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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: U8TF
Facility ID: 00675

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

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

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

4. TYPE OF ACTION: **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 **11/13/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **100** (L18)
13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 12/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245487

December 28, 2017

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

Dear Mr. Root:

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 October 27, 2017 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 28, 2017

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

RE: Project Number S5487029

Dear Mr. Root:

On October 19, 2017, as authorized by the CMS Region V Office, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective October 24, 2017. (42 CFR 488.422)
- Civil Money Penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on September 29, 2017. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On November 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 14, 2017 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 an extended survey, completed on September 29, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on September 29, 2017, as of October 27, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 27, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 19, 2017:

- Civil Money Penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 28, 2017

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

Re: Reinspection Results - Project Number S5487029

Dear Mr. Root:

On November 13, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 29, 2017, with orders received by you on October 27, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: U8TF
Facility ID: 00675

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1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
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6. DATE OF SURVEY **09/29/2017** (L34)

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FISCAL YEAR ENDING DATE: (L35) **09/30**

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To (b) :

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

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X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 10/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/01/2017 (L20)

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(L25)

25. LTC EXTENSION DATE:
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26. TERMINATION ACTION: (L30)

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INVOLUNTARY
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07-Provider Status Change
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28. TERMINATION DATE:
(L28)

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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 5487

A survey was conducted by the Minnesota Department of Health on September 25, 2017 through September 29, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F323. The IJ began on 9/28/17, at 10:25 a.m. and was removed on 9/28/17, at 3:30 p.m. but noncompliance remained at the lower scope and severity level of E, a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2017

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

RE: Project Number S5487029

Dear Mr. Root:

On September 29, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> 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);
>
> Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on September 28, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective October 24, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Elizabeth Medical Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 29, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not

made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 29, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 29, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING ______ B. WING ______	09/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on September 25, 2017 through September 29, 2017 to determine compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to provide adequate supervision and assistive devices for bathing to minimize the risk of injuries and accidents. The IJ began on 9/28/17, at 10:25 a.m. when facility leadership first became aware residents had been left alone in the whirlpool. On 9/28/17, at 11:10 a.m. the director of nursing (DON) and Registered Nurse (RN)-F were informed of the IJ situation. The immediate jeopardy was removed on 9/28/17, at 3:30 p.m. but noncompliance remained at the lower scope and severity level of E, a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. An extended survey was conducted by the Minnesota Department of Health from September 28, 2017 through September 29, 2017. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2017

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
	245487	A. BUILDING ______ B. WING ______	09/29/2017

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

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F 000	Continued From page 1 regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 plan of care regarding activities of daily living including nail care was provided for 1 of 1 resident (R17) reviewed who had soiled and untrimmed nails. Findings Include: R17 had been observed on 9/26/17, at 9:15 a.m. to have long fingernails with substance under the thumbs. On 9/27/17, at 8:36 a.m. R17 had been at dining table eating breakfast using hands to feed self, and the soiled, untrimmed nails were observed. At 3:11 p.m. R17 shook surveyors hand, R17 hands had a sticky substance on both hands and large amount of debris under all nails except right hand index finger which was broke off to the nail bed. On 9/27/17, at 3:21 p.m. interview nursing assistant (NA)-L, stated nail care is completed on bath day. Review of R17 bath schedule read given 9/27/17,	F 282	R17's treatment plan updated to reflect daily hand hygiene to include warm, soapy soaks for 5-10 minutes to promote improved hand hygiene 10/10/17. Policies reviewed and revised as applicable, include "Resident Care Plans, Development, Implementation and Revision", "Using the Care Plan", "Shower/Tub Bath", "Care of Fingernail/Toenails" and "Hand washing/Hand Hygiene" by 11/10/17. Associate education to be completed related to resident hand hygiene/nail care by 11/17/17. DON/Designee to complete fingernail cleanliness/ hand hygiene audits on random residents that are identified as being independent with eating after setup. 3x week x4 weeks (10/29-11/25), 2x week x4 weeks (11/26-12/23) and 1x week x2 weeks (12/23-1/6/18). Audit findings to be identified and discussed at monthly QAPI meetings.	10/27/17

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F 282	Continued From page 2 at 9:56 a.m. R17 current care plan identified one-person assist with hygiene and bathing. The Nursing assistant activity of daily living care plan reads one-person assist with hygiene and bathing. On 9/29/17, at 8:39 a.m. observed R17 at the dining table eating cream of wheat, orange juice, toast and continued to have visible debris/substance under nails. 9/29/17 8:59 a.m. the Director of Nursing (DON) was informed of R17's soiled and untrimmed nails. DON stated the expectation to have staff to complete hand hygiene after meals and bathroom and as needed. A policy was requested for following care plans and none was provided.	F 282		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff provided activities of daily living (ADL) cares and services as assessed for 1 of 1 resident (R17) reviewed who required assistance to clean and trim nails.	F 311	R17's treatment plan updated to reflect daily hand hygiene to include warm, soapy soaks for 5-10 minutes to promote improved hand hygiene 10/10/17. Policies reviewed and revised as applicable, include "Resident Care Plans,	10/27/17

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F 311	Continued From page 3 Findings Include: R17 had been observed on 9/26/17, at 9:15 a.m. to have long fingernails stained with substance under the thumbs. On 9/27/17, at 8:36 a.m. R17 noted to sit at dining table eating breakfast using hands/fingers to eat. The soiled untrimmed nails were still noted. At 3:11 p.m. R17 shook surveyors hand, and R17 hands had a sticky substance on both hands and noted large amount of debris under all nails except right hand index finger which was broke off to the nail bed. On 9/27/17 at 3:21 p.m. interview nursing assistant (NA)-L, stated nail care is completed on bath day. Review of R17 bath schedule read given 9/27/17 at 9:56 a.m. The quarterly Minimum Data Set (MDS) assessment dated 7/14/17, identified R17 required limited assist of one for personal hygiene and one-person physical assist with bathing. R17 current care plan identified one-person assist with hygiene and bathing Nursing assistant activity of daily living care plan reads one-person assist with hygiene and bathing needs. On 9/28/17, at 12:35 p.m. Registered nurse (RN)-F had been interviewed on expectations of nail care. RN-F stated nail care completed on resident's bath day, it's easier to complete when nails are softer. Staff are to chart completed, if any refuses or not completed. RN-F verified in the computer record, R17 had a bath on 9/27/17 and there was no documentation of whether the	F 311	Development, Implementation and Revision", "Using the Care Plan", "Shower/Tub Bath", "Care of Fingernail/Toenails" and "Hand washing/Hand Hygiene" by 11/10/17. Associate education to be completed related to resident hand hygiene/nail care by 11/17/17. DON/Designee to complete fingernail cleanliness/ hand hygiene audits on random residents that are identified as being independent with eating after setup. 3x week x4 weeks (10/29-11/25), 2x week x4 weeks (11/26-12/23) and 1x week x2 weeks (12/23-1/6/18). Audit findings to be identified and discussed at monthly QAPI meetings.	

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F 311	Continued From page 4	F 311		

nail care were cleaned/trimmed.

On 9/28/17, at 12:43 p.m., observation with RN-F of R17 nails verified soiled and untrimmed nails. RN-F stated, "Pretty yucky and dirty." RN-F said that R17 was a finger eater and picks at her food. Surveyor asked if she would expect staff to wash R17 hands after meals knowing R17 is finger eater. RN-F stated, "I expect them to wash her hands." RN-F also said that R17 is independent to use the bathroom independently. Surveyor asked RN-F if she can tell what the substance is under R17 nails, RN-F stated she could not but there is a possibility it could be feces. RN-F asked R17 if she washes her hands after going to the bathroom. R17 was not able to clearly answer the question. RN-F stated there is a possibility R17 may not understand the questions being asked of her.

On 9/29/17, at 8:39 a.m. observed R17 at the dining table eating cream of wheat, orange juice, toast and continues to have debris/substance under nails. At 8:42 a.m. NA-D verified R17 hands were sticky and dirty and should have been wiped clean after eating. At 8:46 a.m. RN-F verified R17 nails remained dirty after staff was asked to clean R17 the day before.

9/29/17, at 8:50 a.m. NA-D took R17 to her room to clean nails after nurse manager asked staff to complete. NA-D asked R17 if ok to clean under nails and R17 stated yes. After starting to clean nail beds, R17 stated, "Don't push so hard." NA-D did not continue and said the debris is hard and packed under the nails and stated the resident often refuses.

9/29/17, 8:59 a.m. the Director of Nursing stated

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F 311	Continued From page 5 the expectation to have staff to complete hand hygiene after meals and bathroom and as needed. Review of the facility policy titled; Care of Fingernails/Toenails reads nail care includes cleaning and trimming. Stop and report to the nurse supervisor if there is evidence of pain. If the resident refused the treatment, document the reason(s) why and the intervention taken. Policy titled; Shower/Tub Bath dated 8/1/17 reads trim the resident's toenails and fingernails unless resident has diabetes. Policy titled Standards for Resident and His/her Environment dated 8/4/11 reads Finger and toenails will be cleaned with morning cares/bath.	F 311		
F 323 SS=K	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		10/27/17

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F 323	Continued From page 6 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safety measures were implemented for 12 of 74 residents (R42, R62, R46, R89, R82, R98, R56, R90, R97, R61, R10, & R4) allowed to use the facility whirlpool without staff in attendance, and without application of the seat belt from the tub chair. This posed a potential for serious harm or death for the 12 residents identified and resulted in an immediate jeopardy (IJ) situation. The IJ began on 9/28/17, at 10:25 a.m. when facility leadership first became aware residents had been left alone in the whirlpool. On 9/28/17, at 11:10 a.m. the director of nursing (DON) and Registered Nurse (RN)-F were informed of the IJ situation. The immediate jeopardy was removed on 9/28/17, at 3:30 p.m. but noncompliance remained at the lower scope and severity level of E, a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. In addition to the IJ related to whirlpool bath safety, the facility also failed to complete a community safety assessment for 1 of 1 resident (R45) who independently utilized a motorized scooter in the community. Findings include:	F 323	R89, R82, R98, R90, R6, R10 had safety assessments completed including risk/benefits related to being in the whirlpool tub unattended with safety measures (call light within reach, safety checks and abdominal safety strap) in place. Care plans updated to reflect. R97, R42 refused to accept the application of safety strap and therefore determined to not be safe to be left alone in the whirlpool tub for any period of time. R62, R46, R56, R4 were determined to not be appropriate candidates to be left unattended in the whirlpool tub for any period of time. Current residents and residents admitted to facility will not be left alone for any period of time in the whirlpool tub until a safety assessment is completed and care plan updated to reflect, if appropriate. Policies "Shower/Tub Bath", "Safety and Supervision of Residents", and "Use of Whirlpool Tub" reviewed/revised as applicable by 11/10/17. Associate education regarding safe bathing practices has been provided to all nursing associates. New associates will receive orientation on use of whirlpool tub and safety measures to be in place during bathing of resident. DON/Designee to complete bathing safety	

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F 323	Continued From page 7 During an observation on 9/27/17 at 7:38 a.m., the surveyor walked by the bathing room located on the 100 wing and observed the bathing room door was open. Although a privacy curtain was in place, there was an approximate 12 inch unclosed area allowing view of R42 in the whirlpool tub. The surveyor knocked on the open bathing room door and announced herself with no response from the resident. Upon entering the room, R42 was observed to be seated in the whirlpool tub with no staff present in the bathing room. The whirlpool jets were on and the tub was filled with water approximately 3 inches from the top which came to R42's chest area. R42 had a call light within reach, and the right arm of the chair R42 was sitting in was in the down position, however the padded safety belt from the tub chair was not in place. At 7:46 a.m. nursing assistant (NA)-A entered the room and questioned R42 as to whether he was ready to get out of the tub. At that time, NA-A told the surveyor she and other nursing assistants use their discretion to determine whether residents can be left alone in the bathtub. When asked if an assessment for safety was completed for residents to determine whether they were safe to be left alone in the whirlpool, NA-A stated she was unaware of any such assessment having been completed. R42's diagnoses list printed on 9/29/17, included diagnoses of: major depressive disorder, osteoarthritis, restless leg syndrome, Alzheimer's disease, and dementia without behavioral disturbance. R42's care plan dated 9/26/17, identified R42 needed one person assist in the whirlpool. The care plan identified R42 has dementia that affected his memory and ability to understand at times, had chronic bilateral knee pain, glaucoma, macular degeneration, and vision	F 323	audits on random residents 3x week x4 weeks (10/29-11/25). 2x week x4 weeks (11/26-12/23) and 1x week x2 weeks (12/23-1/6/18). Audit findings to be identified and discussed at monthly QAPI meetings. R45 had access revoked to his power operated vehicle (electric scooter) related to decreased safety awareness and cognitive deficits as identified with cognitive screening tests conducted by occupational therapist on 9/28/17. Residents currently residing in the facility that utilize power operated vehicles (electric scooters/wheelchairs) will have safety review of appropriateness for use of devices and if concerns identified, referral to occupational therapy for evaluation by 11/10/17. Review/revision as applicable of policy "Motorized Mobility Aids (Electric Scooters/Wheelchairs)" and "Safety and Supervision of Residents" completed by 11/10/17. Associate education regarding facility policy on power operated vehicles (electric scooters/wheelchairs) completed by 11/17/17.	

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F 323	Continued From page 8 loss to his right eye. The care plan identified R42 is at risk for falls due to knee pain and weakness and has a history of falling out of his wheel chair reaching for items. R42's MDS dated 8/11/17, identified R42 needed physical assistance in part of bathing activity and required one person assist. The record lacked identification if R42 could be left unattended in the whirlpool and what safety devices were appropriate. During an observation on 9/27/17 at 8:41 a.m., R62 was observed in the whirlpool tub with NA-A present. The NA stated she was waiting for assistance from a colleague to transfer R62 out of the tub. At 8:47 a.m., NA-B arrived to help NA-A assist R62 out of the tub. During an interview at that time, NA-B stated most residents in the facility receive whirlpool baths and some like to sit and soak. NA-B stated she knew which residents could be left unattended because she was familiar with the residents and used her discretion. When questioned, NA-B stated she was unaware of whether there was any type of safety assessment completed to determine whether residents could be left alone in the tub. NA-B stated the only safety device used with the whirlpool was to keep the call light within reach and proceeded to state that residents usually soak for approximately 10 to 15 minutes. R62 was assisted out of the whirlpool tub at 8:52 a.m. on 9/27/17. Immediately following R62 getting out of the tub, NA-A was interviewed and asked about the use of safety devices while residents were in the tub. NA-A stated the safety devices for the whirlpool tub included the use of the arm on the right side of the whirlpool chair which residents are asked whether they want up or down, and the black padded chair belt that	F 323		

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F 323	Continued From page 9 goes around the resident's abdomen, or under the resident's arms, and clips in the back of the tub chair. NA-A stated she would utilize the safety belts for residents that were unable to maintain stability in the tub chair. However denied any knowledge of an assessment being completed regarding who can or cannot maintain stability while in the tub chair. NA-A further stated she'd given R42 a bath earlier, and confirmed that although the chair arm was in the down position, she had not applied the safety belt. NA-A stated R62 had been left unsupervised while soaking in the whirlpool for approximately 10 minutes. On 9/27/17, at 9:11 a.m. Registered Nurse (RN)-A was interviewed about resident safety while in the whirlpool bath. RN-A stated there are two black safety straps for use when residents have a whirlpool bath but would need to verify whether the straps needed to be utilized at all times. RN-A also stated there was a call light available in the tub room which would need to be in reach for the resident. RN-A was unsure how far staff should be filling the tub with water. When asked, RN-A verified there was no assessment completed to determine whether a resident could be left in the tub unattended, or to determine which safety devices should be utilized. RN-A stated if a resident had been assessed for safety while utilizing the whirlpool tub, it would be documented on the resident's care plan along with any other safety devices the resident required. When asked about R62 having been left unsupervised for ten minutes, RN-A stated R62 was not cognitively intact, had been declining in strength and should definitely not be left unsupervised while in the whirlpool tub. R62's diagnoses list printed on 9/29/17, identified	F 323		

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F 323	Continued From page 10 R62 had dementia without behavior disturbance. A nursing progress note dated 7/13/17, identified R62 to have dementia, generalized depression, and anxiety, and indicated R62 was unable to complete a brief interview of mental status (BIMS) assessment secondary to dementia. The note stated R62 required 24 hour supervision, was unable to make decisions, and had impaired safety awareness. R62's care plan dated 9/24/17, identified R62 needed assist of one in the shower or whirlpool. The care plan further identified R62 does not use a call light, had cognitive impairment, and had a history and was at risk for falls due to safety awareness. R62's Minimum Data Set (MDS) assessment dated 7/7/17, identified R62 needed total dependence with bathing and one person assist. The record lacked identification if R62 could be left unattended in the whirlpool and what safety devices were appropriate. During an observation on 9/27/17 at 10:25 a.m., NA-C was entering the tub room located on the 200 wing. NA-C stated she was giving R46 a bath. Upon entering the tub room, R46 was observed in the tub without any staff present in the room. It was observed the right chair arm was in the down position however, the padded safety belt was not in place, nor was the call light within reach. The tub water was approximately 4 inches from the top of the tub and came to the resident's upper abdomen. There was a stationary call light located to the left of the entry door which did not reach adequately to the tub and was therefore unavailable for the resident's use. NA-C confirmed R46 was unable to reach the call light. NA-C stated a determination about a resident's ability to be left alone in the tub would be indicated on the care plan. Following the bath,	F 323		

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F 323	Continued From page 11 NA-C confirmed that R46's care plan did not identify whether or not f he could be left alone in the tub, or any safety measures needed while in the whirlpool tub. R46's diagnoses list printed on 9/29/17, included diagnoses of: dementia without behavioral disturbance, alcohol induced disorder, weakness, osteoarthritis, scoliosis, and a history of falling. A cognitive loss progress note dated 7/31/17, identified R46 to have cognitive impairment with a BIMs score of 10 out of 15 and R46 had impaired decision making. R46's care plan dated 8/10/17, directed that one person assist in the shower or whirlpool. The care plan identified R46 to be at risk for falls due to impaired safety awareness, balance issues, chronic pain, and psychoactive medications. R46's MDS assessment dated 7/28/17, identified that R46 needed physical help and one person assist with bathing. The record lacked identification if R46 could be left unattended in the whirlpool and what safety devices were appropriate. On 9/27/17, at 11:11 a.m. NA-D was interviewed regarding safety measures to be utilized when residents are in the whirlpool tub. NA-D stated that she placed the safety belt on some residents, using her discretion for when to place it on dependent residents. NA-D also said she thought if the care plan indicated a resident required assist of one staff for bathing, staff should not leave the resident unattended in the bathtub. NA-D added that the whirlpool chair arm should be down and the call light should be in reach at all times. Following review of the care plan, NA-D verified R62's care plan did not indicate whether the resident could be left unattended in the bathtub.	F 323		

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9/27/17, at 2:58 p.m. RN-B was asked about when residents could be left alone while in the whirlpool. RN-B stated that it would need to be care planned and the resident would need to be able to utilize the call light appropriately. RN-B also stated she would need to review operating manuals for the tub, and the facility's expectations of bathing since the baths are usually completed on the day shift. RN-B stated specific resident safety assessment information regarding the safe use of the tub should be indicated on the resident's care plan. Following review of the record, RN-B confirmed R62 did not have a safety assessment specific to use of safety devices required while in the tub, nor assessment of whether the resident could be left alone for periods of time. RN-B stated she would not leave R62 alone since R62 was not cognitively intact and can't independently use the call light. RN-B was unaware of the manufacturer or facility expectations regarding use of the whirlpool chair seatbelts.

On 9/27/17, at 3:13 p.m. the director of nursing (DON) stated that all bathing rooms have operating instructions in them and she expected her staff to have read the instructions about how to operate the whirlpool tubs. The DON also said she was unaware whether the posted tub information was based on the recommendations of the manufacturer's operating manual, and acknowledged education regarding whether residents could be left alone in the whirlpool, or safety devices required had not been completed by the facility.

On 9/27/17, at 3:25 p.m. a telephone interview with a representative of Master Care Integrity (the

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whirlpool tub manufacturer) was conducted. The representative stated the safety belts are not mentioned on the on-site operations reference however, are referenced in the operation manual guide. The representative clarified the two padded safety belts that should be utilized at all times, one for the upper body and one for the lower body, and stated if residents are left unattended without the proper safety devices there was a possibility the resident could slide down into the water.

On 9/27/17, at 4:47 p.m. the DON stated there was no safety assessment completed to determine whether a resident could safely be left unattended for periods of time while in the whirlpool tub. The DON said she expected all staff to use the padded safety belts around a resident's torso area and additionally one on the upper torso if the resident was unable to maintain an upright position. The DON stated she expected documentation of risk/benefits to be completed if a resident refused to use the safety straps. In addition, the DON confirmed the current resident care plans do not identify whether a resident could be left unattended in the whirlpool. The DON could not verify what staff were being taught during orientation regarding operation of the whirlpool tub. At 5:05 p.m. the DON verified that the 200 and 300 wing bathing room call lights do not reach the tub fully and would not be within a resident's reach. In addition, the DON verified that the 300 wing does not have tub operating instructions posted for staff reference when giving a whirlpool bath.

On 9/28/17, at 12:34 p.m. NA-J who stated she regularly gave residents baths on the 100 wing was asked which residents she had left

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unattended while they soaked for periods of time in past several months. NA-J identified R89, R82, R42, R98, R56, R62, and R10 by name.

On 9/28/17, at 12:51 p.m. R42 was interviewed and stated when he takes a whirlpool staff leave him unattended as he soaks. R42 stated the "girls take off and leave and you never know what minute they will come back." R42 stated he was not offered any type of safety belt while in the tub.

R89's diagnoses were identified as Alzheimer's disease, dementia without behavior disturbance, pain in the right hip, atrial fibrillation, macular degeneration, low back pain, spinal stenosis, depression, anxiety, and mood disorder. A cognitive loss progress note dated 2/13/17, identified R89 had a BIMS score of 12 of 15 as cognitively impaired. R89's care plan dated 9/25/17, identified R89 needed extensive assist of one in the whirlpool. The care plan also identified R89 to have a history of agitation, an elopement attempt, was at risk for falls due to impaired safety awareness. R89's MDS dated 7/21/17, identified R89 needed physical help in part of bathing with one assist. The record lacked identification if R89 could be left unattended in the whirlpool and what safety devices were appropriate.

R82's diagnoses were identified as atrial fibrillation, dizziness and giddiness. R82's care plan dated 9/26/17, identified R82 needed assist of one in the whirlpool. The care plan identified R82 had some memory loss and relied on staff for cues. R82 was at risk for falls due to weakness, cardiac issues, and cognitive impairment. R82's MDS dated 8/4/17, identified R82 needed physical help in part of bathing with

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one person assist and scored a 10 of 15 as cognitively impaired on the BIMS assessment. The record lacked identification if R82 could be left unattended in the whirlpool and what safety devices were appropriate.

R98's diagnosis identified R98 to have a left bundle branch block. R98's care plan dated 9/24/17, identified R98 needed assist of one in the whirl pool and had sciatic nerve pain. R98's MDS dated 8/4/17, identified R98 needed physical help in bathing with one person assist. The record lacked identification if R98 could be left unattended in the whirlpool and what safety devices were appropriate.

R56's diagnoses were identified as major depressive disorder and a history of transient ischemic attacks. R56 was a full code. A cognitive loss progress note dated 10/18/16, identified R56 to have major depression with psychotic features, dementia with delusional thinking, and a BIMS score of 3 of 15. The note identified R56 needed 24 hour supervision and does not use the call light even with daily education. R56's care plan dated 9/24/17, identified R56 needed assist of one in the shower or whirlpool. The care plan identified R56 does not understand the call light, has impaired safety awareness, and was at risk of elopement. R56's MDS dated 9/8/17, identified R56 was total dependence with bathing with one assist and scored 8 of 15 as cognitively impaired on the BIMS assessment. The record lacked identification if R56 could be left unattended in the whirlpool and what safety devices were appropriate.

R10's diagnoses were identified as anxiety, major depression, atrial fibrillation, dizziness and

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F 323	Continued From page 16 giddiness. A cognitive progress note dated 6/13/17, identified R10 to have a BIMS score of 10 of 15 as cognitively impaired and short term memory impairment. R10's care plan dated 9/25/17, identified R10 needed one person assist in the shower or whirlpool. R10 had a left foot amputation, memory loss, and was at risk for falls due to impaired safety awareness and weakness. R10's MDS dated 9/3/17, identified R10 needed physical help in part of bathing with one person assist and a BIMS score 7 of 15 as cognitively impaired. The record lacked identification if R10 could be left unattended in the whirlpool and what safety devices were appropriate. On 9/28/17, at 1:00 p.m. NA-C, who indicated she regularly gave resident baths on the 200 wing, was asked which residents were left unattended while they soaked for periods of time in the past few months. NA-C identified R46, R90, R97, and R61 by name. R90's diagnosis list indicated R90 had a diagnosis of major depression disorder. R90's care plan dated 9/8/17, identified R90 needed assist of one in the whirlpool. Further, R90 was at high risk for falls due to leg weakness and chronic pain in legs, feet, arms, and hands. R90's MDS assessment dated 9/25/17, identified R90 needed physical help in part of bathing with one person assist. The record lacked identification if R90 could be left unattended in the whirlpool and what safety devices were appropriate. R97's diagnoses list identified R97 to have cellulitis of the abdominal wall, as in remission for alcohol dependence, respiratory failure, and a lesion of the sciatic nerve. R97's care plan dated 9/28/17, identified R97 needed assist of one in	F 323		

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the shower or whirlpool. R97 had a history of falls was at risk due to abdominal pain and poor endurance. R97's MDS assessment dated 9/1/17, identified R97 was total dependence with one person assist for bathing. The record lacked identification if R97 could be left unattended in the whirlpool and what safety devices were appropriate.

R61's diagnoses list indicated R61 had dementia with behavioral disturbance, anxiety, delirium, mood disorder, restlessness, and agitation. R61's care plan dated 9/8/17, identified R61 needed assist of one in the whirlpool. R61 had dementia with behaviors, impaired insight and judgement, and had a history and at risk for falls due to pain. The care plan identified R61 had depression and indications of feeling bad about self. R61's MDS assessment dated 7/14/17, identified R61 needed physical help with one assist with bathing and a BIMS score of 9 out of 15 as cognitively impaired. The record lacked identification if R61 could be left unattended in the whirlpool and what safety devices were appropriate.

On 9/28/17, at 1:42 p.m. NA-K who said she regularly gave resident baths on the 300 wing, was asked if she left any residents unattended to soak while in the whirlpool tub. NA-K said she had left R4 unattended while in the whirlpool. R4 was observed at that time seated in the wheel chair being pushed to her room. The resident's bottom was observed to be scooted forward in the chair. NA-K stated R4 always scoots forward in her chair and staff frequently need to reposition her.

R4's diagnoses list identified R4 to have dementia, atrial fibrillation, and depression. A

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F 323	Continued From page 18 cognitive loss progress note dated 4/3/17, identified R4 to have significant cognitive impairment with a BIMS score of 3 out of 15. R4's care plan dated 9/27/17, identified R4 needed assist of one in the whirl pool. R4's MDS assessment dated 9/8/17, identified R4 needed physical help with one person assist for bathing and R4 was unable to complete the BIMS assessment due to cognition. The record lacked identification if R4 could be left unattended in the whirlpool and what safety devices were appropriate. The facility's posted instructions "Operating Instructions" for MasterCare Integrity bath model MB-80 lack direction on using safety devices. The document stated only trained operators are allowed to operate the bath system. Further, the document indicated it was only intended as a reference guide. The posted instructions were located in the 100 and 200 wing bathing rooms. The facility's nursing assistant orientation records indicated staff were to be aware of the whirlpool/how to adjust water temp/clean/use lift properly. The orientation record lacked identification of whether residents could be left alone and the safety devices of the whirlpool. The Master Care Model MB-80 Operating Instructions stated to read and follow all instructions in manual. The manual identified individuals should be secured with the two safety belts that are provided by placing one on the upper body and on the lap portion of the residents. The manual also directed staff to turn the tub fill valve open when filling the tub and to fill just below the overflow and turn the valve off. This is several inches below the top of the tub.	F 323		

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The Cascade Elite Transfer tub manual used in the 300 wing bathing room stated this tub is used for nursing homes under direct supervision of trained staff. The manual directed for residents to be secured with safety belts on the upper and lower portions of a resident's torso.

The facility's policy titled "Shower/Tub Bath" last revised on 8/1/17, directed staff to stay with resident throughout the bath unless otherwise care planned. The policy identified if a resident requested to spend extended periods of time in the whirlpool or shower the resident needed to be identified as safe to be left alone, have the call light within reach, and safety checks be completed.

The facility's policy titled "Use of Whirlpool Tub" last reviewed on 9/2/11, directed staff to follow tub manufacturer's operation and procedure manual for operating the tub and/or transport chair.

The immediate jeopardy that began on September 28, 2017, was removed on September 28, 2017, when the facility had educated all staff responsible for bathing residents not to leave residents alone for any amount of time unless the resident has been assessed to be safe in the tub without supervision. In addition staff were educated to use recommended manufacturer safety measures during use of the whirlpool tub. In addition the facility initiated resident assessments for bathing safety if the would choose to be left alone in the tub to soak. Although the IJ was removed, noncompliance remained at the lower scope and severity level of an E, which is a pattern, which indicated no actual

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harm with potential for more than minimal harm that is not immediate jeopardy because the facility has not had time to complete all assessments, or for the interdisciplinary team (IDT) to fully develop interventions to address the concerns and how to audit to ensure compliance.
R45 LACKED A SAFETY ASSESSMENT WHEN OUT IN THE COMMUNITY USING A SCOOTER:

A fall report for R45 dated 6/2/17, indicated the resident tipped an electric scooter over while he was off the hospital/nursing home property. The report indicated R45 had tipped over after hitting a waterhole cover on the side of the road on a local street. Falling this incident, the facility implemented no new interventions.

On 9/14/17, a fall report indicated R45 had failed to return back to the facility following an independent time out of the facility with the scooter. The report indicated facility staff had called the resident's daughter to locate the resident by a GPS located on the resident's scooter. The report indicated the police had been called and had subsequently reported R45 had fallen off his scooter on a walking path between the facility and a local eating establishment, Slippery's. The report further revealed an ambulance had been called to the scene of the fall, however R45 had denied injury, refused care and returned to facility with his sister versus the ambulance or police.

Review of R45's progress notes dated 6/2/17 to 9/14/17, indicated 18 documented incidents when R45 had left the facility alone with his scooter without signing out, or times R45 would refuse to allow staff to assist him with personal cares prior to independently leaving facility on his scooter.

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R45's medical record indicated diagnoses documented by the physician 9/20/17 including: recurrent pneumonitis, dementia, diabetes type 2 diet controlled, chronic obstructive pulmonary disease, major depression, and history of cardio vascular attack with left side hemiplegia (weakness). The physician's notes also indicated; "I have been told by the facility, that on several occasions [R45] was found by police out side the facility, covered in feces and urine. He also used his motorized scooter to physically intimidate other staff members."

Review of R45's quarterly Minimum Data Set (MDS) dated 9/8/17 indicated an admission date of 5/30/13. The MDS also indicated a Brief Interview for Mental Status (BIMS) score of 9/15, which indicated moderate cognitive impairment.

Review of R45's current care plan, identified a self-care deficit related to diabetes, depression, COPD (chronic obstructive pulmonary disease), mild left hemiparesis (weakness) manifested by incomplete activities of daily living (ADL's), decreased ADL participation, some ability to make decisions, and non-compliance with treatment recommendations. The care plan also included a problem area of potential for injury related to: impaired safety awareness and leaving unsupervised on a motorized scooter.

On 9/27/17 at 7:56 a.m., LPN (licensed practical nurse)-F stated, "if we catch him before leaving facility we ask him to sign out. We check the dining room, the floor, and check outside if we cannot find him. If unable to locate him and it's getting late we call his daughter and she will track him on a GPS tracking device located on his

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scooter. We have tried to keep the scooter out of his room, as he will self-transfer and has fallen in the process, but family requested it be returned. He is very non-compliant and his family is "ok" with him going outside alone and independently using his scooter, since the last fall on 9/14/17, we obtained a new physician's order dated 9/20/17, for an Occupational Therapy (OT) evaluation which we are in the process of completing."

On 9/27/17 at 8:13 a.m., NA-Q stated, "sometimes [R45] will ask for help onto the electric scooter if we are in the room. He often refuses to use his call light for help. If we are walking by, and see him attempting to self-transfer we will go in assist with transfer and will ask where he is going. Otherwise he will just self-transfer, even though he is a two assist for safety."

9/27/17, at 8:46 a.m. NA-P said, "R45 usually does not leave on the day shift, it is usually in the late afternoon or evening."

On 9/27/17, at 9:55 a.m. the facility's Medical Director/primary physician was interviewed and stated that she had spoken with R45's daughter and explained the need for further cognitive testing by occupational therapy (OT) to determine the resident's safety when in the community with his scooter. The medical director also stated the cognitive testing needed to be as soon as possible for the safety of R45, and stated after having spoken with R45's daughter, the daughter had been okay with the OT cognitive testing which was completed on 9/28/17. The medical director further stated R45 was not safe to leave the facility alone at this time due to the most

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recent events of 9/14/17 when he'd fallen while outside the facility. However, the medical director also stated that R45's family member (FM)-A was very active with R45's care and wishes. The medical director stated, "[FM-A] is trying hard to keep R45 as independent at possible as his independence with the scooter is crucial to maintain his quality of life.'

On 9/27/2017, at 10:18 a.m. RN (registered nurse)-F was interviewed concerning R45's safety when in the community with his scooter. RN-F said, "[R45] will go to Slippery's, a local restaurant/bar on pretty much a nightly basis to socialize with friends. [R45] is on 30-minute checks while in the facility. Once we know he has left or is gone, we chart that R45 left facility. We attempt to change or toilet [R45] prior to his leaving the facility. We constantly encourage [R45] to sign out and have a cell phone with him so he can for help if needed. [R45] is able to use cell phone correctly to call for help."

On 9/27/17, at 5:00 p.m. licensed practical nurse (LPN)-F said that R45 refuses to wear the seatbelt that is on his scooter. "We encourage him to use the arm rest for stability and we have encouraged [R45] not to go out tonight." RN-E clarified she'd spoken with the resident regarding going out and stated, "it would be best if he does not go out of the facility tonight. From what I know, no community safety assessment was completed prior to 9/27/17."

9/27/17, at 5:01 p.m. NA-O said that if R45 wants to go out into the community there is no way to really stop stop him. He gets pretty upset with you if you try to stop him. "[R45] wants to do [R45's] thing. He has swung at me in the past

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when we don't let him go outside. He usually leaves between 2:00 p.m. in the afternoon to 7:00 p.m. in the evening."

On 9/27/17, at 5:21 p.m. NA-N was asked about R45 and said, "When he is leaving we make sure his pants are up, and make sure the chair arms are down as he does not like to use them. He usually leaves after supper or around 6:00 p.m. to 6:30 p.m. He usually comes back around 10:00 p.m."

On 9/27/17, at 5:42 p.m. RN-D said that R45's family is very involved with his cares. They have a GPS tracker on the scooter. RN-D said, "We encourage him to sign out but he refuses to sign in and out often. If it is already dark out when he leaves we try to encourage him not to go. But [R45] is [R45]. We do our best to keep him safe but R45 makes own choices and decisions."

On 9/27/17, at 6:29 p.m. during an interview with the DON (Director of Nursing) regarding R45's community safety. The DON said, "We are going to have an OT assessment for safety completed soon." The DON further verified there had not been a community safety assessment completed for R45 even though there had been incidents in the community with falls.

The facility's policy regarding falls was provided The policy, Assessment /Reporting last reviewed 2/17/16, indicated the purpose was to provide clinical assessment and/or intervention post fall, and to provide a means of evaluation of cause of fall, events for trending, tracking and initiating interventions.

The facility policy for Resident Sign Out last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING ______ B. WING ______	09/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 reviewed 5/3/11, indicated the purpose was to allow residents to be independent and enjoy life outside the facility while providing accountability to staff of the resident's whereabouts. The facility's policy for Motorized Mobility Aids (Electric Wheelchairs/Scooters) last reviewed 5/1/2013, indicated the purpose was to: provide residents with the opportunity to safely utilize motorized vehicles and to maintain their independence /qualify of life. To establish guidelines for motorized mobility aid usage within St. Elizabeth's. To provide a safe environment for everyone and to prevent damage to the physical structure of the facility. Resident requesting to utilize a motorized mobility aid during stay at St. Elizabeth's medical center must have an evaluation completed by the therapy department to ensure resident is appropriate to safely operate this type of equipment. Residents will be evaluated based on situation, performance, and physical/mental capabilities.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		10/27/17

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 431	Continued From page 26	F 431		

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:

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F 431	Continued From page 27 Based on interview, observation, and document review, the facility failed to ensure 1 of 5 liquid narcotics bottles reviewed for 1 of 4 residents (R21) were able to be accurately accounted for it's content. Findings include: During medication storage review on 9/25/17, at 2:10 p.m. the 200 unit locked narcotic drawer contained Guaifenesin/Codeine Solution 100-10 milligram (mg) per 5 milliliter (ML) for R21. The liquid medication was in dark brown colored bottle and there was no calibrations located on the bottle to determine how much medication was currently in the bottle. The pharmacy label was placed in the middle of the bottle which covered the entire circumference. Licensed Practical Nurse (LPN)-B stated the narcotic count was performed every shift, however, this bottle was not calibrated to determine how much medication remained in the bottle. LPN-B stated the current practice for this bottle was to subtract the amount of medication that was given to the resident from the total in the bottle to get the remaining count. However, there was no way to verify the documented amount remaining was correct. R21's medical plan of care printed on 9/29/17, identified R21 had orders on 9/8/17, for "Codeine/Tussin 10/100" 5 milliliters (ML) by mouth four times a day as needed for cough. On 9/18/17, the orders changed to "Codeine/Tussin 10/100" give 10 ML by mouth daily at bedtime for cough. On 9/28/17, at 1:16 p.m. LPN-C confirmed the count sheet for R21's Guaifenesin/Codeine stated to have 46 ML remaining in the bottle but this	F 431	R21 had new supply of Guaifenesin/Codeine provided in calibrated bottle on 9/29/17 by pharmacy. Review/revision as applicable of policy "Narcotic Management at SEMC" completed by 11/10/17. Associate education for licensed associates and trained medication aides regarding storage and accounting of liquid controlled substances to be completed by 11/17/17. Consultant Pharmacist/DON or designee to complete audits of liquid controlled substances to verify medication stored in a measurable, calibrated container 2x month x3 months. Audit finding to be identified and discussed at monthly QAPI meetings.	

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F 431	Continued From page 28	F 431		

amount was unable to be verified and cannot be counted. LPN-C stated the level of the liquid was unable to be visualized due to the pharmacy label covering the circumference of the bottle.

On 9/28/17, at 1:19 p.m. Registered Nurse (RN)-F was questioned about the accurate counting of the medication for R21. RN-F stated that there was no measurement markings on the bottle and therefore staff were instructed to subtract the dosage given to the resident from the previous amount remaining in the bottle. RN-F verified she cannot measure the medication in the bottle and unable to verify if it matches the count sheet of 46 ML.

On 9/28/17, at 1:34 p.m. the facility pharmacist stated that Guaifenesin/Codeine was a controlled substance and should be counted per facility policy. The pharmacist stated the medication could have been put in a different bottle and/or worked with manufacture so it was able to be counted. The pharmacist expected a call from facility staff if they are unable to count a medication per policy or had a concern regarding any medication.

On 9/28/17, at 3:16 p.m. the director of nursing (DON) stated that Guaifenesin/Codeine was a controlled substance and expected her staff to count the remaining amount every shift. The DON confirmed that staff are unable to verify the amount of the medication left in the bottle due to not having measurement markings. The DON confirmed that the facility has not been in contact with the pharmacy regarding R21's bottle of narcotics due to not being able to accurately count the medication.

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F 431	Continued From page 29 On 9/29/17, at 9:09 a.m. RN-C stated that she completed narcotic count this morning and R21's Guaifenesin/Codeine and because it was not measurable in the bottle we did not count it. The facility's "Narcotic Check Sheet" has "date, time, name, discrepancy, reported to" sections on the form. In review of this form from 9/8/17, it indicated two personnel have signed off every shift with no discrepancy. On 9/28/17, the form indicated that pharmacy was called following the surveyors concerns with the lack of accurately counting R21's cough syrup. The facility's policy titled "Narcotic Procurement/Accountability/Inventory/ Destruction in Long-Term Care Facilities" was revised on 7/18/17. The policy identified inventory of narcotics was required at the end of each shift with two personnel and recorded on the controlled drug administration record. During the inventory staff should verify the resident's name, drug, and the number remaining of the medication.	F 431		
F 496 SS=F	483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and	F 496		10/27/17

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F 496	Continued From page 30 competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 75 nursing assistants (NA) was on the registry. This had the potential to affect all 75 residents in the facility. Findings include: Nursing Assistant (NA) verification was reviewed on 9/29/17, at 9:28 a.m., NA-R certification was found to have expired on 4/30/17. Review of staff schedules and time detail from 5/1/17, to 9/29/17, indicated NA-R had worked on the floor in the facility 70 days since expiration of	F 496	NA-R submitted required information to be reinstated to MN CNA Registry and returned to work on 10/20/17 once registry verification complete. Review/revision of policy "Nursing Assistant Registration" completed by 11/10/17. DON/Designee to audit newly hired CNA personnel files to verify MN Nursing Assistant Registry Verification of Registration has been complete x3 months.	

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F 496	Continued From page 31 nursing assistant certificate. Interview on 9/29/17, at 10:00 a.m., with the director of nursing (DON) verified NA-R was currently employed at the facility and stated that NA-R works casual status, at least every other weekend. DON stated my expectation is to have the nursing assistants' certificates to remain current if they maintain employment with us. A policy on nursing assistant certification verification policy and procedure was requested and policy, "Nursing assistant registration," dated 2017, was given. Policy indicated, "Before allowing an individual to serve as a nursing assistant, the DON/designee must receive registry verification ..."	F 496		

Electronically delivered
October 19, 2017

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

Re: State Nursing Home Licensing Orders - Project Number S5487029

Dear Mr. Root:

The above facility was surveyed on September 25, 2017 through September 29, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or email gary.nederhoff@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992   Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00675	A. BUILDING: ______ B. WING ______	09/29/2017

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

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

Minnesota Department of Health

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

Electronically Signed — 10/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00675	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On September 25, 26, 27, 28, and 29, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow plan of care regarding activities of daily living including nail care was provided for 1 of 1 resident (R17) reviewed who had soiled and untrimmed nails. Findings Include: R17 had been observed on 9/26/17, at 9:15 a.m. to have long fingernails with substance under the thumbs. On 9/27/17, at 8:36 a.m. R17 had been at dining table eating breakfast using hands to feed self, and the soiled, untrimmed nails were observed. At 3:11 p.m. R17 shook surveyors hand, R17 hands had a sticky substance on both hands and large amount of debris under all nails except right hand index finger which was broke off to the nail bed. On 9/27/17, at 3:21 p.m. interview nursing assistant (NA)-L, stated nail care is completed on	2 565	R17's treatment plan updated to reflect daily hand hygiene to include warm, soapy soaks for 5-10 minutes to promote improved hand hygiene 10/10/17. Policies reviewed and revised as applicable, include "Resident Care Plans, Development, Implementation and Revision", "Using the Care Plan", "Shower/Tub Bath", "Care of Fingernail/Toenails" and "Hand washing/Hand Hygiene" by 11/10/17. Associate education to be completed related to resident hand hygiene/nail care by 11/17/17. DON/Designee to complete fingernail cleanliness/ hand hygiene audits on random residents that are identified as being independent with eating after setup. 3x week x4 weeks (10/29-11/25), 2x week x4 weeks (11/26-12/23) and 1x week x2 weeks (12/23-1/6/18). Audit findings to be	10/27/17

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2 565	Continued From page 3 bath day. Review of R17 bath schedule read given 9/27/17, at 9:56 a.m. R17 current care plan identified one-person assist with hygiene and bathing. The Nursing assistant activity of daily living care plan reads one-person assist with hygiene and bathing. On 9/29/17, at 8:39 a.m. observed R17 at the dining table eating cream of wheat, orange juice, toast and continued to have visible debris/substance under nails. 9/29/17 8:59 a.m. the Director of Nursing (DON) was informed of R17's soiled and untrimmed nails. DON stated the expectation to have staff to complete hand hygiene after meals and bathroom and as needed. A policy was requested for following care plans and none was provided. A Suggested Method of Correction: (1) Develop a system which ensures that resident care plans are current and that all staff are delivering care according to the care plan; educate all care givers. (2) Ensure all Nurse Managers are observing resident care for accurate delivery of interventions. Time Period for Correction: Twenty one (21) days.	2 565	identified and discussed at monthly QAPI meetings.	
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 915		10/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00675	A. BUILDING: ______ B. WING ______	09/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 4 comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff provided activities of daily living (ADL) cares and services as assessed for 1 of 1 resident (R17) reviewed who required assistance to clean and trim nails. Findings Include: R17 had been observed on 9/26/17, at 9:15 a.m. to have long fingernails stained with substance under the thumbs. On 9/27/17, at 8:36 a.m. R17 noted to sit at dining table eating breakfast using hands/fingers to eat. The soiled untrimmed nails were still noted. At 3:11 p.m. R17 shook surveyors hand, and R17 hands had a sticky substance on both hands and noted large amount of debris under all nails except right hand index finger which was broke off to the nail bed.	2 915	R17's treatment plan updated to reflect daily hand hygiene to include warm, soapy soaks for 5-10 minutes to promote improved hand hygiene 10/10/17. Policies reviewed and revised as applicable, include "Resident Care Plans, Development, Implementation and Revision", "Using the Care Plan", "Shower/Tub Bath", "Care of Fingernail/Toenails" and "Hand washing/Hand Hygiene" by 11/10/17. Associate education to be completed related to resident hand hygiene/nail care by 11/17/17. DON/Designee to complete fingernail cleanliness/ hand hygiene audits on random residents that are identified as being independent with eating after setup.	

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2 915	Continued From page 5 On 9/27/17 at 3:21 p.m. interview nursing assistant (NA)-L, stated nail care is completed on bath day. Review of R17 bath schedule read given 9/27/17 at 9:56 a.m. The quarterly Minimum Data Set (MDS) assessment dated 7/14/17, identified R17 required limited assist of one for personal hygiene and one-person physical assist with bathing. R17 current care plan identified one-person assist with hygiene and bathing Nursing assistant activity of daily living care plan reads one-person assist with hygiene and bathing needs. On 9/28/17, at 12:35 p.m. Registered nurse (RN)-F had been interviewed on expectations of nail care. RN-F stated nail care completed on resident's bath day, it's easier to complete when nails are softer. Staff are to chart completed, if any refuses or not completed. RN-F verified in the computer record, R17 had a bath on 9/27/17 and there was no documentation of whether the nail care were cleaned/trimmed. On 9/28/17, at 12:43 p.m., observation with RN-F of R17 nails verified soiled and untrimmed nails. RN-F stated, "Pretty yucky and dirty." RN-F said that R17 was a finger eater and picks at her food. Surveyor asked if she would expect staff to wash R17 hands after meals knowing R17 is finger eater. RN-F stated, "I expect them to wash her hands." RN-F also said that R17 is independent to use the bathroom independently. Surveyor asked RN-F if she can tell what the substance is under R17 nails, RN-F stated she could not but	2 915	3x week x4 weeks (10/29-11/25), 2x week x4 weeks (11/26-12/23) and 1x week x2 weeks (12/23-1/6/18). Audit findings to be identified and discussed at monthly QAPI meetings.	

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2 915	Continued From page 6	2 915		

there is a possibility it could be feces. RN-F asked R17 if she washes her hands after going to the bathroom. R17 was not able to clearly answer the question. RN-F stated there is a possibility R17 may not understand the questions being asked of her.

On 9/29/17, at 8:39 a.m. observed R17 at the dining table eating cream of wheat, orange juice, toast and continues to have debris/substance under nails. At 8:42 a.m. NA-D verified R17 hands were sticky and dirty and should have been wiped clean after eating. At 8:46 a.m. RN-F verified R17 nails remained dirty after staff was asked to clean R17 the day before.

9/29/17, at 8:50 a.m. NA-D took R17 to her room to clean nails after nurse manager asked staff to complete. NA-D asked R17 if ok to clean under nails and R17 stated yes. After starting to clean nail beds, R17 stated, "Don't push so hard." NA-D did not continue and said the debris is hard and packed under the nails and stated the resident often refuses.

9/29/17, 8:59 a.m. the Director of Nursing stated the expectation to have staff to complete hand hygiene after meals and bathroom and as needed.

Review of the facility policy titled; Care of Fingernails/Toenails reads nail care includes cleaning and trimming. Stop and report to the nurse supervisor if there is evidence of pain. If the resident refused the treatment, document the reason(s) why and the intervention taken. Policy titled; Shower/Tub Bath dated 8/1/17 reads trim the resident's toenails and fingernails unless resident has diabetes. Policy titled Standards for Resident and His/her Environment dated 8/4/11

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2 915	Continued From page 7 reads Finger and toenails will be cleaned with morning cares/bath. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents are given appropriate treatment and services to maintain abilities of daily living. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		10/27/17

Minnesota Department of Health

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21426	Continued From page 8	21426		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 1 of 6 employees (E)-A records reviewed who provides direct care to facility residents were free of tuberculosis (TB). This practice had the potential to affect all 75 residents, staff, and visitors in the facility.

Corrected 11/17/17

Findings include:

During review of the employee personnel files revealed E-A was hired 7/26/17, lacked evidence that first and second step testing for TB had not been administered upon hire. On asking for the TB risk assessment and TB testing the staff said they used the previous hire date of 4/25/16 when E-A had met the requirement for risk assessment and TB test. E-A currently provides direct care to residents.

On 9/29/17, at 1:06 p.m. the Director of Nursing verified E-A should have received risk assessment and TB test after being rehired on 7/26/17.

SUGGESTED METHOD FOR CORRECTION:
The Director of Nursing and/or
designee could monitor to assure tuberculin screening procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents.

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

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21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure 1 of 5 liquid narcotics bottles reviewed for 1 of 4 residents (R21) were able to be accurately accounted for it's content. Findings include: During medication storage review on 9/25/17, at 2:10 p.m. the 200 unit locked narcotic drawer contained Guaifenesin/Codeine Solution 100-10 milligram (mg) per 5 milliliter (ML) for R21. The liquid medication was in dark brown colored bottle and there was no calibrations located on the bottle to determine how much medication was currently in the bottle. The pharmacy label was placed in the middle of the bottle which covered the entire circumference. Licensed Practical Nurse (LPN)-B stated the narcotic count was performed every shift, however, this bottle was not calibrated to determine how much medication remained in the bottle. LPN-B stated the current practice for this bottle was to subtract the amount of medication that was given to the resident from the total in the bottle to get the remaining count. However, there was no way to verify the documented amount remaining was correct. R21's medical plan of care printed on 9/29/17, identified R21 had orders on 9/8/17, for "Codeine/Tussin 10/100" 5 milliliters (ML) by mouth four times a day as needed for cough. On	21620	R21 had new supply of Guaifenesin/Codeine provided in calibrated bottle on 9/29/17 by pharmacy. Review/revision as applicable of policy "Narcotic Management at SEMC" completed by 11/10/17. Associate education for licensed associates and trained medication aides regarding storage and accounting of liquid controlled substances to be completed by 11/17/17. Consultant Pharmacist/DON or designee to complete audits of liquid controlled substances to verify medication stored in a measurable, calibrated container 2x month x3 months. Audit finding to be identified and discussed at monthly QAPI meetings.	10/27/17

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21620	Continued From page 10	21620		

9/18/17, the orders changed to "Codeine/Tussin 10/100" give 10 ML by mouth daily at bedtime for cough.

On 9/28/17, at 1:16 p.m. LPN-C confirmed the count sheet for R21's Guaifenesin/Codeine stated to have 46 ML remaining in the bottle but this amount was unable to be verified and cannot be counted. LPN-C stated the level of the liquid was unable to be visualized due to the pharmacy label covering the circumference of the bottle.

On 9/28/17, at 1:19 p.m. Registered Nurse (RN)-F was questioned about the accurate counting of the medication for R21. RN-F stated that there was no measurement markings on the bottle and therefore staff were instructed to subtract the dosage given to the resident from the previous amount remaining in the bottle. RN-F verified she cannot measure the medication in the bottle and unable to verify if it matches the count sheet of 46 ML.

On 9/28/17, at 1:34 p.m. the facility pharmacist stated that Guaifenesin/Codeine was a controlled substance and should be counted per facility policy. The pharmacist stated the medication could have been put in a different bottle and/or worked with manufacture so it was able to be counted. The pharmacist expected a call from facility staff if they are unable to count a medication per policy or had a concern regarding any medication.

On 9/28/17, at 3:16 p.m. the director of nursing (DON) stated that Guaifenesin/Codeine was a controlled substance and expected her staff to count the remaining amount every shift. The DON confirmed that staff are unable to verify the amount of the medication left in the bottle due to

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21620	Continued From page 11	21620		

Continued From page 11

not having measurement markings. The DON confirmed that the facility has not been in contact with the pharmacy regarding R21's bottle of narcotics due to not being able to accurately count the medication.

On 9/29/17, at 9:09 a.m. RN-C stated that she completed narcotic count this morning and R21's Guaifenesin/Codeine and because it was not measurable in the bottle we did not count it. The facility's "Narcotic Check Sheet" has "date, time, name, discrepancy, reported to" sections on the form. In review of this form from 9/8/17, it indicated two personnel have signed off every shift with no discrepancy. On 9/28/17, the form indicated that pharmacy was called following the surveyors concerns with the lack of accurately counting R21's cough syrup.

The facility's policy titled "Narcotic Procurement/Accountability/Inventory/ Destruction in Long-Term Care Facilities" was revised on 7/18/17. The policy identified inventory of narcotics was required at the end of each shift with two personnel and recorded on the controlled drug administration record. During the inventory staff should verify the resident's name, drug, and the number remaining of the medication.

A Suggested Method of Correction:
(1) Develop a system which ensures that staff are able to accurately count narcotics per facility policy. Also monitor for compliance.

Time Period for Correction: Twenty one (21) days.

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

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	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING ______	**09/28/2017**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (St. Elizabeth Health Care) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/27/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This is a 1-story building and has a partial basement. This building was constructed in 1970 and was determined to be of Type II(111) construction. The Chapel is a 1-story addition and has a full basement. The chapel addition was constructed in December 2003 and was determined to be of Type II(111) construction. The Four Season Sun Room is a 1-story addition to and has a no basement. The Four Season Sun Room Addition was constructed in December 2012 and was determined to be of Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 81 beds and had a census of 76 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 as evidenced by:	K 000		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923		10/27/17

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K 923	Continued From page 3 considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored	K 923	Oxygen vendor supplied separate holder for empty e-tanks on 11/26/17.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 4 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Findings Include: On facility tour between 10:30 AM and 02:30 PM on 9/28/17, based on observation and interview revealed that the following include: Found the oxygen cylinders are mixed together full and empty in lower level oxygen storage room. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923		

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

F5487029

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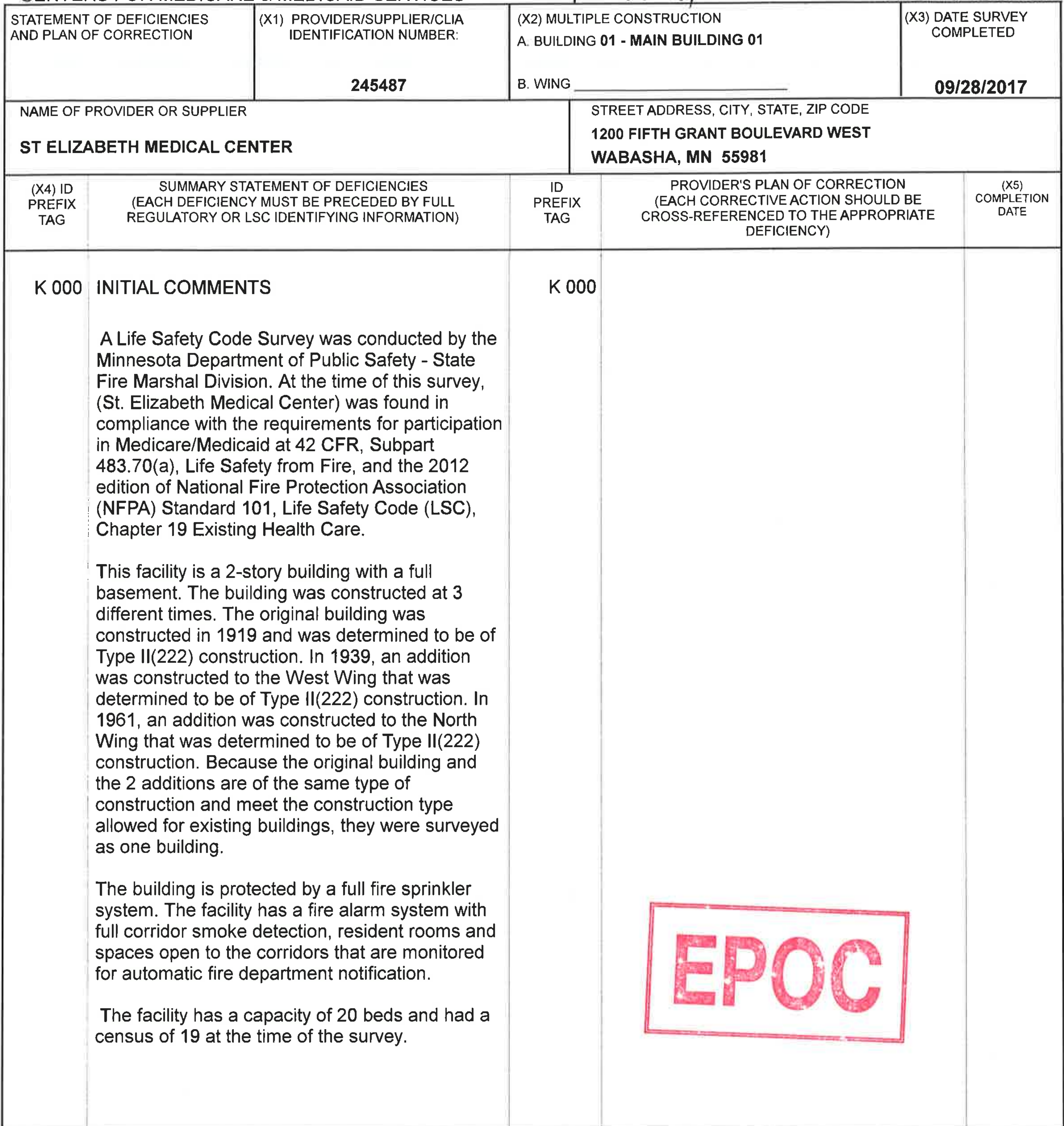
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/28/2017**

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

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K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (St. Elizabeth Medical Center) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

This facility is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type II(222) construction. In 1939, an addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1961, an addition was constructed to the North Wing that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification.

The facility has a capacity of 20 beds and had a census of 19 at the time of the survey.

EPOC

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

Electronically Signed — 10/27/2017

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.