CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

					AND TRANSMITTAL TE SURVEY AGENCY	ID: SMXS Facility ID: 00675
MEDICARE/MEDICAID PROVIDER (L1) 245487 2.STATE VENDOR OR MEDICAID NO. (L2) 394347000 5. EFFECTIVE DATE CHANGE OF OW		3. NAME AND AL (L3) ST ELIZAB (L4) 1200 FIFTH (L5) WABASHA, 7. PROVIDER/SU	ETH MEDICAI GRANT BOUL , MN	L CENTEI LEVARD V		4. TYPE OF ACTION:
(L9) 6. DATE OF SURVEY 10/22/2013 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IIE 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 100	19 SNF	Complian1. B. Not in Co Requirem ICF	nce With Requirements ace Based On: Acceptable POC mpliance with Progents and/or Applied	ram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
16. STATE SURVEY AGENCY REMAIN Post Certification Revisit to V CMS 2567B. Effective Sept 17. SURVEYOR SIGNATURE Marietta Lee, HFE N.	verify that the fa tember 24, 2013	cility has achieve	ed and mainta	ined com	nursing facility beds. 18. STATE SURVEY AGENCY	Tication Regulations. Please refer to the APPROVAL Date: rogram Specialist 12/27/2013 (L20)
P	ART II - TO BE	COMPLETED	BY HCFA RI		L OFFICE OR SINGLE S	··
DETERMINATION OF ELIGIBILIT _X	articipate		MPLIANCE WITH GHTS ACT:	CIVIL		rancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) ve :
22. ORIGINAL DATE OF PARTICIPATION 02/14/1986 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	VE SANCTIONS of Admissions:	4. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTIONS VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburser 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	00 INVOLUNTARY 05-Fail to Meet Health/Safety ment 06-Fail to Meet Agreement
28. TERMINATION DATE:	29	INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL D	ATE		

(L33)

DETERMINATION APPROVAL

11/21/2013

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5487

December 27, 2013

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

Dear Mr. Crowley:

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 September 24, 2013, the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen B. Leach, Program Specialist

Colleen Feach

Program Assurance Unit, Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

P.O. Box 64900, St. Paul, MN 55164-0900

Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

St Elizabeth Medical Center December 27, 2013 Page 2



Protecting, Maintaining and Improving the Health of Minnesotans

October 29, 2013

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

RE: Project Number S5487025

Dear Mr. Crowley:

On August 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 18, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, effective September 24, 2013 and therefore remedies outlined in our letter to you dated August 26, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen B. Leach, Program Specialist Licensing and Certification Program

Colleen Feach

Division of Compliance Monitoring

Minnesota Department of Health

Enclosure

cc: Licensing and Certification File

St Elizabeth Medical Center October 29, 2013 Page 2

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245487	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/22/2013
Nam	e of Facility		Street Address, City, State, Zip Code	
S	Γ ELIZABETH MEDICAL CENTER		1200 FIFTH GRANT BOULEVAN WABASHA. MN 55981	RD WEST

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix	F0371	Correction Completed 09/24/2013	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. #	483.35(i)								-
ID Prefix Reg. #		Correction Completed	ID Prefix		Correction Completed	ID Prefix Reg. #			Correction Completed
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed				Correction Completed
Reg. #		Correction Completed			Correction Completed				Correction Completed
Reg. #			Reg. #		Correction Completed	Reg. #			
Reviewed E	су	Reviewed By GN/cbl	Date: 10/29/2013	Signature of Sur		15425		Date:	10/22/2013
CMS RO	Ву	Reviewed By	Date:	Signature of Sur	veyor:			Date:	
Followup t	o Survey Co 8/15	mpleted on: /2013		Check for any Uncor Uncorrected Defic	rected Deficiencies (CM	ciencies. Was a S-2567) Sent to	Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245487	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 9/18/2013
Name of Facility		Street Address, City, State, Zip Code	

ST ELIZABETH MEDICAL CENTER

1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 08/26/2013	ID Prefix		Correction Completed		ID Prefix			Correction Completed
•	NFPA 101 K0050									_
Reg. #			ID Prefix Reg. #		Correction Completed		ID Prefix Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed					Correction Completed
Reg. #					Correction Completed					Correction Completed
Dog #			D #				ъ "			
Reviewed E	Bv Revie	ewed By	Date:	Signature of Sur	vevor:				Date:	
State Agen	DC/		10/29/2013	Signature or our	,	258	22			/18/2013
Reviewed E	By Revie	ewed By	Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Complete 8/13/2013			Check for any Uncor Uncorrected Defic					YES	NO

ST ELIZABETH MEDICAL CENTER

Form Approved OMB NO. 0938-0390

1200 FIFTH GRANT BOULEVARD WEST

WABASHA, MN 55981

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA /	(Y2) Multiple Con		(Y3) Date of Revisit		
Identification Number 245487	A. Building B. Wing	02 - ST.	ELIZABETHS CARE CENTER	9/18/2013	
Name of Facility			Street Address, City, State, Zip Code		

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4)	Item	()	/ 5)	Date
ID Prefix		Correction Completed 09/04/2013	ID Prefix		Correction Completed 08/26/2013		ID Prefix			Correction Completed 08/19/2013
Reg. #	NFPA 101		Reg. #	NFPA 101			Reg. #	NFPA 101		
LSC	K0025		LSC	K0050			LSC	K0144		=
		Correction			Correction					Correction
ID D ('		Completed	15.5 "		Completed					Completed
	-							-		
Reg. # LSC			Reg. # LSC				Reg. # LSC			_ _
		Correction			Correction					Correction
		Completed			Completed					Completed
							ID Prefix			_
Reg. #			Reg. #				Reg. #			=
			130				130			_
		Correction			Correction					Correction
ID Prefix		Completed	ID Profix		Completed		ID Profix			Completed
										_
Reg. # LSC			Reg. # LSC				Reg. # LSC			 =
		Correction			Correction					Correction
		Completed			Completed					Completed
										_
Reg. # LSC			Reg. # LSC				Reg. # LSC			-
Reviewed I	By Re	eviewed By	Date:	Signature of	of Surveyor:				Date:	
State Agen	cy]	PS/cbl	10/29/201	.3		2582	2		09/18	3/2013
Reviewed I	Ву Re	eviewed By	Date:	Signature of	of Surveyor:				Date:	
CMS RO										
Followup t	to Survey Comp				Uncorrected Def					
	8/13/20)13		Uncorrected	Deficiencies (CI	vi5-256	(i) Sent to	tne Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

Name of Facility
ST ELIZABETH MEDICAL CENTER

Street Address, City, State, Zip Code 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 08/26/2013	ID Prefix		Correction Completed 08/19/2013	ID Prefix		Correction Completed
Reg. #	NFPA 101		Reg. #	NFPA 101		Reg. #		
LSC	K0050		LSC	K0144	-	LSC		-
			Reg. #		Correction Completed			Correction Completed
		Correction			Correction			Correction
		Completed			Completed			Completed
					-			
Reg. #			Reg. #		-	Reg. #		_
								_
ID Prefix Reg. # LSC			Reg. #			Reg. #		
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed
Reviewed E	DC	ewed By /cbl	Date: 10/29/20	Signature of Sur	rveyor:	25822	Date:	9/18/2013
Reviewed E	_	ewed By	Date:	Signature of Su	rveyor:		Date:	
Followup to	o Survey Completo 8/13/2013			Check for any Unco Uncorrected Defice		iencies. Was a Su S-2567) Sent to the		NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245487	(Y2) Multiple Construction A. Building B. Wing 04 - 4 SEASON SUN ROOM	(Y3) Date of Revisit 9/18/2013
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Name of Facility

ST ELIZABETH MEDICAL CENTER

Street Address, City, State, Zip Code 1200 FIFTH GRANT BOULEVARD WEST

WABASHA, MN 55981

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	()	/5) I	Date
		Correction			Correction				Correction
ID Prefix		Completed 08/26/2013	ID Prefix		Completed 08/19/2013	ID Prefix			Completed
	NFPA 101		Reg. # NF						=
•	K0050		LSC K			LSC			- -
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #			Reg. #			
LSC			LSC			LSC			
		Correction		,	Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix			ID Prefix			_
Reg. #			Reg. #			Reg. #			=
									_
		Correction		(Correction				Correction
ID Profix		Completed	ID Profix		Completed	ID Profix			Completed
Reg. #									_
LSC			LSC			LSC			<u> </u>
		Correction Completed			Correction Completed				Correction Completed
ID Prefix			ID Prefix		Completed	ID Prefix			
Reg. #			Reg. #			Reg. #			_
LSC			LSC			LSC			<u>-</u>
Reviewed E	Ву	Reviewed By	Date:	Signature of Surv	veyor:	•		Date:	
State Agend	су	PS/cbl	10/29/201			25822		09	/18/2013
Reviewed E	Ву	Reviewed By	Date:	Signature of Surv	veyor:			Date:	
CMS RO									
Followup t	o Survey Co	-		Check for any Uncor	rected Defic	iencies. Was a	Summary of		
	8/13	/2013		Uncorrected Defici	iericies (CIVI	3-230/) Sent to	ine racinty?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

October 29, 2013

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

Re: Enclosed Reinspection Results - Project Number S5487025

Dear Mr. Crowley:

On October 22, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 15, 2013, with orders received by you on September 9, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Colleen B. Leach, Program Specialist

Colleen Feach

Licensing and Certification Program Division of Compliance Monitoring

Minnesota Department of Health Telephone: (612) 201-4117

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

State Form: Revisit Report Provider / Supplier / CLIA / (Y2) Multiple Construction (Y3) Date of Revisit **Identification Number** A. Building 10/22/2013 00675 B. Wing Street Address, City, State, Zip Code Name of Facility 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

WABASHA, MN 55981

Y4) Item	(Y5) Da	te (Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
	Correc Comp 21015 09/24/ MN Rule 4658.0610 Subp.	oleted /2013 ID Prefix Reg. # N	Correction Completed 10/22/2013 MN Rule 4658.0810 Subp. :	_	Correction Completed
ID Prefix Reg. #	Correc	ction pleted ID Prefix Reg. #	Correction Completed	·	Correction Completed
Reg. #	Correc Comp	ID Prefix Reg. #	Correction Completed	Reg. #	Correction Completed
Reg. #	Correc Comp	ID Prefix Reg. #	Correction Completed		Correction Completed
ID Prefix Reg. #	Correc Comp	ction bleted ID Prefix Reg. #	Correction Completed	ID Prefix	Correction Completed
Reviewed B State Agend Reviewed B CMS RO	GN/cbl	Date: 10/29/201 Date:	Signature of Surveyor: Signature of Surveyor:	15425	Date: 10/22/2013 Date:
Followup to	o Survey Completed on: 8/15/2013 M: REVISIT REPORT (5/99)		Check for any Uncorrected Defi Uncorrected Deficiencies (CM	/IS-2567) Sent to the	

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: SMXS

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

	PART	I - TO BE COMI	PLETED BY T	THE STAT	E SURVE	YAG	ENCY		Fa	cility ID: 006	75
MEDICARE/MEDICAID PROVIDER NO. (L1)		3. NAME AND ADD (L3) ST ELIZA (L4) 1200 FIFT (L5) WEST WA	BETH MED H GRANT B	ICAL CI		(L6)	55981	1. Initi	mination	2 (L8) 2. Recer 4. CHOW 6. Complai	tification _{nt}
5. EFFECTIVE DATE CHANGE OF OWNERSHI (L9) 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 2 AOA 1 TJC 3 Other		7. PROVIDER/SUP 01 Hospital 02 SNF/NF/Dt 03 SNF/NF/Distinct 04 SNF	05 HHA	Y 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 13 PTIP 14 CORE 15 ASC 16 HOSP	F	22 CLIA	8. Full	Site Visit Survey After Com TEAR ENDING I 09/30		(L35)
	00 (L18)	X B. Not in Comp	ce With quirements Based On: cceptable POC	n	2 3 4	2. Tech: 3. 24 H 4. 7-Da 5. Life	nical Personnel		Scope of Service Medical Directo Patient Room Si. Beds/Room	r	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 100 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS (IF A	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILI		EETS 1861 (j) (1):		(L15)		
See Attached Remarks 17. SURVEYOR SIGNATURE Michele McFarland, HFE NE		Date :	09/09/2013	(L19)			vey agency Fon, Enfo	APPROVAL rcement Sp	ecialist	Date:	/2013 (L20)
PA 19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible	(L21)		D BY HCFA RI PLIANCE WITH C TS ACT:			1. S 2. C	statement of Fina	ancial Solvency (F	HCFA-2572)	1513)	
OF PARTICIPATION 02/14/1986 (L24) 25. LTC EXTENSION DATE: 27. A			4. LTC AGREEMI ENDING DAT (L25)		VOLUNTA 01-Merger 02-Dissatis 03-Risk of	ARY r, Closur sfaction Involur	-	00 ment	(L INVOLUNTA 05-Fail to Mee 06-Fail to Mee OTHER 07-Provider S	kRY et Health/Safet et Agreement	у
(L27) 28. TERMINATION DATE:		pension Date: D. INTERMEDIARY/CA	(L44) (L45) ARRIER NO.		30. REMA	ARKS			00-Active		
(L	28)	03001		(L31)							
31. RO RECEIPT OF CMS-1539 (L:		2. DETERMINATION O 11/21/2013	F APPROVAL DA	(L33)	DETER	MINA	ATION APPE	ROVAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

E TI ID 0007

Facility ID: 00675

C&T REMARKS - CMS 1539 FORM STATE

STATE AGENCY REMARKS

CCN# 245487

At the time of the standard survey completed 08/15/13 the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5322

August 26, 2013

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

RE: Project Number S5487025

Dear Mr. Crowley:

On August 15, 2013, 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 wereby 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>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

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 September 24, 2013, 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 September 24, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 15, 2013 (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 February 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5487s13.rtf

SEP 5 ~ 2013

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRนี้ได้ที่โดห" of Health Rochester NG	(X3) DATE SURVEY COMPLETED	
		245487	B. WNG	grander - Al-	08/15/2013	
İ	PROVIDER OR SUPPLIER ABETH MEDICAL CEI	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981	St	
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	as your allegation of Department's accept bottom of the first pipe used as verificate. Upon receipt of an arevisit of your facility validate that substa	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance. acceptable POC an on-site y may be conducted to nital compliance with the en attained in accordance with	9/9/13 2pn	Minnesota Department of Heal documenting the State Licensing Correction Orders using the fed software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes assigned tag number appears in left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statute/rule out of compliance is in the "Summary Statement of Deficiencies" column and replace "To Comply" portion of the comporder. This column also includes findings which are in violation of state statute after the statement, Rule is not met as evidenced by. Following the surveyors finding the Suggested Method of Correct and the Time Period for Correct PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ON THIS WILL APPEAR ON EAC	g eral en The the far Tag." d the listed esthe ection s the of the "This " s are etion ion.	
ABORATORY	DIRECTOR'S OR PROVIDE	RISHPPLIER REPRESENTATIVE'S SIGN	ATIBE	TITLE	/YALDATE	

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.

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

Event ID: SMX\$11

Facility ID: 00675

SEP 5 - 2013

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COMPLETED
		245487	B. WING _		08/15/2013
	PROVIDER OR SUPPLIER	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981	
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F 000	Continued From pa	ge 1	F 00	PAGE. THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECTION FOR VIOLAT OF MINNESOTA STATE STATUTES/RULES.	
F 371 SS=F	The facility must - (1) Procure food fro considered satisfac authorities; and	m sources approved or tory by Federal, State or local	F 37	* Survey results and tentative plan of correction reviewed with facility staff at interdepartmental meet on 8/23/13, nursing st meetings on 8/21/13, 8/23/13, and 8/27/13, nutritional services s on 8/29/13. * Wabasha County Public Health Environmental Health Environmental Health Environmental	ing aff /22/13, and taff
	by: Based on observate review, the facility fasanitary practices. The facility fasanitary practices of 72 of 72 residents of 7	ion, interview and document ailed to serve foods using This had the potential to affect esiding in the facility. e observation in the kitchen on m., cook-A was observed the the same soiled pair of m when handling the food in cooler handle, handle of a	9/9/13 XPN	inservice to nutrition services staff on 8/29 titled "Handwashing an Employee Hygiene" (glo lights, handouts and p	/13 d w ost- irector or using food 3. irector

Event ID: SMXS11

SEP 5 - 2019

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROMDER OR SUPPLIER STELIZABETH MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX PAGE (AND DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR U.S.C IDENTIFYING INFORMATION) F 371 Continued From page 2 drawer and the soiled apron cook-A had been wearing. During interview on 8/14/13, at 11:44 a.m., cook-A stated gloves they wore when handling food were to be changed when contaminated. During interview on 8/14/13, at 11:37 a.m., dietary manager stated he would expect staff to change contaminated gloves they wore when handling food. Review of facility SUBJECT: Infection Control-Guidelines for acceptable hygiene practices of food service personnel dated November 4, 2004, read "POLICY: Sanitary conditions will be maintained throughout the Dietary Services Department Sanitary conditions will be maintained throughout the Dietary Services Department Sanitary conditions will be maintained throughout the Dietary Services Department Sanitary conditions will be maintained throughout the Dietary Services Department Sanitary conditions will be maintained throughout the Dietary Services Department Sanitary conditions refer to storing, preparing, distributing, and serving food properly to prevent food-borne illness; and in accordance with Federal, State, and local health department regulations APROCEDURE: 1 All Dietary personnel will demonstrate consistent personal sanitation and infection control standards and regulations PROCEDURE: 1 All Dietary personnel will demonstrate consistent personal sanitation and infection control practices 4 Clean disposable gloves must be worn when handling food." **Nutraing staff meeting agenda items related to \$731 deficiency included: food handling when delivering trays to residents, preparing food requiring handling (bread, cookies, eggs, etc.) and proper use of barriers, appropriate hand hygiene during meal times. Meetings hald 8/21/13, 8/22/13, 8/23/13, 8/23/13.	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION AND Dark of Health		E SURVEY PLETED
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F 371 Continued From page 2 drawer and the soiled apron cook-A had been wearing. During interview on 8/14/13, at 11:44 a.m., cook-A stated gloves they wore when handling food were to be changed when contaminated. During interview on 8/14/13, at 11:37 a.m., dletary manager stated he would expect staff to change contaminated gloves they wore when handling food. Review of facility SUBJECT: Infection Control Guidelines for acceptable hygiene practices of food service personnel dated November 4, 2004, read "POLICY' Sanitary conditions will be maintained throughout the Dietary Services Department Sanitary conditions refer to storing, preparing, distributing, and serving food properly to prevent food-borne illness; and in accordance with Federal, State, and local health department regulations All Dietary personnel demonstrate consistent sanitation and infection control sanitation and infection control sanitation and infection control sanitation and infection control standards and regulations PROCEDURE: 1 All Dietary personnel wild demonstrate consistent personnel sanitation and infection control standards and regulations PROCEDURE: 1 All Dietary personnel demonstrate consistent personnel sanitation and infection control standards and regulations procedure to such a service storeview and address any opportunities for improvement. * Nursing staff meeting agenda items related to F371 deficiency included: food handling when delivering trays to residents, preparing food requiring handling (bread, cookies, eggs, etc.) and proper use of barriers, appropriate hand hygiene during meal times. Meetings held 8/21/13,					1200 FIFTH GRANT BOULEVARD WEST	,	
drawer and the soiled apron cook-A had been wearing. During interview on 8/14/13, at 11:44 a.m., cook-A stated gloves they wore when handling food were to be changed when contaminated. During interview on 8/14/13, at 11:37 a.m., dietary manager stated he would expect staff to change contaminated gloves they wore when handling food. Review of facility SUBJECT: Infection Control-Guidelines for acceptable hygiene practices of food service personnel dated November 4, 2004, read "POLICY: Sanitary conditions will be maintained throughout the Dietary Services Department Sanitary conditions refer to storing, preparing, distributing, and serving food properly to prevent food-borne illness; and in accordance with Federal, State, and local health department regulations All Dietary personnel demonstrate consistent sanitation and infection control practices The Dietary Manager and Food Service Supervisor are responsible for training, supervising, and monitoring compliance with sanitation and infection control standards and regulations PROCEDURE: 1 All Dietary personnel will demonstrate consistent personal sanitation and infection control practices 4 Clean disposable gloves must be worn when handling food." Questions and Answers" for nutritional services staff to conduct random audits of peers and report findings back to director to verify compliance. Focused audits to be completed at least weekly for month of September 2013, twice monthly October 2013, twice monthly October 2013, staff to utilize "Performance Evaluation Rating Form Food Safety Compliance" form as guide to audit. Director of nutritional services to review and address any opportunities for improvement. *Nursing staff meeting agenda items related to F371 deficiency included: food handling when delivering trays to residents, preparing food requiring handling (bread, cookies, eggs, etc.) and proper use of barriers, appropriate hand hygiene during meal times.	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
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Facility ID: 00675

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ExIT: 08	Health Care Fire In State Fire Marshal 445 Minnesota St. St Paul, MN 55101 By email to: Barbara.Lundberg	Division Suite 145 I-5145, or					
		PERICURBULER REPRESENTATIVE'S SIG	SNATURE		TITLE		(X6) DATE

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

RN UCDirector Music

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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	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
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	2. The actual, or pr	oposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					
	buildings, which are addresses. St. Eliz	surveyed as four separate e located at two different street abeths Medical Center building 00 Fifth Grant Boulevard					
	basement. The buildifferent times. The constructed in 191 Type II(222) constructed to determined to be of 1961, an addition with Wing that was determined to be construction. Becauthe 2 additions are construction and more different times.	story building with a full lding was constructed at 3 e original building was 9 and was determined to be of ruction. In 1939, an addition of the West Wing that was of Type II(222) construction. In was constructed to the North ermined to be of Type II(222) use the original building and of the same type of neet the construction type g buildings, they were surveyed					
	The building is fully	y sprinklered. The facility has a					

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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	PROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
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K 050 SS=D	fire alarm system we detection and space monitored for autor notification. The facility has a consus of 18 at the tensus of 1	with full corridor smoke es open to the corridor that is matic fire department apacity of 20 beds and had a etime of the survey. 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. Idanning and conducting drills is competent persons who are e leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible	K 00		duled least each inning st 2014	•
	Findings include: On facility tour bet	ween 9:00 AM and 12:30 PM				

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			01 - MAIN BUILDING 01	COMPLETED	
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PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 02 - ST. ELIZABETHS CARE CENTER		SURVEY PLETED
		245487	B. WING			08/1	3/2013
	PROVIDER OR SUPPLIER	ITER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
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	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY					
	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145 -5145, or					(X6) DATE
ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(VO) DVIE

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days following the date program participation.

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - ST. ELIZABETHS CARE CENTER		SURVEY PLETED
		245487	B. WING			08/	13/2013
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		245487	B. WING		08/1	3/2013
NAME OF F	PROVIDER OR SUPPLIER	245401	1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
		JTED		1200 FIFTH GRANT BOULEVARD WEST		
ST ELIZA	BETH MEDICAL CE	NIER		WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
K 025 K 025 SS=D	Smoke barriers are least a one half hot accordance with 8. terminate at an atri protected by fire-ra panels and steel fra separate compartn floor. Dampers are penetrations of smo	reconstructed to provide at ur fire resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass ames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted, and air conditioning systems.		* The smoke separations above the fire doors of the 300 Wing have been sealed with fire cault	1	4-13
	Based on observa maintain smoke ba the following requir Section 19.3.7.3, 8 practice could affect Findings include:	is not met as evidenced by: tion, the facility failed to irrier wall in accordance with rements of 2000 NFPA 101, .3.2 and 8.3.6. The deficient ct 20 out of 76 residents.		Sign.		
	on 08/13/2013, obs smoke barrier by repentrations above	ween 9:00 AM and 12:30 PM servation revealed that the esident room #312, has open to the lay in ceiling around ables, around conduits and				
	NOTE: All smoke if from exterior wall to	parriers need to be checked o exterior wall.				
	This deficient prac	tice was confirmed by the				

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE COMF	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG 0	2 - ST. ELIZABETHS CARE CENTER		
		245487	B. WING			08/1	3/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST FLIZA	BETH MEDICAL CEI	NTER			00 FIFTH GRANT BOULEVARD WEST ABASHA, MN 55981		
		ATEMENT OF DEFICIENCIES	ID	- 1	PROVIDER'S PLAN OF CORRECTIO	N_	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
K 025 K 050 SS=D	discovery. NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to conducted between announcement manual arms. This STANDARD Based on docume interview, the faciliars.	AFETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. clanning and conducting drills is competent persons who are e leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible is not met as evidenced by: entation review and staff ty failed to assure fire drills		025	* Fire drill schedules heen reviewed and schede each shift to vary at 1 1 1/2 hours apart for eshift for the year begin August 2013 to August Schedule developed on August 26, 2013. Facil Management Director to monitor compliance.	uled east ach nning t 2014	•
€0	were conducted or staff under varying required by 2000 N. This deficient pracresidents. Findings include: On facility tour bet on 08/13/2013, the documentation for 2012 to July 2013) following shift were sufficiently vary the conducted:	ty falled to assure life drills ance per shift per quarter for all times and conditions as IFPA 101, Section 19.7.1.2. tice could affect all 76 ween 9:00 AM and 12:30 PM are review of the fire drill the past 12 months (August a revealed the drills for the the example completed but did not the times that the drills were					

Event ID: SMXS21

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CENTERS FOR MEDICARE & MEDICARD SERVICES		& WEDICAID SERVICES				OVOLDATE	CHDVEV
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ST. ELIZABETHS CARE CENTER			(X3) DATE SURVEY COMPLETED	
		245487	B. WING			08/1	3/2013
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST		
ST ELIZA	BETH MEDICAL CEN	ITER		ı	ABASHA, MN 55981		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	·		K	050			
K 144 SS=F	facility maintenance discovery. NFPA 101 LIFE SA	ce was confirmed by the staff (TH) at the time of	K	144	* Weekly inspections of t generator will be compl	he Leted	19-13
	under load for 30 m accordance with Ni		d		and documented by designation and to designeer an assigned to designee in their absence. Complet 8/15/13. * The generator will be bank tested annually for 2 hours at 25%, 50%, AM 75%. Agreement signed 8 and testing will be November 2013. This to	nd/or need Load or ND B/19/1	3:
	Based on docume interview, the facilit generators in accord of 2000 NFPA 101	s not met as evidenced by: ntation review and staff y failed to test the emergency dance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice esidents.			monitored by Facilities Management Director or designee.	3	
	Findings include:						
	on 08/13/2013, dod weekly visual inspe	veen 9:00 AM and 12:30 PM cumentation review of the action and monthly emergency (August 2012 to July 2013), billowing was found:					
	1. The weekly eme inspections were mand 9/17/2012	rgency generator visual iissed for 5/20/2013, 8/20, 9/10					

Facility ID: 00675

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 02 - ST. ELIZABETHS CARE CENTER	(X3) DATE SURVEY COMPLETED	
		245487	B. WING			08/13/2013	
NAME OF F	PROVIDER OR SUPPLIER	_ 10.0.			TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST		
ST ELIZA	BETH MEDICAL CEN	NTER		ı	VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144	2. The facility did n generator at 30% o the following means a. loading that m	ot run the diesel emergency f nameplate rating or by one of s for January 2013. aintains the minimum exhaust	K.	144		r.	
=	manufacturer or	s recommended by the so percent or more of the generator or					
	c. 2 hour load bar 25%, next 30 minut 75%)	nk test (first 30 minutes - tes - 50%, and last 1 hour -					
	These deficient pra facility maintenance discovery.	ctices were confirmed by the e staff (TH) at the time of					
	TEAM COMPOSIT Gary Schroeder, Li	ΓΙΟΝ fe Safety Code Spc.					

F5487025

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 03 - CHAPEL ADDITION	(X3) DATE SURVEY COMPLETED	
		245487	B. WING		08/	13/2013
	PROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	/EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	ΚO	000		
	ALLEGATION OF DEPARTMENT'S ASIGNATURE AT TO PAGE OF THE CM VERIFICATION OF UPON RECEIPT OF AN ON-SITE REVIBE CONDUCTED SUBSTANTIAL COREGULATIONS HACCORDANCE WAS A Life Safety Code Minnesota Departrice Marshal Divising St. Elizabeths Med Chapel Addition, who compliance with the in Medicare/Medical Assumers of National (NFPA) Standard Chapter 18 New HACCORRECTION FOR DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal A45 Minnesota St. St Paul, MN 55101	OF AN ACCEPTABLE POC, SIT OF YOUR FACILITY MAY TO VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the ment of Public Safety - State on. At the time of this survey, lical Center, Building #3 was found not in substantial e requirements for participation aid at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), ealth Care. I THE PLAN OF OR THE FIRE SAFETY		POC OK POC OK 9-13-13		(X6) DATE

RN Director & 1 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.

CLIVILLI	OT ON MEDIONINE	A MEDIONID CENTRICE				WO DATE	CUDVEV
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 03 - CHAPEL ADDITION	(X3) DATE SURVEY COMPLETED	
		245487	B. WING	_		08/	13/2013
	PROVIDER OR SUPPLIER	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From particles and has a full based constructed in Decederation of the facility has a fir detection in the concert that is mondepartment notifica. Continued From particles and particles a	ge 1 Destate.mn.us and tate.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DEMATION: What has been, or will be, done ency. Deposed, completion date. If title of the person ection and monitoring to ence of the deficiency. Cal Center, Building # 3 located at 626 Shields Avenue ency. Story addition to Building #2, ment. The chapel addition was ember 2003 and was and spaces open to the itored for automatic fire		0000			
	The requirement at	42 CFR, Subpart 483.70(a) is					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	SURVEY PLETED			
		245487	B. WING			08/13/2013	
	PROVIDER OR SUPPLIER	NTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 050 SS=D	NOT MET as evide NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to conducted between announcement manalarms. 18.7.1.2 This STANDARD is Based on docume interview, the facility were conducted on staff under varying required by 2000 N This deficient practices are idents. Findings include: On facility tour betwon 08/13/2013, the documentation for 2012 to July 2013) following shift were sufficiently vary the conducted:			0000	* Fire drill schedules had been reviewed and schedule ach shift to vary at let 1 1/2 hours apart for eashift for the year begin in August 2013 to August Schedule developed on August 26, 2013. Facili Management Director to monitor compliance.	led ast ch ning 2014.	

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OVOL DATE	CUDVEV
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 03 - CHAPEL ADDITION	(X3) DATE SURVEY COMPLETED	
		245487	B. WING	_		08/1	3/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST FI 17.6	BETH MEDICAL CEN	NTER .			200 FIFTH GRANT BOULEVARD WEST /ABASHA, MN 55981		
OT LLIEF				VV	PROVIDER'S PLAN OF CORRECTION	V	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
	Continued From parthis deficient practifacility maintenance discovery. NFPA 101 LIFE SA Generators are insunder load for 30 m accordance with NF accordance with NF assed on docume interview, the facility generators in accordance of 2000 NFPA 101 6-4.2 (a) & (b) and could affect all 76 m Findings include: On facility tour betwon 08/13/2013, document of the facility tour betwoen 08/13/2013, document o	ge 3 ice was confirmed by the estaff (TH) at the time of a staff (TH) at the time of a	K	144		he eted nated d/or ed oad r D /19/13	
	generator at 30% of the following means	f nameplate rating or by one of s for January 2013.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - CHAPEL ADDITION			(X3) DATE SURVEY COMPLETED	
		245487	B. WING	i		08/13/2013		
	PROVIDER OR SUPPLIER ABETH MEDICAL CEN			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST NABASHA, MN 55981			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 144	Continued From pa	ge 4	K ′	144				
		aintains the minimum exhaust as recommended by the						
	b. under load of 3 nameplate rating of	30 percent or more of the f generator or						
		nk test (first 30 minutes - tes - 50%, and last 1 hour -						
		ctices were confirmed by the e staff (TH) at the time of						
	*TEAM COMPOSIT Gary Schroeder, Life							
					4			

PRINTED: 08/26/2013 F5487025 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING 04 - 4 SEASON SUN ROOM AND PLAN OF CORRECTION 08/13/2013 245487 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER WABASHA, MN 55981 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 | INITIAL COMMENTS POCOK : 9-13-13 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 #4 Four Season Sun Room 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,

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

TITLE

(X6) DATE

Nursing Mecta 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.

(K-TAGS) TO:

Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 04 - 4 SEASON SUN ROOM	(X3) DATE COMP	SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NOMBER	A. BUILDI	NG U	14 - 4 SEASON SUN ROOM		
		245487	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	08/1	3/2013
	PROVIDER OR SUPPLIER				200 FIFTH GRANT BOULEVARD WEST		
ST ELIZA	ABETH MEDICAL CE	NTER		W	ABASHA, MN 55981		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	К0	00			
	By email to: Barbara.Lundberg@s Marian.Whitney@s						
	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO	RRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION:					
	A description of to correct the deficition.	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.					
	3. The name and/o responsible for cor prevent a reoccurre	or title of the person rection and monitoring to ence of the deficiency.					
	St. Elizabeths Med Season Sun Room Shields Avenue Sc	ical Center, Building # 4 - Four Addition, is located at 626 buth.					
	to Building #2, and Season Sun Room	Sun Room is a 1-story addition has a no basement. The Four Addition was constructed in the determined to be of ruction.					
	detection in the col	re alarm system with smoke rridors and spaces open to the hitored for automatic fire ation.					
	The facility has a consus of 76 beds	apacity of 80 beds and had a at the time of the survey.					

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG 04 - 4 SEASON SUN ROOM	COMF	PLETED
		245487	B. WING		08/1	3/2013
	(EACH DEFICIENC)	NTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 000 K 050 SS=D	The requirement at NOT MET as evide NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to conducted between announcement man alarms. 18.7.1.2 This STANDARD Based on docume interview, the facility were conducted or staff under varying required by 2000 NThis deficient practice in the property of the property	42 CFR, Subpart 483.70(a) is inceed by: FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. Ianning and conducting drills is impetent persons who are to leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible	K O	00	luled least each inning t 2014	

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CENTER	(S FOR MEDICARE	& MEDICAID SERVICES		_		(V(0) DATE	CHDVEV
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - 4 SEASON SUN ROOM			(X3) DATE SURVEY COMPLETED	
		245487	B. WING			08/1	3/2013
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	BETH MEDICAL CEN	ITER			200 FIFTH GRANT BOULEVARD WEST /ABASHA, MN 55981		9
		TEMENT OF DEFICIENCIES	ID	- 1	PROVIDER'S PLAN OF CORRECTION	١	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE RIATE	COMPLÉTION DATE
K 050	Continued From pa	ge 3	K	050			
K 144	This deficient practice was confirmed by the facility maintenance staff (TH) at the time of discovery. 4 NFPA 101 LIFE SAFETY CODE STANDARD		K	K 144 * Weekly inspection		the	
SS=F	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			æ	generator will be completed and documented by design maintenance engineer and assigned to designee in their absence. Complete 8/15/13. * The generator will be lobank tested annually for 2 hours at 25%, 50%, AND 75%. Agreement signed 8/ and testing will be November 2013. This to		
	generators in accord	y failed to test the emergency rdance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice esidents.			monitored by Facilitie Management Director or designee.		
	Findings include:						
l I	on 08/13/2013, doc weekly visual inspe generator testing lo	ween 9:00 AM and 12:30 PM cumentation review of the ection and monthly emergency og (August 2012 to July 2013), billowing was found:	9.5				
	1. The weekly eme inspections were mand 9/17/2012	rgency generator visual nissed for 5/20/2013, 8/20, 9/10					
	2. The facility did r generator at 30% of	not run the diesel emergency of nameplate rating or by one of					

Facility ID: 00675

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - 4 SEASON SUN ROOM			(X3) DATE SURVEY COMPLETED	
		245487	B. WING			08/	13/2013
	PROVIDER OR SUPPLIER	NTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144	gas temperatures a manufacturer or b. under load of 3 nameplate rating of c. 2 hour load bar 25%, next 30 minut 75%) These deficient pra	aintains the minimum exhaust is recommended by the O percent or more of the generator or ok test (first 30 minutes - es - 50%, and last 1 hour - ctices were confirmed by the estaff (TH) at the time of	K	144			