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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SSSG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00588

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245125**

2.STATE VENDOR OR MEDICAID NO.
(L2) **112847700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FITZGERALD NH AND REHAB**
(L4) **227 MCKINLEY AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/26/2014** (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 **24** (L18)

13.Total Certified Beds **24** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Teri Ament, HFE NEII — 03/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/15/1967
(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
02/25/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5125

On February 21, 2014, this Department notified the facility of a change in Scope and Severity (S/S) of health deficiency cited at F465, which was reduced from a S/S level of F to a S/S level of E.

On February 26, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify correction of deficiencies reissued at the time of the December 27, 2013 PCR where three deficiencies were reissued and one new deficiency was cited. The February 26, 2014 PCR deteremined correction of the deficiencies as of February 7, 2014. As a result of the change in S/S level of deciency cited at F465 and the February 26, 2014 PCR, this Department discontinued the category 1 remedy of State monitoring, effective February 7, 2014. In addition, we recommended the following to the CMS RO for imposition:

- Per day civil money penalty, effective October 30, 2013, be rescinded due to the reduction in S/S for deficiency cited at F465. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January30, 2014 be discontinued effective February 7, 2014. (42 CFR 488.417 (b))

Since Mandatory denial of payment for new Medicare and Medicaid admissions went into effect, the facility would be subject to a loss of NATCEP for a two year period, effective January 30, 2014. Refer to the CMS 2567b for health only.

Effective February 7, 2014; the facility is certified for 24 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5125

March 4, 2014

Ms. Patricia Banks, Administrator
Fitzgerald Nursing Home and Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

Dear Ms. Banks:

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 February 7, 2014 the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement 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

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 4, 2014

Ms. Patricia Banks, Administrator
Fitzgerald Nursing and Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

RE: Project Number S5125026

Dear Ms. Banks:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement actions, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On January 20, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 23, 2013. (42 CFR 488.422)

On January 20, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Per day civil money penalty, effective October 30, 2013 . (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 8, 2014. (42 CFR 488.417 (b))

Also, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 8, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on October 30, 2013 and lack of substantial compliance at the Post Certification Revisit (PCR) completed on December 27, 2013. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On, February 21, 2014, this Department notified you of the change in Scope and Severity (S/S) level of deficiency cited at F465 from S/S level F (widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy) to the reduced S/S level of E (a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was

not immediate jeopardy).

On February 26, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 27, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 27, 2013, effective February 7, 2014. As a result of the revisit findings and the reduction in S/S of deficiency cited at F465, this department discontinued the Category 1 remedy of State monitoring, effective February 7, 2014.

In addition, this Department recommended the following to the CMS Region V Office, CMS has concurred and authorized this Department to notify you of the recommendations:

- Per day civil money penalty, effective October 30, 2013, be rescinded due to the reduction in S/S for deficiency cited at F465. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective Februrary 8, 2014 be rescinded, effective February 7, 2014. (42 CFR 488.417 (b))

As we notified you in our letter of November 18, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 8, 2014. Since the primary trigger of denial of payment did not go into effect, the NATCEP prohibition is also rescinded.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure 5125r2_14sff.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245125	A. Building B. Wing	2/26/2014

Name of Facility	Street Address, City, State, Zip Code
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/07/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **02/07/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **02/07/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	03/04/2014	29433	02/26/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/30/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SSSG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00588

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245125**

2.STATE VENDOR OR MEDICAID NO.
(L2) **112847700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FITZGERALD NH AND REHAB**
(L4) **227 MCKINLEY AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/27/2013** (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 **24** (L18)

13.Total Certified Beds **24** (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
	24			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 02/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/15/1967
(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
02/25/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5125

On December 27, 2013 the Department of Health complete a Post Certification Revisit (PCR) and on December 9, 2013 the Department of Public Safety completed a PCR to determine correction of deficience issued at the time of the standard survey completed on October 30, 2013. Based on our PCR we have determined the life safety code deficiencies were corrected, but three health deficiencies were reissued and one new health deficiency was citeded. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

As a result of the PCR findings, the Category 1 remedy of State monitoring, effective November 23, 2013 will remain in effect. In addition, we recommended the following to the CMS RO for imposition:

-CMP per day, effective October 30, 2013
-Mandatory Denial of Payment for New Admissions (DOPNA), effective January 30, 2014

If Mandatory DOPNA goes into effect, the facility would be subject to a two year loss of NATCEP, effective January 30, 2014.

Refer to the CMS 2567 along with the facilities plan of correction and CMS 2567b. Post Certification Revisit to follow..

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3919

January 20, 2014

Ms. Patricia Banks, Administrator
Fitzgerald Nursing Home and Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

RE: Project Number S5125026

Dear Ms. Banks:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement actions, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On November 18, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 23, 2013. (42 CFR 488.422)

On November 18, 2013 this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office that the following enforcement remedy be imposed:

- Per day civil money penalty effective Ocotber 30, 2013 (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on October 30, 2013. The most serious deficiencies were found 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 December 27, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 9, 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 October 30, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the health deficiencies issued pursuant to our standard survey completed on, October 30, 2013 and PCR completed December 27, 2013. The health deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

In addition, at the time of this revisit, we identified the following deficiency:

F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of January 20, 2013:

- Per day civil money penalty effective October 30, 2013 would remain in effect. (42 CFR 488.430 through 488.444)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, This Department is recommending to the CMS Region V Office following additional remedy for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions, effective 15 days after receipt of this notice. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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) and Statement of Deficiencies (CMS-2567) from this visit.

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

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

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.

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

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 April 30, 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement 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 5125r1_14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245125	A. Building B. Wing	12/27/2013

Name of Facility	Street Address, City, State, Zip Code
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **12/13/2013**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **12/13/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/13/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/13/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/13/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/13/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	01/16/2014	29433	12/27/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/30/2013			

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245125	01 - MAIN BUILDING 01	12/9/2013

Name of Facility	Street Address, City, State, Zip Code
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0052	Correction Completed **11/05/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** MM/PS	**Date:** 01/16/2014	**Signature of Surveyor:** 03005	**Date:** 12/09/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/29/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	R 12/27/2013

RECEIVED
FEB 03 2014
MN Dept of Health
Duluth

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. Census 21	{F 000}	01C 2-3-14 RLN	
{F 282} SS=D	This facility is a Special Focus Facility (SFF) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services as directed by the plan of care for 3 of 3 residents (R20, R31, R25) reviewed for range of motion services. Findings include: R20 was not provided range of motion services	{F 282}		

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

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

F282

1. It is the intent of this facility to provide care to our Residents by qualified persons in accordance to the care plan. Resident R20, R31 and R25 care plans have been re-evaluated.
2. All care plans have been reviewed and updated when necessary.
3. Practices for assessment and communication of assessment results have been revised when appropriate.
4. All nursing staff members have been educated to the change in expectation for communication of Resident care needs. Audits of Resident care and documentation will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will be completed once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: February 7, 2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 282}	Continued From page 1 as directed in the care plan. R20's diagnosis list included dementia, and osteoarthritis of the right wrist. The significant change Minimum Data Set (MDS) dated 12/29/13, indicated R20 had short and long term memory problems, and severely impaired cognitive skills for daily decision making (rarely/never made decisions). The MDS further indicated R20 had upper extremity (shoulder, elbow, wrist, hand) impairment on one side, and lower extremity (hip, knee, ankle, foot) impairment to both sides of his body. The care plan dated 12/11/13, indicated R20 was at risk for pain related to contractures of the lower extremities, and directed caregivers to assist in applying a right wrist/arm splint daily. The restorative maintenance record for 12/13, directed staff to perform ROM as follows: ROM on upper extremity and lower extremity daily. Place your hand on elbow and bend his arm at the elbow towards body and then away from body x10 (repetitions) both arms. Raise both arms as high as tolerated over head as he tolerates by holding wrist and elbow x10 (repetitions). Rotate both wrists in a circular motion x10 (repetitions). While in bed supporting ankle and knee and bring knee towards chest as high as tolerated straighten leg by lowering it back down to the bed x10 (repetitions). Rotate ankle in circular motion both ankles x10 (repetitions). The restorative maintenance record and restorative nursing in the computer indicated ROM was not provided on 12/16/13, 12/19/13,	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 282}	Continued From page 2 12/24/13, 12/25/13, and 12/26/13. On 12/27/13, at 9:48 a.m. nursing assistant (NA)-A was interviewed and stated she did ROM on R20 that morning when completing morning cares. NA-A stated she did about five repetitions to R20's hands and arms, it took just a few minutes, "I didn't go crazy with it." NA-A further stated if she does any ROM on a resident, she documents it as being completed, even if she is unable to complete the ROM as ordered. R31 was not provided range of motion services as directed in the care plan. days. R31's care plan indicated diagnoses that included Alzheimer's disease and muscular atrophy disuse. The admission MDS dated 10/25/13, indicated R31 had short and long term memory problems, and had moderately impaired cognitive skills for daily decision making. The restorative maintenance record for 12/13 directed staff to perform ROM as follows: ROM on upper extremity and and lower extremity daily. Place your hand on elbow and bend his arm at the elbow towards body and then away from body x10 (repetitions) both arms. Raise both arms as high as tolerated over head as he tolerates by holding wrist and elbow x10 (repetitions). Rotate both wrists in a circular motion x10 (repetitions). While in bed supporting ankle and knee and bring knee towards chest as high as tolerated straighten leg by lowering it back down to the bed x10 (repetitions). Rotate ankle in circular motion both ankles x10 (repetitions). Ambulate with 2	{F 282}		

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{F 282}	Continued From page 3 staff, gait belt, and walker in hallway 15 feet in the a.m. and p.m. The restorative maintenance record and restorative nursing in the computer indicated ROM was not provided on 12/15/13, 12/19/13, 12/24/13, and 12/25/13. On 12/27/13, at 9:15 a.m. NA-B was interviewed and stated he did ROM on R31 that morning when he was getting him dressed. NA-B stated he only did his arms, did them both about 10 times, then proceeded to demonstrate by lifting up his arm. NA-B stated he did not complete any further ROM. On 12/27/13, at 1:49 p.m. NA-C was interviewed and stated she has done ROM on evening shift a couple of times. NA-C further stated she checks the restorative maintenance record every shift, and if she has time she will complete ROM as ordered. At 1:52 p.m. NA-D was interviewed and stated she looks at the restorative maintenance book at the start of the evening shift, and will try to complete ROM if days shift did not get it done. On 12/27/13, at 10:24 a.m. the DON was interviewed and stated she would expect ROM services be completed for R20 and R31 as ordered on the restorative maintenance record. The DON said she would expect staff inform her if they were unable to complete ROM as ordered, and document the reason it was not completed.	{F 282}		

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{F 282}	Continued From page 4 The facility was unable to provide a policy and procedure on following the care plan. R25 was not provided Range of Motion (ROM) services as directed in the care plan. R25's care plan, dated 10/17/13, noted diagnoses including Alzheimer's disease, difficulty walking, and arthritis. The significant change MDS dated 11/25/13, indicated R25 had severe cognitive impairment and required extensive assistance with all activities of daily living. R25's ROM care plan, dated 10/17/13, included in the maintenance program binder, directed staff to provide upper and lower extremity ROM every day. Staff were instructed to, "Perform ROM on UE (upper extremities) and LE (lower extremities) daily. Place your hand on elbow and bend his arm at the elbow towards body and then away from body x10 both arms. Raise both arms as high as tolerated over head as he tolerates by holding wrist and elbow x10. Rotate both wrists in a circular motion x10. While in bed supporting ankle and knee towards chest as high as tolerated straighten leg by lowering it back down to the bed x10. Rotate ankle in circular motion both ankles x10." Review of the Nursing Rehab Time Log since 12/13/13 established R25 was provided only six sessions of ROM in 14 days. NA-A stated on 12/27/13 at 10:07 a.m. she did "a few reps" (repetitions) with R25's upper	{F 282}		

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{F 282}	Continued From page 5 extremities that morning while getting her dressed. She said she did about five reps with her shoulders elbows and fingers. She then demonstrated elbow extension, shoulders - arm away from body to above head, and spread fingers apart. She said she did nothing with R25's wrists and nothing with the resident's lower extremities. She added the afternoon shift would be completing the lower extremity ROM for R25. The Director of Nursing (DON) stated on 12/27/13, at approximately 10:45 a.m., she expected staff to provide ROM services for R25 and to communicate to the other staff if it had not been completed.	{F 282}		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide maintenance range of motion (ROM) services for 1 of 3 residents (R31, R20) reviewed for ROM services. Findings include: R25 was not provided ROM services as directed.	F 311		

F311

1. Resident R25 care plan for range of motion have been revised to include appropriate and attainable goals to meet their needs for range of motion. She is no longer receiving hospice support services.
2. All Residents range of motion care plan goals have reviewed with revisions made when appropriate.
3. Facility practices for the implementation of restorative nursing have been reviewed.
4. All nursing staff members have been educated to the change in expectation for communication of Resident care needs. Audits of Resident care and documentation will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: February 7, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 311	Continued From page 6 R25's care plan, dated 10/17/13, noted her diagnoses included Alzheimer's disease, difficulty walking, and arthritis. The significant change MDS dated 11/25/13, indicated R25 had severe cognitive impairment and required extensive assistance with all activities of daily living. R25's ROM care plan, dated 10/17/13, included in the maintenance program binder, directed staff to provide upper and lower extremity ROM every day. Staff were instructed to, "Perform ROM on UE (upper extremities) and LE (lower extremities) daily. Place your hand on elbow and bend his arm at the elbow towards body and then away from body x10 both arms. Raise both arms as high as tolerated over head as he tolerates by holding wrist and elbow x10. Rotate both wrists in a circular motion x10. While in bed supporting ankle and knee towards chest as high as tolerated straighten leg by lowering it back down to the bed x10. Rotate ankle in circular motion both ankles x10." Review of the Nursing Rehab Time Log since 12/13/13 established R25 was provided six sessions of ROM in 14 days. NA-A stated on 12/27/13, at 10:07 a.m. she did "a few reps" (repetitions) with R25's upper extremities that morning while getting her dressed. She said she did about five reps with her shoulders, elbows and fingers. She then demonstrated elbow extension, shoulders - arm away from body to above head, and spread	F 311		

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F 311	Continued From page 7 fingers apart. She said she did nothing with R25's wrists and nothing with the resident's lower extremities. She added the afternoon shift would be completing the lower extremity ROM for R25. The DON stated on 12/27/13, at approximately 10:45 a.m., she expected staff to provide ROM services for R25 and to communicate to the other staff if it had not been completed.	F 311		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 2 of 3 residents (R20, R31) reviewed for ROM services. Findings include: R20 was not provided ROM services as directed by the plan of care. R20's diagnoses list included dementia, and osteoarthritis of the right wrist. The significant	{F 318}		

F318

1. Resident R20 and R31 care plans for range of motion have been revised to include appropriate and attainable goals to meet their needs for range of motion.
2. All Residents range of motion care plan goals have reviewed with revisions made when appropriate.
3. Facility practices for the implementation of restorative nursing have been reviewed.
4. All nursing staff members have been educated to the change in expectation for communication of Resident care needs. Audits of Resident care and documentation will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: February 7, 2014

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{F 318}	Continued From page 8 change Minimum Data Set (MDS) dated 12/29/13, indicated R20 had short and long term memory problems, and severely impaired cognitive skills for daily decision making (rarely/never made decisions). The MDS further indicated R20 had upper extremity (shoulder, elbow, wrist, hand) impairment on one side, and lower extremity (hip, knee, ankle, foot) impairment to both sides of his body. The care plan dated 12/11/13, indicated R20 was at risk for pain related to contractures of the lower extremities, and directed caregivers to assist in applying a right wrist/arm splint daily. The restorative maintenance record for 12/13, directed staff to perform ROM as follows: ROM on upper extremity and lower extremity daily. Place your hand on elbow and bend his arm at the elbow towards body and then away from body x10 (repetitions) both arms. Raise both arms as high as tolerated over head as he tolerates by holding wrist and elbow x10 (repetitions). Rotate both wrists in a circular motion x10 (repetitions). While in bed supporting ankle and knee and bring knee towards chest as high as tolerated straighten leg by lowering it back down to the bed x10 (repetitions). Rotate ankle in circular motion both ankles x10 (repetitions). The restorative maintenance record and restorative nursing documentation in the computer indicated ROM was not provided on 12/16/13, 12/19/13, 12/24/13, 12/25/13, and 12/26/13.	{F 318}		

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{F 318}	Continued From page 9 On 12/27/13, at 9:48 a.m. nursing assistant (NA)-A was interviewed and stated she completed ROM for R20 that morning when completing morning cares. NA-A stated she did about five repetitions to R20's hands and arms, it took just a few minutes,"I didn't go crazy with it." NA-A demonstrated by moving her wrist in a circular motion and lifting up her arm. NA-A stated she did not attempt to do lower extremity ROM. At 12:28 p.m. NA-A stated she was not always able to complete ROM, and would inform the charge nurse, director of nursing (DON) or the administrator when she was unable to complete it. NA-A further stated if she does any ROM on a resident, she documents it as being completed, even if she is unable to complete the ROM as ordered. R31 was not provided ROM services. R31's care plan indicated diagnoses that included Alzheimer's disease and muscular atrophy disuse. The admission MDS dated 10/25/13, indicated R31 had short and long term memory problems with moderately impaired cognitive skills for daily decision making. The MDS further indicated R31 had no impairment to upper or lower extremities. The restorative maintenance record for 12/13 directed staff to perform ROM as follows: ROM on upper extremity and and lower extremity daily. Place your hand on elbow and bend his arm at the elbow towards body and then away from body x10 (repetitions) both arms. Raise both arms as high as tolerated over head as he tolerates by holding wrist and elbow x10 (repetitions). Rotate	{F 318}		

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{F 318}	Continued From page 10 both wrists in a circular motion x10 (repetitions). While in bed supporting ankle and knee and bring knee towards chest as high as tolerated straighten leg by lowering it back down to the bed x10 (repetitions). Rotate ankle in circular motion both ankles x10 (repetitions). Ambulate with 2 staff, gait belt, and walker in hallway 15 feet in the a.m. and p.m. The restorative maintenance record and restorative nursing documentation in the computer indicated ROM was not provided for R31 on 12/15/13, 12/19/13, 12/24/13, and 12/25/13. A physical therapy note dated 12/19/13, indicated R31 had reached maximum functional potential, and will continue with ROM with nursing staff for p.m. cares for lower extremities. On 12/27/13, at 9:15 a.m. NA-B was interviewed and stated he did ROM on R31 that morning when he was getting him dressed. NA-B stated he only did his arms, did them both about 10 times, then proceeded to demonstrate by lifting up his arm. NA-B stated he did not complete any further ROM. At 12:41 p.m. NA-B stated if he is unable to complete ROM he documents it as not completed. On 12/27/13, at 1:49 p.m. NA-C was interviewed and stated she has done ROM on the evening shift a couple of times. NA-C further stated she checks the restorative maintenance record every shift, and if she has time she will complete ROM as ordered. At 1:52 p.m. NA-D was interviewed and stated she looks at the restorative maintenance book at the start of the evening	{F 318}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	R 12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 318}	Continued From page 11 shift, and will try to complete ROM if day shift did not get it done. On 12/27/13, at 10:24 a.m. the DON was interviewed and stated she would expect ROM services be completed for R20 and R31 as ordered on the restorative maintenance record. The DON stated she started the ROM program with registered nurse (RN)-B, and they decided to start residents with daily ROM with 10 repetitions to upper and lower extremities because they had to start somewhere. The DON further stated she had provided staff education on ROM by supplying paper instructions that indicated how ROM was to be performed on each resident. The DON verified she did not do any hands on staff education. The DON stated she had not completed audits on range of motion; she would do them at the end of the month to see how things were going. The DON said she would expect staff to inform her if they were unable to complete ROM as ordered, and document the reason it was not completed. On 12/27/13, at 12:55 p.m. the administrator and the DON were interviewed. The DON stated if the NAs were having problems or questions on how to complete ROM, she would show them how to do it. The administrator stated the audits were being completed during the direct care audits on a.m. cares. The direct care audits included. "Was the care plan followed for the cares being provided?" and had a check box for yes or no. All facility audits were provided, and of the four direct care audits, all were answered, "Yes," indicating all of the required care was provided appropriately. The DON verified ROM documentation was being completed in the	{F 318}		

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{F 318}	Continued From page 12 restorative maintenance record and in the computer, staff had not been consistent in where they were documenting. The undated facility policy and procedure on nursing rehabilitation program directed nursing rehabilitation provide restorative nursing to residents to improve their range of motion through exercises and ambulation programs. The program is overseen by the DON and restorative RN nurse and assessed/documented monthly for appropriateness. Nursing assistants will do documentation of range of motion, number of repetitions as indicated, and initials of nursing staff will be completed on the treatment record upon completion or refusal.	{F 318}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	{F 441}		

F441

1. It is the policy of this facility to follow infection control protocols. R31 and R25 have been monitored for any potential infections with no negative outcomes.
2. All Residents are monitored for potential infections.
3. Procedure related to care delivery and hand washing have been reviewed. NA-A and NA-B have demonstrated proper procedure related to gloving and changing of a soiled brief.
4. All nursing staff members have demonstrated knowledge of proper procedure related to gloving and hand washing. Random hand washing audits will be completed three times a week for four weeks, then one time a week for four weeks. Audits will continue at least once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: February 7, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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{F 441}	Continued From page 13 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 2 of 3 residents (R31, R25) observed to receive personal cares. Findings include: Staff did not change gloves and wash their hands while providing incontinence care for R31. R31's care plan indicated diagnoses that included Alzheimer's disease and muscular atrophy disuse. The admission MDS dated 10/25/13, indicated R31 had short and long term memory problems, and had moderately impaired cognitive skills for daily decision making. The MDS also	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 14 for toileting and for personal hygiene. On 12/27/13, at 9:15 a.m. R31 was observed being toileted with nursing assistant (NA)-A and NA-B. Both NAs washed their hands, applied gloves, and used a lift stand to transfer R31 onto the toilet. NA-A removed R31's soiled incontinent brief, took a clean incontinent brief out of the drawer and handed it to NA-B. NA-A then used wipes to cleanse R31's perineal area. NA-A and NA-B fastened R31's clean brief, adjusted his clothing and transferred him to the wheelchair. NA-B was questioned, and stated she should have changed gloves and washed her hands after providing personal hygiene, and before applying the clean brief and adjusting R31's clothing. On 12/27/13 at 10:24 a.m. the director of nursing (DON) was interviewed, and stated she would expect staff would change gloves, wash hands after removing a soiled brief and providing incontinence care. R25 was provided personal cares without appropriate hand washing on 12/27/13. R25's care plan, dated 10/17/13 noted diagnoses including Alzheimer's disease, difficulty walking, and arthritis. The significant change MDS dated 11/25/13, indicated R25 had severe cognitive impairment and required extensive assistance with all activities of daily living, including assistance with toileting and personal hygiene.	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 441}	Continued From page 15 R25's care plan dated 10/17/13, indicated R25 was unable to care for herself with activities of daily living such as bathing, grooming, dressing and transferring. The POC directed the staff to provide assist with perineal care when toileting On 12/27/13, at 9:34 a.m. NA-A brought R25 to the large bathroom near the dining room to provide toileting. At 9:34 a.m., NA-A washed her hands with soap and water at the sink, dried them with paper towel and donned clean gloves. NA-A applied a transfer belt to R25, moved the walker close to the resident and stood the resident at her walker and pivoted to the toilet. NA-A removed R25's pants and assisted her to sit on the toilet. Once R25 indicated she was done, NA-A assisted her to stand from the toilet, wiped R25's peri area, pulled up her underwear and pants, pulled her shirt down neatly around her waist, assisted her to sit again in the wheel chair, and flushed the toilet. She then removed her gloves and washed her hands at the sink. NA-A was interviewed on 12/27/13, at 9:42 a.m.. She acknowledged she should have removed the soiled gloves after cleansing R25's peri area and before she pulled her pants back up. The DON was interviewed on 12/27/13, at approximately 10:45 a.m. and stated it is expected that staff wash their hands when going from dirty to clean and in this instance, NA-A should have washed her hands after providing peri care and before she assisted R25 in getting her pants back into place.	{F 441}		

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{F 441}	Continued From page 16 The Hand Hygiene policy revised on 1/26/04, directed staff to change gloves, "after offering incontinence care... After handling items potentially contaminated with any resident blood/body fluid."	{F 441}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: SSSG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00588

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245125**
2.STATE VENDOR OR MEDICAID NO.
(L2) **112847700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FITZGERALD NH AND REHAB**
(L4) **227 MCKINLEY AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **10/30/2013** (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 **24** (L18)

13.Total Certified Beds **24** (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
	24			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Chris Elmgren, HFE NEII 12/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(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 **05/15/1967** (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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5125

This facility is designated as a Special Focus Facility (SFF), Previously their name was Eveleth Health Services. A standard survey was completed at this facility on October 30, 2013. The most serious deficiency was cited at a S/S level of F which constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy.

As a result of the facility's designation as a SFF, a facility of this designation is subjec to increasingly stringent enforcement action. Since this nursing home meets the this criteria, this Department imposed the Category 1 remedy of State monitoring, effective November 23, 2013. In addition, this Department recommended teh following enforcement remedy listed below to the CMS Region V Office:

¿ Per day civil money penalty, effective October 30, 2013 . (42 CFR 488.430 through 488.444)

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6695

November 18, 2013

Ms. Patricia Banks, Administrator
Eveleth Health Services Park
227 McKinley Avenue
Eveleth, Minnesota 55734

RE: Project Number S5125026

Dear Ms. Banks:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On October 30, 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, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Patricia Halvorson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

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

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 23, 2013. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per day civil money penalty, effective October 30, 2013 . (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 January 30, 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 April 30, 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

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

PRINTED: 11/18/2013
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
DEC 02 2013
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Name Changed to Fitzgerald NH & Rehab EVELETH HEALTH SERVICES PARK	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS = 23	F 000	OK 12-9-13 BLH	
F 157 SS=D	This Facility is a Special Focus Facility (SFF) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

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

Patti Blesha, Administrator 12/2/2013

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.

Received Time Dec. 2. 2013 1:18PM No. 4955

F157

1. It is the policy of this facility to notify others of changes in Resident condition. Resident R2's family has been notified that he had developed a reddened area on his left buttock. This area is currently healed.
2. All Residents' records have been reviewed. All family members have been notified when necessary.
3. The facility practice for communication of Resident changes has been reviewed and revised.
4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue one time per month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: December 13, 2013

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVELETH HEALTH SERVICES PARK	227 MCKINLEY AVENUE EVELETH, MN 55734

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely family notification regarding a new pressure ulcer for 1 of 1 residents (R2) reviewed for pressure ulcers. Findings include: R2's diagnoses included vascular dementia with delusions, diabetes type 2 and acute cerebrovascular insufficiency. Medical record review indicated R2's responsible person was not notified when the left buttock reddened area developed an open area. The quarterly Minimum Data Set (MDS) dated 8/1/13, indicated R2 was cognitively intact, required extensive assistance with transfers and repositioning, was assessed to be at risk for the development of pressure ulcers, and currently had 1 stage 2 pressure ulcer.	F 157		

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F 157	Continued From page 2 A resident progress note dated 5/7/13, indicated R2 was observed to have developed unblanchable dark red areas on both buttocks, measuring 5 cm in length by 4.2 cm in width on the right buttock and 8.1 cm in length by 6.2 cm in width on the left buttock. A resident progress note dated 5/17/13, indicated R2 had an area of redness on (L) [left] buttocks measuring 10.0 cm by 9.5 cm with an open area in the middle of the reddened area measuring 3.0 cm by 3.0 cm. that was treated with off loading pressure relief and a duoderm dressing. On 10/30/13, at 10:00 a.m. the director of nursing (DON) the responsible person should have been notified when the left buttock opened up as that constituted a change in R2's condition.	F 157		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 274		

F274

1. R26 no longer resides in facility. The Minnesota Department of Health-Case Mix Review department was contacted regarding submission of a modification/correction MDS.
2. The care plans of all current Residents have been reviewed to assess for the potential need for the completion of a significant change MDS.
3. The policy and procedure for changes in Resident condition has been revised.
4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
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F 274	Continued From page 3 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a significant change in condition assessment for 1 of 1 residents (R26) who had a decline in activities of daily living (ADLs), was placed on comfort care and developed pressure ulcers. Findings include: R26's diagnoses included cirrhosis of the liver, hepatitis C, chronic airway obstruction, epilepsy and ascites. The admission Minimum Data Set (MDS) dated 5/29/13, indicated R26 was cognitively intact and required stand by assistance of one staff for bed mobility. The MDS directed R26 required limited assistance of one staff for transfers, ambulation, locomotion on and off the unit, dressing, toileting and eating. The MDS further indicated R26 did not have a terminal diagnoses and was not at risk for the development of pressure ulcers. Physician's orders on 7/30/13, included comfort cares (care at the end of life). The order directed to discontinue all medications (with the exception of pain medications, antianxiety medications, antinausea medications, and medication to dry up secretions), insert a Foley catheter for urinary drainage, administer oxygen as needed, and follow a diet as tolerated.	F 274		

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F 274	Continued From page 4	F 274		

The quarterly MDS dated 8/19/13, indicated R26 required increased staff assistance in the following areas: extensive assistance of one staff for bed mobility, dressing, bathing, and total staff dependence for toileting and locomotion on and off the unit. The MDS further indicated R26 did not have a terminal diagnoses was not at risk for the development of pressure ulcers.

On 8/29/13, a care conference summary indicated R26 had a decline in ADLs and disease process, required assistance of two staff, and was on comfort care.

Closed medical record review indicated R26 developed a pressure ulcer on each buttock on 9/22/13. The pressure ulcer on the right buttock measured 1 centimeter (cm) by 1 cm. The pressure ulcer on the left buttock measured 2 cm by 3 cm. Both areas were open, bleeding, and a transparent dressing was applied. The areas were not staged (staging is a description of the underlying tissue damage caused by a pressure ulcer). The pressure ulcers increased in size, eventually measuring 4 cm by 3.2 cm on the right buttock, and 6.5 cm by 4.9 cm on the left buttock on 10/9/13. R26 expired on 10/12/13.

On 10/29/13, at 10:07 a.m. the director of nursing (DON) was interviewed and stated the facility team considers potential resident change of condition assessments at morning meetings. The DON stated a change in ADLs would be a reason to complete a significant change assessment, as would a revision of the care plan when comfort

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F 274	Continued From page 5 cares were provided. The DON confirmed a significant change in condition assessment should have been completed for R26. The facility was unable to provide a policy and procedure on significant change in condition assessments.	F 274		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address psychoactive medications for 2 of 6 residents (R15, R11) reviewed for unnecessary medications; and for 1 of 3 residents (R16)	F 279		

F279

1. The care plans for R11, R15 and R16 have been reviewed and revised.
2. The care plans of all current Residents have been reviewed and revised when needed.
3. Inter-disciplinary practices for assessment and communication of Resident changes have been revised.
4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: December 13, 2013

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F 279	Continued From page 6 reviewed for skin conditions. Findings included: Review of the electronic medication order history log indicated R15 received Zoloft 75 milligrams (mg) (antidepressant medication) since on 12/7/12. R15's diagnoses included mental disorder, end stage renal disease, impulsive emotional state and dementia. The care plan lacked a problem statement, goals and approaches related to the use, risks and monitoring of the antidepressant medication. On 10/30/13, at 10:45 a.m. the director of nursing (DON) verified the antidepressant was not on the care plan and should have been. R11's care plan did not address the indications for use of an antidepressant (Celexa). R11's diagnoses included depressive disorder. R11's quarterly minimum data set (MDS) dated 8/19/13, indicated R11 was cognitively intact, had no mood problems, and occasionally exhibited verbal behavioral symptoms. Physician orders dated and signed 10/13/13, directed R11 to receive citalopram [Celexa] 10 mg oral daily. R11's care plan dated 8/5/13, did not address depression or the use of the antidepressant	F 279		

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F 279	Continued From page 7 medicaiton. On 10/30/13, at approximately 10:00 a.m. registered nurse (RN)-B stated R11's plan of care did not address the use of an antidepressant with indications for use, individualized approaches or interventions, and target behaviors. R16 did not have a care plan to address interventions related to a history of bruising easily. R16's diagnoses included end stage renal disease, diabetes and pain. The significant change minimum data set (MDS) dated 8/9/13 indicated R16 was cognitively intact. On 10/28/13, at 2:17 p.m. R16 was observed to be laying on his bed. R16's entire left forearm was bruised, and there were several smaller bruises noted on his left upper arm near the elbow. R16 stated he bruised easily, and the bruises on the left arm were from the dialysis shunt infiltrating, and subsequent surgery to repair the shunt. On 10/29/13, at 7:28 a.m. R16 was observed during a blood draw. The registered nurse (RN)-A used a tourniquet on R16's right upper arm to aid in finding a vein. RN-A stated she did not like to tighten the tourniquet too tight because R16 bruises easily. RN-A was unable to draw a blood sample on the first try. She released the tourniquet, and went to get more supplies. RN-A again used the tourniquet, and was able to obtain	F 279		

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F 279	Continued From page 8 a blood sample. When RN-A released the tourniquet, R16 was noted to have a bruise on the right upper arm that had not been there prior to the blood draw. On 10/30/13, at 10:14 a.m. the director of nursing stated R16 is able to tell the facility the origin of the bruising. The DON verified R16's care plan did not address bruising, and she stated it would be her expectation it be on the care plan. The facility was unable to provide a policy and procedure on care plans.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 1 of 1 residents (R19) reviewed for dialysis. Finding include: R19's diagnoses included renal failure with hemodialysis.	F 282		

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F282

1. It is the intent of this facility to provide care to our Residents by qualified persons in accordance to the care plan. Resident R19 dialysis access site has been re-assessed. Assessment indicates no adverse results to R19.
2. All Residents have been re-assessed for any potential changes in condition.
3. Practices for assessment and communication of assessment results have been revised when appropriate. RN-A and RN-B have been re-educated to policy and procedures regarding dialysis plans of care and communication of resident assessment results.
4. All nursing staff members have been educated to the change of practice. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will be completed once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
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F 282	Continued From page 9 R19's care plan edited 9/5/13, indicated R19 was receiving dialysis three times weekly. R19's care plan further directed monitoring of R19's split ash catheter in the right upper chest for signs and symptoms of infection and to notify dialysis unit if signs or symptoms of infection were noted. On 10/29/13, at 2:10 p.m. R19 was back from dialysis. RN-A was in the room but did not not observe R19's catheter or the right chest dressing site. At 2:45 p.m. RN- A stated R19 has a catheter for dialysis treatments. On 10/30/13, at approximately 10:30 a.m. RN- B stated there were no cares required for R19 since dialysis was the day before. On 10/30/13, at 1:30 p.m. RN-B stated monitoring of R19's catheter and dressing was not provided as directed by the plan of care.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor the dialysis access site for 1 of 1 residents (R19) reviewed for	F 309		

F309

1. It is the intent of this facility to provide the necessary care and services so our Residents attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with a comprehensive assessment and plan of care. Resident R19 dialysis access site has been re-assessed. Assessment indicates no adverse results to R19.
2. All Residents with dialysis access sites present have been re-assessed. Assessments indicate no adverse effects.
3. Practices for assessment and care planning have revised when appropriate. RN-A and RN-B have been re-educated to policy and procedures regarding dialysis plans of care.
4. All nursing staff members have been educated to the change of practice. Audits of Resident care and Resident interviews will be conducted three times a week for four weeks, then one time a week for four weeks. Direct care audits and interviews will continue monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
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F 309	Continued From page 10 dialysis. Finding include: R19 was admitted on 5/30/13, with diagnoses that included included end stage renal failure with dialysis. A quarterly minimum data set (MDS) dated 9/6/13, indicated R19 was cognitively intact and receiving dialysis. R19's care plan edited 9/5/13, indicated R19 was receiving dialysis three times weekly. R19's care plan further directed monitoring of R19's split ash catheter in the right upper chest for signs and symptoms of infection and to notify dialysis unit if signs or symptoms of infection were noted. On 10/29/13, at 7:00 a.m. R19 was observed to be absent from the facility. Registered nurse (RN)-A stated R19 was the dialysis unit. At approximately 11:30 a.m. R19 was observed in their room, having returned from dialysis treatment. On 10/29/13, at 2:30 p.m. RN-A entered R19's room, per R19's request, with supplement for when meal intake was low. RN-A stayed with R19 but did not observe R19's catheter or dressing site on the right chest. At 2:45 p.m. RN-A stated R19 has a catheter for dialysis treatments three times per week.	F 309		

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F 309	Continued From page 11 On 10/30/13, at 1:30 p.m. RN-B stated monitoring of R19's catheter and dressing was on R19's care plan, but was not being provided. R19 had been back and forth between dialysis via shunt and catheter and access site monitoring was not on the electronic medication/treatment record.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide restorative range of motion (ROM) for 2 of 3 residents (R14, R22) who had physical limitations. Findings include: R14's diagnoses included depression and cognitive impairment. Registered Nurse -A (RN-A) stated, on 10/27/13, at 4:46 p.m. R14 had contractures of the hands, neck and both lower extremities. R14 was observed on 10/28/13, at 8:26 a.m., in the wheel	F 318		

F318

1. R19 no longer resides at this facility; however, prior to discharge, range of motion exercise was added to the plan of care. R14 continues to reside at this facility; this plan of care has been assessed to include the elimination of a wheel chair seat belt and the addition of rolled wash cloth used in the palm of each hand.
2. All Residents with restorative nursing services in their care plan have been re-assessed for appropriateness of care.
3. Facility policy and procedure for restorative nursing have been reviewed and revised. Facility practices for the implementation of restorative nursing have been reviewed.
4. All nursing staff members have been educated to the change of practice. Audits of Resident care and records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least monthly for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: December 13, 2013

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVELETH HEALTH SERVICES PARK	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 318	Continued From page 12 chair with hands clenched on the lap. R14 had no splints or padding observed in the room. The 4/8/13, quarterly MDS noted bilateral impairment in both her upper and lower extremities. The quarterly MDS, dated 7/7/13, noted bilateral impairment in her lower extremities and one side in her upper extremities. The annual Minimum Data set (MDS) dated 10/2/13, identified R14 with functional limitation in ROM on both sides (bilaterally) of the body, upper and lower extremities. A Fax to R14's physician, dated 5/15/13, stated, "Noting [decreased] ROM in bilateral hands - seeking OT (occupational therapy) evaluate and treat as indicated orders." The request was signed by the Director of Nursing (DON) and approved by the physician on 5/17/13. On 5/17/13, OT completed an initial assessment and determined R14 would "be set up on an appropriate ROM program for bilateral hands to protect skin integrity and maintain ROM for ease with self care. A second goal noted R14 would "achieve optimal positioning of bilateral hands with appropriate orthotic or skin protector..." The OT - Therapist Progress and Discharge Summary, dated 5/24/13, indicated R14 met goals, was discharged from OT, and, "Set up on appropriate U/E (upper extremity) ROM program to include hand wrist/finger ROM to protect skin integrity, and maintain for ease with self care". The Discharge Summary also noted nursing staff at the facility was educated on the importance of completing ROM and on the use of palm protectors for R14 to use at night. The Discharge Plan was for R14 to remain in the nursing home	F 318		

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F 318	Continued From page 13 with a Functional Maintenance Program. R14's care plan, dated 9/29/13, lacked direction for the required ROM and the OT orders were not in the restorative binder where the orders are kept for staff to document treatment provided. The DON, interviewed on 10/30/13, at 9:11 a.m., stated that OT discharge orders, including R14's from 5/21/13, should have been used to develop the functional maintenance program for R14. The DON said nothing was done and no hand splints or palm protectors were provided for R14. At 9:45 a.m., the DON stated there was no facility policy regarding initiation of OT recommended restorative ROM services. R22 was not provided consistent restorative nursing services. R22's diagnoses included incomplete quadriplegia (partial damage to the spinal cord) and cervical spondylosis with myopathy (characterized by neck stiffness, arm pain, numbness in the hands, and weakness of the hands and legs). R22 was observed on 10/27/13, at 4:12 p.m. in the wheelchair with the right arm laying limp on the lap. RN-A stated, on 10/27/13 at 4:46 p.m., R22 did not have contractures, but had significant weakness in the upper and lower extremities. R22's admission MDS, dated 9/27/13, established R22 had upper and lower extremity limitations on both sides of the body. The care plan dated 9/19/13, indicated R22 had	F 318		

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F 318	Continued From page 14 no ability to ambulate related to poor muscle coordination of his lower extremities, secondary to incomplete quadriplegia. The Care plan directed staff to encourage and educate R22 to complete independent ROM. RN-A interviewed on 10/29/13 at 9:51 a.m., stated R22 should be provided daily staff assisted ROM to both upper and lower extremities.	F 318		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

F329

1. R27 no longer resides at this facility; however, the physician was scheduled to visit with R27 to review medications prior to discharge.
2. All Residents have been assessed for side effects with gradual dose reductions implemented when necessary.
3. Policies and procedures regarding negative side effects of psychotropic medication and Resident responsible party refusal of care have been reviewed with revisions made when needed.
4. All nursing staff members have been educated. Audits of Resident records will be conducted three times a week for four weeks, then one time a week for four weeks. Audits will continue at least once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: December 13, 2013

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F 329	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify, assess and monitor ongoing use of medications for 1 of 6 residents (R27) whose medications were reviewed. Findings include: R27 was admitted from a hospital on 7/9/13, with diagnoses that included chronic airway obstruction, hypertension and atrial fibrillation. Admission physician's orders included risperdal (antipsychotic medication used to treat schizophrenia and bipolar disorders) 1 milligram (mg) twice a day. The risperdal order did not address symptoms or side effects to be monitored. The temporary care plan, dated 7/9/13, indicated R27 had behaviors of crawling out of bed and pulling on medical tubing such as catheter. The care plan directed staff to monitor behaviors, calmly explain the harm that could be caused by pulling on tubing, and to administer risperdal twice daily. Nursing notes on 7/10/13, at 10:45 p.m. indicated R27 was too weak to get out of bed to sit in a chair. On 7/11/13, at 11:01 a.m., nursing notes indicated R27 required assistance of 2 staff for bed mobility and transfers with a mechanical lift. On 7/11/13 at 11:30 p.m., nursing notes indicated R27 required assistance of 2 staff for bed mobility, ate only a few bites of supper and fell asleep. On 7/13/13, at 1:43 p.m., nursing notes	F 329		

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F 329	Continued From page 16 indicated R27's family was concerned about sedation and confusion possibly from risperdal. Nursing notes on 7/14/13, at 1:22 p.m. indicated R27 had expired. The director of nurses (DON), interviewed on 10/28/13, at 1:52 p.m., verified the lack of symptom identification and/or side effect monitoring for the use of risperdal. When asked if anyone questioned the admission physician's orders, the DON shook her head, "No". The DON verified the family concern with the use of risperdal, but they did not contact the physician to report R27's confusion and sedation.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		

F441

1. It is the policy of this facility to follow infection control protocols. R2 has been monitored for any potential infections with no negative outcomes.
2. All Residents are monitored for potential infections.
3. Procedure related to care delivery and hand washing have been reviewed. NA-A has been re-educated to this procedure and the risk to the Residents of not following procedure.
4. All nursing staff members have been educated. Random direct care audits will be completed three times a week for four weeks, then one time a week for four weeks. Audits will continue at least once a month for one year. The results of these audits will be reviewed during the monthly QA meeting with recommendation for continued process improvement given.
5. The Director of Nursing or her designee will be responsible for completion.
6. Correction date: December 13, 2013

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F 441	Continued From page 17 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure infection control precautions were followed for 1 of 4 residents (R2) during observation of personal care. Findings include: R2's diagnoses included vascular dementia with delusions and urethral stricture. The quarterly minimum data set (MDS) dated 8/1/13, indicated R2 was cognitively intact and required extensive assistance with transfers, repositioning, and toileting activities. The 8/1/13, MDS further indicated R2 had an indwelling urinary catheter.	F 441		

Received Time Dec. 2. 2013 1:18PM No. 4955

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F 441	Continued From page 18 R2's care plan edited 4/29/13, directed catheter cares were to be provided every shift and catheter bag and extension tubing were to be changed every week and as needed. On 7/29/13, at 7:37 a.m. nursing assistant (NA)-A was observed providing catheter cares for R2 following a shower. NA-A applied disposable gloves, disconnected the urinary drainage bag from R2's indwelling suprapubic catheter, and disposed of the drainage bag. NA-A wiped the catheter end with an alcohol wipe, attached a new extension tubing to the catheter end, and then secured a new leg bag to the other end of the extension tubing. NA-A secured the extension tubing to R2's left thigh using a pre-applied velcro tape, removed the gloves, and opened the door to the shower room with her unwashed hands and left the shower room. NA-A returned at 7:41 a.m. to the shower room with straps for the leg bag to secure it to R2's lower leg. NA-A applied the straps to the leg bag and then to R2's lower leg. NA-A applied a transfer belt around R2's waist and used an EZ-stand to assist R2 to stand up from the shower chair. NA-A used a large white towel to dry R2's bottom, pulled up R2's brief and pants, and assisted R2 to sit in the wheelchair. NA-A pushed R2 in the wheelchair, after opening the shower room door with her unwashed hands, out to R2's room, stating she would complete R2's morning cares in the bedroom. When interviewed on 10/29/13, at 10:20 a.m., NA-A stated she usually washes her hands after completion of catheter cares and removal of	F 441		

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F 441	Continued From page 19 gloves. NA-A stated she forgot to wash her hands after removing the gloves and leaving the shower room. On 10/30/13, at approximately 2:00 p.m. the director of nursing (DON) stated the NA's should be washing their hands after glove removal with catheter cares. A Hand Washing policy revised 1/26/04, indicated handwashing was to be performed after offering incontinence care and Foley [catheter] care and before and after gloving.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure cleanliness and good repair of walls and furniture in 3 of 12 resident rooms (R20, R14, R11); cleanliness of 2 of 4 mechanical lifts observed, and in the main corridor utilized by all persons passing from the main entrance to the living area, the dining room and all resident rooms. This had the potential to affect all 23 residents residing in the facility. Findings include:	F 465		

F465

1. This facility works to provide a safe, functional, clean and comfortable environment for residents, staff and the public and is currently in a position to work on improving this. R20's bedside stand was fixed and the walls in his room were patched. R14's bedroom walls were patched. The toilet pipe in R11's room was repaired. The floor mat in R11's room was replaced. The corridor was cleaned of scuff marks. The wood trim and handrails were sanded and re-finished. The tile trim has been cleaned and re-grouted. The mechanical lifts have been cleaned.
2. All residents, staff and visitors could be affected.
3. The facility's practices addressing preventative maintenance and cleaning routines have been reviewed with revision when needed. This facility now has the ability to address physical plant needs ongoing. A painting company has been contracted with a plan in place to assure completion of necessary work.
4. All staff members have been educated on these practice changes. Audits of progress and prevention will be completed three times a week for four weeks and then one time a month; ongoing, with the results brought to QA meetings for review and recommendation.
5. The Administrator or her designee will be responsible for completion.
6. Correction date: 12/13/13

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F 465	Continued From page 20 During the environmental tour with the maintenance staff (MS) on 10/30/13, at 9:00 a.m., the following was observed: R20's room had numerous nail holes in the wall next to the bed. The paint was cracked and there were two pieces of missing plaster measuring approximately 5 by 3 inches and 2 by 1 inches. The door of R20's bedside stand was loose and hanging from the stand. R14's room had numerous nail holes in the wall next to the bed. There was square of different color paint, approximately 6 by 6 inch square, on the wall and an area of missing plaster, approximately 2 by 4 inches, on the wall under the over bed light. There was chipped and missing paint exposing the plaster around the thermostat next to the bed. R11's bathroom had rust colored stains around a pipe coming from the wall to the toilet as well as behind the toilet near the floor. The bedroom wall on the right of the entry door was discolored and had different colored paint on wall. There was a fall mat standing in the bathroom with torn edges, a long tear on the center that was covered with gray duct tape, and had several areas of exposed foam where the vinyl covering was absent. The facility has one long corridor with 12 resident rooms along one side of the corridor. The lower three feet of wall on both sides of the corridor were painted green with many scrapes and soiled	F 465		

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F 465	Continued From page 21 areas along the entire length. There was a strip of varnished wood trim, approximately four inches wide, and approximately one foot above the floor along both sides of the corridor. The wood trim was scraped with exposed rough wood. Below the wood trim there were 6 inch square ceramic tiles along the floor and curving up the wall on both sides of the corridor. The grout was black with soil. The corner of the wall at the utility room entry near the nursing station was marred and the wallpaper was torn. All of the doors, door jams and wall corners throughout the entire corridor were scraped and scratched. The walls were scraped and scratched in the entryways to all 12 of the resident's rooms. The baseboards were scratched with black marks on them. The the metal kick plates on the bottom of all the room doors were scratched, soiled and had black marks. Two of four mechanical lifts were observed to be soiled on all days of the survey, from 10/27/13 to 10/30/13. The foot plate on the easy move lift was covered with loose light brown colored substance. The Hoyer lift foot plate was soiled a black gray color. During the tour, the MS verified the observations and stated he does a weekly walk through of the facility. The MS was the only maintenance person and had been focusing on the boilers and the equipment on the roof. The MS stated staff notified him via email, paper, or verbally when repairs were needed. On 10/30/13, at 10:22 a.m. the housekeeping	F 465		

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F 465	Continued From page 22 manager (HM) stated that deep cleaning was done on Saturdays and Sundays. There were checklists to follow for cleaning. The checklists were not provided. The director of nursing (DON), interviewed on 10/30/13, at 10:45 a.m., stated she was not aware of the condition of the fall mat in R11's room. The DON indicated there was no cleaning schedule for the mechanical lifts but expected staff to clean the lifts weekly and whenever the lifts were soiled. On 10/30/13, at approximately 11:30 a.m., the administrator was notified of the concerns identified during the tour. During the conversation, a white cone shaped device with a vent around the end of it was observed to be hanging away from the ceiling. The administrator did not comment when the device was pointed out. The Preventive Maintenance policy and procedure (not dated) indicated there would be a preventive maintenance procedure established for each piece of equipment. The preventive maintenance program was set up according to a schedule. The doors and door jams were to be checked biweekly and the lifts were checked monthly.	F 465		

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	245125	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fitzgerald NH And Rehab ~~EVELETH HEALTH SERVICES PARK~~ Name Change	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 FIRE SAFETY SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Health Care Fire Inspections State Fire Marshal Division 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, OR By E-Mail to: Marian.whitney@state.mn.us, and Barbata.lundbery@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.	K 000	POC ok B 12-3-13 RECEIVED DEC 2 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-9-13

EXIT: 10-30-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patti Blanka	Administrator	12/2/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2013**

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K 000	Continued From page 1 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Eveleth Health Services Park 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. Eveleth Health Services Park is a 1-story building with a partial basement. The building was constructed in 1959, with one addition in 1996. The original building and the addition are Type I(111) therefore, the building was inspected as one building. The building also contains a mental health unit operated by others. The mental health portion of this building is not properly separated and was inspected on this date. The ESRD is properly 2 hour fire rated separated. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 24 beds and had a census of 23 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is not met.	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72. This deficient practice could affect all building occupants in the event of a fire. Findings include: Based on observation during the facility tour on 10-29-13 between 8:00-9:00 AM, it was observed that doors are being held open with electric magnetic devices and they do not have a fire alarm connected smoke detector within 5 feet of the door opening. These doors are the Business Managers Office, Social Services Office, and the Administrators Office. One fire alarm system smoke detector that is centrally located would	K 052		

K052

1. On November 5, 2013, a new smoke detector was installed. A wire to this smoke detector was run to connect the smoke detector to zone two. A test was performed. The smoke detector is installed correctly by ESC Systems.
2. November 5, 2013
3. The Maintenance Director is responsible for monitoring this.

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K 052	Continued From page 3 meet the requirement. These deficient practices were verified by the Director of Facility Maintenance and the Administrator at the time of exit.	K 052		