleaned to ensure removal of white substance 9/15/14. Dietary manager ordered a new green cutting board to replace current one with grooves on 9/15/14, arrived 9/16/14. Old board disposed of 9/16/14. Policies reviewed and revised (where applicable) completed by 10/8/14 include: -Mixer -Monitoring & replacing Pots/Pans/Utensils/Cutting Boards -Dish, Utensil and Cutting Board Washing Staff meetings held 10/8/14 and 10/9/14 with dietary team members to review findings during state survey and to review policies identified above. Team members not in attendance at these identified meetings to review policies identified above and provide signature verifying reading/understanding of policies by 10/28/14. Audits of kitchen observation to be completed 1x weekly for 1 month, 2x monthly November through January. Feedback to be shared with team members and corrections made as indicated if determined. Random audits thereafter to ensure continued compliance.	

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F 371	Continued From page 5 During interview with the dietary supervisor, registered dietician (RD) on 9/18/14, at 10:01 a.m. verified that steam table pans are required to be stored dry, the mixer blades in the large mixer are required to be clean prior to being covered with a plastic bag, and that additional cutting boards had been purchased.	F 371		
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. 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	F 431		10/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(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 431	Continued From page 6 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 that expired medications were removed from the refrigerated emergency medication kit so they are not used for resident use during medication storage review. This had the potential to affect all 18 residents residing in the nursing home connected to the Critical Access Hospital (CAH) and separate from the free standing nursing home. Findings include: A tour of the medication storage room, where the locked medication refrigerator was located, was conducted on 9/18/14 at 8:50 a.m. with registered nurse (RN)-C. During the tour it was noted there was a locked emergency medication kit in the refrigerator. Upon review of the contents of the locked kit it was noted that there were two vials, labeled Ativan 2 milligrams per milliliter (mg/ml) that had the expiration date of 7/2014. This was confirmed by RN-C at the time. During a telephone interview on 9/19/14 at 9:15 a.m., the registered pharmacist (RP)-A stated that he would expect that the expired Ativan vials should have been removed from the emergency medication kit. The facility policy titled Emergency Kit in the Long Term Care Facilities, dated 12/2013 indicated:	F 431	Corrective action: Expired medication (2 Ativan vials) removed from NH emergency kit 9/19/14 and replaced. E-Kit medications stored in refrigerator at HCC checked for expiration date, expiration 10/15. Expiration dates identified on bag medication stored in as well as highlighted on "Long Term Care Drug Administration Record" inventory sheet. Nursing staff to account for refrigerated e-kit medication(s) every shift during narc count. This is verified by signature of two team members. Policies reviewed and revised (as indicated) 10/10/14 -Emergency Kit in the LTC Facilities -Consultant Pharmacist in LTC Emergency kits from both buildings reviewed and observed for any expired medications by 10/8/14. Review of policies and changes in processes to be completed at nursing staff meetings (10/14/14, 10/15/14, 10/21/14, 10/23/14 and 10/28/14) by 10/28/14.	

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	245487	A. BUILDING _____ B. WING _____	09/18/2014

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F 431	Continued From page 7 The supply shall be checked and inventoried periodically by the consultant pharmacist.	F 431	Random audits of medication storage areas to be conducted monthly x3 months (Oct-Nov-Dec 2014) to observe for any outdated/expired medications. Findings to be discussed at IDT meetings. Random audits thereafter to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/18/2014**

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ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

(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	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Elizabeths Medical Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/10/2014

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as four separate buildings, which are located at two different street addresses. St. Elizabeths Medical Center building # 1 is located at 1200 Fifth Grant Boulevard West. This facility is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type II(222) construction. In 1939, an addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1961, an addition was constructed to the North Wing that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is	K 000		

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K 000	Continued From page 2 monitored for automatic fire department notification. The facility has a capacity of 20 beds and had a census of 18 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 18 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 09/18/2014, documentation review for fire damper testing for the past 4 years revealed, that the fire/smoke dampers have not been tested with-in a 4 years period. Tests were conducted on 3/25/2010 and 08/28/2014. This deficient practice was confirmed by the	K 067	Fire/smoke dampers at the Hospital Nursing Home were tested on 8/27/14 and 8/28/14 at the Health Care Center Nursing Home. This will be monitored by Facilites Director or designee.	10/10/14

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K 067	Continued From page 3 Director of Maintenance (JF) at the time of discovery.	K 067		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 18 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 09/18/2014, documentation review of the weekly inspection logs (September 2013 to September 2014) for the diesel emergency generator revealed that the weekly operational inspection were missed for the weeks of 2/24, 3/3/2014 and 9/30, 10/7,10/21, 10/28/13. This deficient practice was confirmed by the Director of Maintenance (JF) at the time of discovery.	K 144	Maintenance staff have been reminded of the importance of inspecting the generator and logging the inspection on the generator inspection form. This will be monitored by Facilities Director or designee.	10/10/14

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K 144	Continued From page 4 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Elizabeths Medical Center , Building #2, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Elizabeths Medical Center, Building # 2, is located at 626 Shields Avenue South. This is a 1-story building and has a partial basement. This building was constructed in 1970 and was determined to be of Type II(111) construction. The building is partially sprinklered as noted in K56 tag. The facility has a fire alarm system with corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 76 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		10/10/14

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K 029	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 7 out 76 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 09/18/2014, observation revealed, that the following was found: 1. Basement - storage(over 50 sq. ft.)/rest room door will not shut/latch 2. 1st floor - # 3 and #7 soiled utility room doors will not shut and latch These deficient practices were confirmed by the Director of Maintenance (JF) at the time of discovery.	K 029	1. The door and latch have been adjusted to latch from the corridor to the basement storage/bathroom; this was completed 9/19/14. 2. Self closing door closers were added to both soiled utility rooms on 10/3/04.	

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K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. The deficient practice could affect 5 out of 76 residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:30 PM on 09/18/2014, observation revealed that in resident room # 204 closet does not have fire sprinkler protection. The resident room sidewall sprinkler head does not protect the closet. NOTE: The entire facility needs to be checked for this deficiency This deficient practice was confirmed by the Director of Maintenance (JF) at the time of	K 056	A quick response sprinkle head will be added to the closet in resident room 204 by 10/27/14.	10/10/14

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K 056	Continued From page 4 discovery.	K 056		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 76 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 09/18/2014, documentation review for fire damper testing for the past 4 years revealed, that the fire/smoke dampers have not been tested with-in a 4 years period. Tests were conducted on 3/25/2010 and 08/28/2014. This deficient practice was confirmed by the Director of Maintenance (JF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067	Fire/smoke dampers at the Hospital Nursing Home were tested on 8/27/14 and 8/28/14 at the Health Care Center Nursing Home. This will be monitored by the Facilities Director or designee.	10/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	245487	A. BUILDING **03 - CHAPEL ADDITION** B. WING _____	**09/18/2014**

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Elizabeths Medical Center , Building #3 Chapel Addition, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH MEDICAL CENTER	**1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981**

(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 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Elizabeths Medical Center, Building # 3 Chapel Addition, is located at 626 Shields Avenue South. The Chapel is a 1-story addition to Building #2, and has a full basement. The chapel addition was constructed in December 2003 and was determined to be of Type II(111) construction. The facility has a 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 capacity of 80 beds and had a census of 76 beds at the time of the survey.	K 000		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		10/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **03 - CHAPEL ADDITION** B. WING _____	**09/18/2014**

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K 067	Continued From page 2 specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 76 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 09/18/2014, documentation review for fire damper testing for the past 4 years revealed, that the fire/smoke dampers have not been tested with-in a 4 years period. Tests were conducted on 3/25/2010 and 08/28/2014. This deficient practice was confirmed by the Director of Maintenance (JF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067	Fire/smoke dampers at the Hospital Nursing Home were tested on 8/27/14 and 8/28/14 at the Health Care Center Nursing Home. This will be monitored by Facilities Director or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **04 - 4 SEASON SUN ROOM** B. WING _____	**09/18/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Elizabeths Medical Center , Building #4 Four Season Sun Room Addition, 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 18 New Health Care. St. Elizabeths Medical Center, Building # 4 - Four Season Sun Room Addition, is located at 626 Shields Avenue South. The Four Season Sun Room is a 1-story addition to Building #2, and has a no basement. The Four Season Sun Room Addition was constructed in December 2012 and was determined to be of Type V(111) construction. The facility has a 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 capacity of 80 beds and had a census of 76 beds 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

Electronically Signed | 10/10/2014

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

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

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	245487	A. BUILDING **04 - 4 SEASON SUN ROOM** B. WING _____	**09/18/2014**

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