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: UGTQ
Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245283**

2. STATE VENDOR OR MEDICAID NO. (L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

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 **04/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **83** (L18)

13. Total Certified Beds **83** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(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 :
Kathie Killoran, HFE NEII 04/10/2015 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 04/22/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/06/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5283

At the time of the February 12, 2015 standard survey the facility was not in substantial compliance with Federal participation requirements. A Post Certification Revisit (PCR) was completed on March 27, 2015 and determined deficiencies issued pursuant to the February 12, 2015 standard survey were corrected, as of March 24, 2015.

Documentation supporting the facility's request for a continuing waiver involving K14, K38, K67 and K103 was previously forwarded to CMS Region V Office. Approval of the waiver requests was recommended. Refer to the CMS 2567b for the results of this visit.

Effective, March 24, 2015 the facility is certified for 83 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245283

April 10, 2015

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

Dear Ms. High:

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 March 24, 2015 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

Based on submitted documentation, we have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K14, K38, K67 and K103.

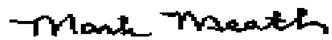
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiencies or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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

Sincerely,



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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 10, 2015

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

RE: Project Number S5283025

Dear Ms. High:

On February 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 12, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On April 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2015, effective March 24, 2015 and therefore remedies outlined in our letter to you dated February 25, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiencyies cited under K14, K38, K67, K103 at the time of the February 12, 2015 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Sincerely,

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

5283r15

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245283	A. Building B. Wing	3/27/2015

Name of Facility	Street Address, City, State, Zip Code	
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792	revised exit date 04/01/2015 per CC

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	03/24/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	03/24/2015	ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	03/24/2015
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	03/24/2015	ID Prefix F0309 Reg. # 483.25 LSC	03/24/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	03/24/2015
ID Prefix F0356 Reg. # 483.30(e) LSC	03/24/2015	ID Prefix F0496 Reg. # 483.75(e)(5)-(7) LSC	03/24/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	04/10/2015	29625	03/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/12/2015

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

April 10, 2015

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

Re: Reinspection Results - Project Number S5283025

Dear Ms. High:

On April 1, 2015 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 February 12, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

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

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

5283r15lic

AH Form Approved

4/10/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00582	A. Building B. Wing	3/27/2015

Name of Facility	Street Address, City, State, Zip Code	
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792	revised exit date 04/01/2015 per CC

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	03/24/2015	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	03/24/2015	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	03/24/2015
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	03/24/2015	ID Prefix 21980 Reg. # MN St. Statute 626.557 Subd. 3 LSC	03/24/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	04/10/2015	29625	03/24/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/12/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UGTQ
Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245283**

2. STATE VENDOR OR MEDICAID NO. (L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **83** (L18)

13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 5** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(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 :
Kathie Killoran, HFE NEII 02/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/04/2015 (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 **08/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 03/06/2015 Co.
AW LSC sent to CMS 03/06/2015 Co.

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: 24-5283

At the time of the February 12, 2015 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility is given an opportunity to correct before remedies would be imposed. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Documentation supporting the facility¿s request for a continuing waiver involving K14, K38, K67 and K103 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 25, 2015

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

RE: Project Number S5283025

Dear Ms. High:

On February 12, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 24, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 12, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

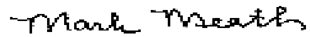
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,



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

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

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POC NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING ______ B. WING ______	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		3/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 02/26/2015

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

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

POC NOT FINAL

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of mistreatment for 1 of 3 resident cases (R153) reviewed for mistreatment. Findings include: Review of R153's admission Minimum Data Set [MDS], dated 1/22/15, revealed R153 was cognitively intact and experienced no symptoms of psychosis. R153 required extensive assistance of two staff to transfer, physical help of one staff for bathing and extensive assistance from one staff for mobility in wheelchair. R153 was noted as experiencing pain almost constantly at a very high level that interfered with her ability to sleep and limited participation in daily activities. During interview on 2/9/15, at 6:33 p.m. R153 reported she had been mistreated by nursing assistant, (NA)-Z, while being assisted with a	F 225	R153 no longer resides in the facility. All current residents residing in the facility will be interviewed for any concerns of mistreatment. The Facility Abuse Prevention Plan has been reviewed and revised. Nursing and Social Services staff will be trained on the Abuse Prevention Plan including elements necessary for a thorough investigation. There will be an inter-disciplinary team review of all allegations of abuse or maltreatment to assure that a thorough investigation has occurred to support the conclusion of the investigation. The Abuse Prevention Coordinator is	

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F 225	Continued From page 2 shower. R153 reported NA-Z was not thorough in helping her wash and rinse her hair, was verbally curt with her and used her injured leg to pull her in the shower chair to the safety bars. R153 elaborated that NA-Z had told her she would either have to wait for someone to come and help move R153 over to the shower safety bars or lift her leg off the floor. R153 reported she told NA-Z her leg was injured and she was not able to lift her leg of the floor. R153 described her leg as a "piece of meat, very tender" and had no control over her leg. R153 explained NA-Z told her there were not enough people to help move her so she grabbed her foot and pulled her across the room in her shower chair to the safety grab bars. The bars were approximately 10 feet away. R153 reported this caused intense pain and reported she felt "like I am going to die" R153 added there were no foot pedals on the shower chair, like there were in her wheelchair. R153 reported she told a nurse, whose name she did not recall, and then talked to the nurse manager, (RN)-C about her concern and possibly another manager, whose name she did not recall. On 2/11/15 at 9:14 a.m. RN-C reported she had spoke with R153 about staff being rough with her surgical leg in the shower room. RN-C reported she had been on leave from work during the time it was initially reported by R153's family, but knew it was reported to the administrator and a formal complaint was filed. A review of a Customer Concern Feedback Form, dated 1/17/15, revealed R153's family member, (F)-A reported to staff concerns that "this woman [NA-Z] was short and curt with her [R153]. She roughly washed her hair. She only washed the top of her head. She quickly rinsed her head. [R153]	F 225	responsible.	

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F 225	Continued From page 3 required to be more thoroughly rinsed and the aide responded rudely telling her that it was already rinsed. After the shower she grabbed [R153] by her left ankle (her bad leg) and drug her across the room. This was extremely painful." A note written by a nurse, [RN]-Z read "Confirmed with [F-A] that described aide is [NA-Z]. Confirmed pulled solely by leg (not one hand on leg, one on chair)." A review of the Investigative Report, submitted to the state agency on 1/23/15, and accompanying word documents, included a review of R153's medical record, a written statement from NA-Z, an interview with R153 and F-A and documented interviews with staff working at the time of the incident (NA-Y, NA-X and LPN-Z). R153 confirmed statements from F-A, stating "Aide was curt and unaccommodating. Said she cannot lift affected limb. Aide grabbed and pulled her across shower room floor by leg causing extreme pain." Only NA-Z was able to account for how R153 was moved in the shower chair to the safety bars and included in her written statement, undated "After shower was completed and she was dressed and ready to transfer into chair, I asked if she wanted to go to the bars so she would have something to hold on to or did she want to hold on to 2 of us. She wanted to utilize the bar so we took it very slow I was guiding her foot as she could not pick up her feet. I then put the call light on and [NA-X] came in to help with the transfer." The statement from NA-Z also included that NA-Y helped take R153 to the shower room in the shower chair, which was consistent with the statement from NA-Y. No interviews were done with other residents who received care from NA-Z. During interview with the administrator on 2/12/14	F 225		

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F 225	Continued From page 4 at approximately 11:00 a.m., the administrator confirmed no other residents cared for by NA-Z were interviewed regarding their care experiences or to determine if other residents had experienced rough treatment. The administrator reported she did not ask NA-Z to demonstrate how she moved R153 to the safety bars in the shower room on her own, when she had needed assistance of NA-Y to move her in the shower chair from the room to the shower room. The administrator reported she did not do so because "nothing was adding up to what [R153] said based on other interviews." The Abuse Prevention Plan and Policy, last revised 12/22/14, directed staff "The investigation will be well documented and will focus on whether the abuse or neglect occurred and to what extent the causative factors and what interventions were provided to prevent further injury. It should be promptly concluded and include interviews with all persons having information concerning the incident. Internal Investigation Goals are to: I. Conduct clinical examination for signs of injury. II. Conduct and document interviews of staff and residents that include actual words of interviewees. III. Evaluation of potential/actual causative/risk factors (as applicable) : Related resident Care Plan/Assessments, Assignment Sheet for resident, Staffing schedule for day of incident IV. Determine and implement interventions to prevent further injury. V. Re-assess related function (ADL [activities of daily living] Safety risk etc) VI Update Care Plan and NAR [nursing assistant] Assignment as appropriate VII. Determine if abuse/neglect/maltreatment occurred and to what extent."	F 225		

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F 226	Continued From page 5	F 226		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy which directed them to thoroughly investigate an allegation of mistreatment for 1 of 3 resident cases (R153) reviewed for mistreatment. Findings include: The Abuse Prevention Plan and Policy, last revised 12/22/14, directed staff "The investigation will be well documented and will focus on whether the abuse or neglect occurred and to what extent the causative factors and what interventions were provided to prevent further injury. It should be promptly concluded and include interviews with all persons having information concerning the incident. Internal Investigation Goals are to: I. Conduct clinical examination for signs of injury. II. Conduct and document interviews of staff and residents that include actual words of interviewees. III. Evaluation of potential/actual causative/risk factors (as applicable) : Related resident Care Plan/Assessments, Assignment Sheet for resident, Staffing schedule for day of incident IV. Determine and implement interventions to prevent further injury. V. Re-assess related function (ADL [activities of	F 226	R153 no longer resides in the facility. All current residents residing in the facility will be interviewed for any concerns of mistreatment. The Facility Abuse Prevention Plan has been reviewed and revised. Nursing and Social Services staff will be trained on the Abuse Prevention Plan including elements necessary for a thorough investigation. There will be an inter-disciplinary team review of all allegations of abuse or maltreatment to assure that a thorough investigation has occurred to support the conclusion of the investigation. The Abuse Prevention Coordinator is responsible.	3/24/15

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F 226	Continued From page 6 daily living] Safety risk etc) VI Update Care Plan and NAR [nursing assistant] Assignment as appropriate VII. Determine if abuse/neglect/maltreatment occurred and to what extent." Review of R153's admission Minimum Data Set [MDS], dated 1/22/15, revealed R153 was cognitively intact and experienced no symptoms of psychosis. R153 required extensive assistance of two staff to transfer, physical help of one staff for bathing and extensive assistance from one staff for mobility in wheelchair. R153 was noted as experiencing pain almost constantly at a very high level that interfered with her ability to sleep and limited participation in daily activities. During interview on 2/9/15, at 6:33 p.m. R153 reported she had been mistreated by nursing assistant, (NA)-Z, while being assisted with a shower. R153 reported NA-Z was not thorough in helping her wash and rinse her hair, was verbally curt with her and used her injured leg to pull her in the shower chair to the safety bars. R153 elaborated that NA-Z had told her she would either have to wait for someone to come and help move R153 over to the shower safety bars or lift her leg off the floor. R153 reported she told NA-Z her leg was injured and she was not able to lift her leg of the floor. R153 described her leg as a "piece of meat, very tender" and had no control over her leg. R153 explained NA-Z told her there were not enough people to help move her so she grabbed her foot and pulled her across the room in her shower chair to the safety grab bars. The bars were approximately 10 feet away. R153 reported this caused intense pain and reported she felt "like I am going to die" R153 added there were no foot pedals on the shower chair, like	F 226		

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F 226	Continued From page 7 there were in her wheelchair. R153 reported she told a nurse, whose name she did not recall, and then talked to the nurse manager, (RN)-C about her concern and possibly another manager, whose name she did not recall. On 2/11/15, at 9:14 a.m. RN-C reported she had spoke with R153 about staff being rough with her surgical leg in the shower room. RN-C reported she had been on leave from work during the time it was initially reported by R153's family, but knew it was reported to the administrator and a formal complaint was filed. A review of a Customer Concern Feedback Form, dated 1/17/15, revealed R153's family member, (F)-A reported to staff concerns that "this woman [NA-Z] was short and curt with her [R153]. She roughly washed her hair. She only washed the top of her head. She quickly rinsed her head. [R153] required to be more thoroughly rinsed and the aide responded rudely telling her that it was already rinsed. After the shower she grabbed [R153] by her left ankle (her bad leg) and drug her across the room. This was extremely painful." A note written by a nurse, [RN]-Z read "Confirmed with [F-A] that described aide is [NA-Z]. Confirmed pulled solely by leg (not one hand on leg, one on chair)." A review of the Investigative Report, submitted to the state agency on 1/23/15, and accompanying word documents, included a review of R153's medical record, a written statement from NA-Z, an interview with R153 and F-A and documented interviews with staff working at the time of the incident (NA-Y, NA-X and LPN-Z). R153 confirmed statements from F-A, stating "Aide was curt and unaccommodating. Said she cannot lift	F 226		

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F 226	Continued From page 8 affected limb. Aide grabbed and pulled her across shower room floor by leg causing extreme pain." Only NA-Z was able to account for how R153 was moved in the shower chair to the safety bars and included in her written statement, undated "After shower was completed and she was dressed and ready to transfer into chair, I asked if she wanted to go to the bars so she would have something to hold on to or did she want to hold on to 2 of us. She wanted to utilize the bar so we took it very slow I was guiding her foot as she could not pick up her feet. I then put the call light on and [NA-X] came in to help with the transfer." The statement from NA-Z also included that NA-Y helped take R153 to the shower room in the shower chair, which was consistent with the statement from NA-Y. No interviews were done with other residents who received care from NA-Z. During interview with the administrator on 2/12/14 at approximately 11:00 a.m., the administrator confirmed no other residents cared for by NA-Z were interviewed regarding their care experiences or to determine if other residents had experienced rough treatment. The administrator reported she did not ask NA-Z to demonstrate how she moved R153 to the safety bars in the shower room on her own, when she had needed assistance of NA-Y to move her in the shower chair from the room to the shower room. The administrator reported she did not do so because "nothing was adding up to what [R153] said based on other interviews."	F 226		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		3/24/15

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F 278	Continued From page 9 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 2 of 3 residents (R91, R118) who required assistance with activities of daily living (ADL's). Findings Include: R91's annual MDS was inaccurately coded for dressing assistance.	F 278	R91's Annual MDS was modified on 2/12/15 to correct the ADL coding transcription error. R118's 14-day MDS was modified on 2/12/15 to correct the ADL coding transcription error. The MDS Coordinator will review 5 (five) MDS' completed between January 1st and January 31st to assure that the ADL coding is reflected accurately in the MDS.	

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F 278	Continued From page 10 The Clinical Diagnoses Report dated 2/12/15, indicated R91 diagnoses included a left hip fracture with replacement, osteoporosis, and muscle weakness. The annual MDS dated 9/15/14, indicated R91 was independent after set up with dressing. The quarterly MDS dated 12/4/14, indicated R91 required the extensive assistance of one staff with dressing. The ADL Report from 8/27/14 through 9/2/14, indicated R91 received extensive assistance of one staff with dressing. The annual progress note dated 9/3/14, and the quarterly progress note dated 11/26/14, indicated R91 required the extensive assistance of one staff with dressing. On 2/12/15, at 9:45 a.m. nursing assistant (NA)-H stated she puts on R91's bra then handed R91 her shirt and R91 is able to put her shirt on. The NA puts on R91's pants, shoes and socks. On 2/12/15, at 1:49 p.m. registered nurse (RN)-B verified the annual MDS dated 9/15/14, was incorrect. RN-B stated "it was a typo and should have been coded extensive assistance of one staff". The facility failed to ensure R118's 14-day MDS reflected the nursing services provided for dressing. Review of R118's 14-day MDS, with target date 12/18/14, revealed R118 was cognitively intact and required supervision - oversight, encouragement or cueing from staff with dressing. R118's temporary care plan dated 12/10/14,	F 278	If there is a discrepancy, a modified MDS will be submitted to the State. The errors made were an accidental transposition of numbers so no systemic changes or additional training is warranted. The Assistant MDS Coordinator will conduct at least one weekly audit to assure that the ADL score is accurately recorded in the MDS prior to final submission. Monitoring will be completed at a consistent level (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the Quality Council. The Director of Nursing is responsible.	

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F 278	Continued From page 11 indicated R118 was independent with dressing and undressing the upper and lower body. Review of the 7 day observation data collection tool for 12/18/14, revealed R118 required extensive assistance X 2 otherwise was independent in dressing on all days of the assessment review dates, 12/12/14 through 12/18/14. During an interview on 2/12/15 at 1:23 p.m. the registered nurse (RN)-B, verified R118's 14-day MDS was not accurate and stated, "It was a typo, it should have been coded supervision." On 2/12/15 at 1:20 p.m. DON stated, they use Resident Assessment Instrument (RAI) manual for coding. The RAI manual provided by the facility verified R118's MDS coding was inaccurate.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure care and services were provided as directed by the care plan to reduce the risk of pressure ulcers for 1 of 3 residents (R29) who were reviewed for pressure ulcers.	F 282	R29's care plan has been updated to have a cushion in the recliner and a cushion in the wheelchair so that staff does not need to transfer the cushion from one surface to another. Current residents who have pressure	3/24/15

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	245283	A. BUILDING ______ B. WING ______	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 12 Findings include: R29 was admitted to the facility with a stage three pressure ulcer (full thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle are not exposed) that healed on 2/5/15. R29 was not provided a Roho cushion (an air filled pressure reducing cushion) in the recliner as directed by the care plan. R29's Clinical Diagnoses Report 2/12/15, indicated R29's diagnoses included type two diabetes, a gluteal pressure ulcer and debility. R29's Potential Alteration in Skin Integrity care plan edited 2/5/15, indicated R29 had a history of pressure ulcers and was at risk for further breakdown. R29 preferred to sleep in a recliner and had been for a long time. The care plan directed R29 was to have a Roho cushion in the wheelchair and the recliner alternating between the wheelchair and the recliner when in use. During continuous observation on 2/11/15, from 7:35 a.m. to 8:40 a.m. R29 was observed sleeping in the recliner. R29's Roho cushion remained in the wheelchair and was not on the recliner. On 2/11/15, at 1:30 p.m. nursing assistant (NA)-A stated R29 slept in the recliner and not the bed. The Roho cushion was to be placed in the recliner at night and put in the wheelchair before R29 got into the wheelchair. NA-A verified the Roho cushion was not in the recliner when she got R29 up that morning. On 2/11/15, at 1:41 p.m. registered nurse (RN)-A stated the Roho cushion was to be placed in the	F 282	ulcers will have their care plan reviewed and revised as appropriate in regards to special device usage. The Special Needs Equipment and Devices Policy has been reviewed and remains appropriate. The Care Plan Reference Sheet Policy was reviewed and remains appropriate. The Nursing Staff will be trained on these policies and the importance of delivering the care and services as directed by the Care Plan. Random Audits will be completed weekly by the Clinical Manager or designed to assure that care and services are being provided as directed by the Care Plan. Monitoring will be completed at a consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the Quality Council. The Director of Nursing is responsible.	

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F 282	Continued From page 13 recliner before R29 sat in the recliner. On 2/11/15, at 2:30 p.m. R29's buttocks were observed with RN-A. The recently healed pressure ulcer on R29's buttock remained healed and no other open areas were observed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assess 1 of 1 resident (R44) reviewed for table height while eating. Findings include: On 2/9/15, at 5:14 p.m. R44 was observed at a dining room table, seated in a low wheelchair with the table at his shoulder level. R44's arms rested horizontally-straight across the table, and his plate was at his collarbone level. R44's diagnoses included dementia, and osteoarthrosis, left shoulder. R44's quarterly minimum data set (MDS) dated 12/30/14 identified R44 was cognitively impaired. In addition the MDS stated R44 needed supervision with eating (oversight, encouragement or cueing). The Dietician (D)-A, responsible for dietary staff and facility quality assurance, was interviewed on	F 309	R44 no longer resides at the facility. Residents who are independent in eating or who still participate in self feeding will be reviewed for appropriate table height. The Dining and Food Service Policy has been reviewed and revised to include monitoring for dining experience including appropriate table height. Staff involved will be trained on the updated policy. Random audits will be completed weekly by the Dietician or designee monitoring for dining experience and appropriate table height. Monitoring will be completed at a	3/24/15

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NAME OF PROVIDER OR SUPPLIER: **ST MICHAELS HEALTH & REHAB CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1201 8TH STREET SOUTH, VIRGINIA, MN 55792**

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F 309	Continued From page 14 2/12/15, at 1:16 p.m. D-A stated that R44 was moved from Table 18 to Table 4 about a month ago. D-A could not find any notes concerning the rationale for a change in tables for R44. D-A also stated the move and table height were not care planned for R44. According to D-A, the facility's Restorative Aide (RA)-A is also involved with decisions concerning the residents' dining positioning. During interview on 2/12/15, at 1:29 p.m., RA-A stated the facility did not assess R44's positioning at the dining table and the high table could be an issue for R44. RA-A stated that R44's overall condition was declining so R44 was moved from the independent side of the dining room to the assistance-side of the dining room. RA-A also stated R44 leaned forward more in his wheelchair and that this could be an issue at a higher table.	F 309	consistent level (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the Quality Council. The Dietician is responsible.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure care and services were provided to reduce the risk of	F 314	R29's care plan has been updated to have a cushion in the recliner and a cushion in the wheelchair so that staff	3/24/15

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

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F 314	Continued From page 15 pressure ulcers for 1 of 3 residents (R29) reviewed for pressure ulcers. Findings include: R29 was admitted to the facility with a stage three pressure ulcer (full thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle are not exposed) that healed on 2/5/15. R29 was not provided a Roho cushion (an air filled pressure reducing cushion) in the recliner as directed by the care plan. R29's Clinical Diagnoses Report 2/12/15, indicated R29's diagnoses included type two diabetes, a gluteal pressure ulcer and debility. The admission Minimum Data Set (MDS) dated 12/23/14, indicated R29 had moderate cognitive impairment, had no behaviors or rejection of cares. R29 required extensive assistance of one staff with bed mobility and transferring. R29 was at risk for pressure ulcers and required pressure relieving devices on the bed and chairs. A Skin-Wound Documentation dated 12/16/14, indicated R29 had a 9 centimeter (cm) by 4 cm area between the gluteal folds of the buttocks that had a 1 cm open open area on the lower portion. Pressure ulcer measurements dated 12/24/14, indicated R29 had five pressure ulcers. At that time R29 stated she had pain in the area of the pressure ulcers. R29 was issued a Roho cushion for the wheelchair and the recliner. R29 would lay in the bed for 30 minutes to one hour two times a day to off load. Pressure ulcer measurements dated 1/7/15, indicated R29's pressure ulcer was decreasing in size. On 1/15/15, R29's pressure ulcer was healing with pink tissue present. The	F 314	does not need to transfer the cushion from one surface to another. Current residents who have pressure ulcers will have their care plan reviewed and revised as appropriate in regards to special device usage. The Special Needs Equipment and Devices Policy has been reviewed and remains appropriate. The Care Plan Reference Sheet Policy was reviewed and remains appropriate. The Nursing Staff will be trained on these policies and the importance of delivering the care and services as directed by the Care Plan. Random Audits will be completed weekly by the Clinical Manager or designed to assure that care plan interventions for pressure ulcers are being provided as directed by the Care Plan. Monitoring will be completed at a consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the Quality Council. The Director of Nursing is responsible.	

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F 314	Continued From page 16 pressure ulcer was not open. On 2/5/15, the wound documentation indicated R29's buttocks were healed. R29's Potential Alteration in Skin Integrity care plan edited 2/5/15, indicated R29 had a history of pressure ulcers and was at risk for further breakdown. R29 preferred to sleep in a recliner and had been doing so for a long time. The care plan directed R29 was to have a Roho cushion in the wheelchair and the recliner alternating between the wheelchair and the recliner when in use. During continuous observation on 2/11/15, from 7:35 a.m. to 8:40 a.m. R29 was observed sleeping in the recliner. R29's Roho cushion remained in the wheelchair and was not on the recliner seat. On 2/11/15, at 1:30 p.m. nursing assistant (NA)-A stated R29 slept in the recliner and not the bed. The Roho cushion was to be placed in the recliner at night and put in the wheelchair before R29 got into the wheelchair. NA-A verified the Roho cushion was not in the recliner when she got R29 up that morning. On 2/11/15, at 1:41 p.m. registered nurse (RN)-A stated the Roho cushion was to be placed in the recliner before R29 sat in the recliner. On 2/11/15, at 2:30 p.m. R29's buttocks were observed with RN-A. The recently healed pressure ulcer on R29's buttock remained healed and no open areas were observed.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		3/24/15

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F 356	Continued From page 17 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the nurse staffing posting included the actual hours worked for both licensed and unlicensed staff. This had the potential to affect all 71 residents residing in	F 356	The Nursing Service Hours Form Completion Procedure has been reviewed and revised. The Nursing Service Hours Form has been updated to comply with requirements.	

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F 356	Continued From page 18 the facility, family members, and any visitors who may have chosen to view the information. Findings include: During the initial tour of the facility on 2/9/15, at 2:15 p.m. the facility's Nursing Service Hours Form (nurse staff posting) was observed to lack the actual hours worked for the RN's (registered nurses), LPN's (licensed practical nurses) and NAR's (nursing assistants registered). The director of nursing (DON) verified the nurse staff posting lacked the actual hour worked. On 2/9/15, at 2:21 p.m. the DON stated they had been putting up the incorrect form. The DON provided the form that was supposed to be used. The DON stated she thought they had discarded all of the old ones, but the business office staff were responsible for posting the nurse staff posting and somehow had the wrong form. The nurse staff posting forms were reviewed from 1/1/14 through 2/9/15. All of the forms were the same and did not include the actual hours worked. On 2/11/15, at 1:50 p.m. the DON stated she was not aware the nurse staff postings were incorrect for 2014 and 2015. The facility's Nursing Service Hours Form policy reviewed and revised on 7/11/11, indicated the Nursing Service Hours Form would include the facility name, current date, total number and actual hours worked for RN's. LPN's, and NA's and the resident census.	F 356	Weekly audits will be completed by the Administrator or designee to assure that the form is being completed and posted as required. Monitoring will be completed at a consistent level (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the Quality Council. The Administrator is responsible.	
F 496	483.75(e)(5)-(7) NURSE AIDE REGISTRY	F 496		3/24/15

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F 496 SS=E	Continued From page 19 VERIFICATION, RETRAINING 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 the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and 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. 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. 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 3 newly hired nursing assistants reviewed, (NA)-B, was active on the state nursing assistant registry. This had the	F 496	The nursing assistant was removed from the schedule and will not return to work until such time that she is listed on the Nurse Aide Registry.	

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F 496	Continued From page 20 potential to impact 31 of 71 residents residing in 1 of 3 units in the facility. Findings include: A review of the employee file for NA-B revealed a hire date of 1/6/15 for a nursing assistant trainee position. A job description for nursing assistant trainee, signed 1/6/15, included job functions that included working under the supervision of a licensed nurse to: implement the plan of care developed by a registered nurse, provide direct resident care, report resident condition changes, and perform initial and ongoing data collection on all residents. A certificate from the nursing assistant registry indicated NA-B was originally issued a certificate on 8/7/2004. No current verification of active in good standing status on the nursing assistant registry was found in the file. NA-Z's application listed her last work experience as a nursing assistant was August 2012. A telephone call to the state nursing assistant registry representative on 2/12/15 at 11:15 a.m. revealed NA-B was not active on the nursing assistant registry and should not be working as a nursing assistant unless she was currently enrolled in an approved nursing assistant course. On 2/12/15, at 11:14 a.m. the staffing coordinator (SC)-A and human resources representative (HR)-A reported NA-B was not enrolled in a nursing assistant training program and was not active on the nursing assistant registry. HR-A and SC-A reported they were told by NA-B that she could work for 120 days as long as she took her nursing assistant competency test within that time frame. HR-A and SC-A stated NA-B had	F 496	All current Nursing Assistants will be audited to assure that verification of registry is included in their personnel file. The Pre-employment Form, the Conditional Job Offer Form, and the Personnel File Checklist have been reviewed and revised to assure that individuals are not allowed to start working until verification of registration has been completed. The Staffing Coordinator, Human Resource Coordinator and Department Managers have been trained in the procedure. Audits will be completed on all new NAR hires by the Staffing Coordinator to assure that verification of the registry has been completed prior to them being placed on the schedule. Monitoring will be completed at a consistent level (100% of new NAR hires) until compliance is achieved and then monitoring will be completed a level to maintain compliance as determined by the Quality Council. The Director of Nursing is responsible.	

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F 496	Continued From page 21 completed orientation and was working on the unit providing direct care to residents, consistent with the job description. A review of the schedule for 1/15/15 through 2/11/15, confirmed NA-B had worked 19 shifts on the unit as a nursing assistant. On 2/12/15 at 11:35 a.m. the director of nursing (DON) confirmed NA-B was working as a nursing assistant, doing direct care tasks for residents such as bathing and feeding. The DON explained it was her understanding NA-B had 120 days to retake her nursing assistant competency test since her certificate was expired. The Nursing Assistant Trainee job description directed staff the qualifications required for a nursing assistant trainee included "Must be currently attending the State CNA/NAR Training Program; Must be eligible to be on the State Nursing Assistant registry or other appropriate entity pending successful completion of the training; If the trainee does not pass the school testing, they are not eligible to apply to the State Registry and will no longer be able to work in this position in the facility. The training and the testing must be completed within 90 days."	F 496		

F5283

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	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/10/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY At the time of this survey, St. Michael's Health and Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and National Fire Protection Association (NFPA) Standard 101 - 2000 editioion. The original one-story building constructed in 1967, was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this inspection the building was inspected as a Type V(000), as one building, which meets the standard. It has a full basement and is fully sprinklered. The facility has a capacity of 83 beds. At the time of the survey the census was 72. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR Subpart 483.70(a) is NOT Met.	K 000		
K 014 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as	K 014	Waiver at K14	2/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/26/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/10/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	**1201 8TH STREET SOUTH** **VIRGINIA, MN 55792**

(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 014	Continued From page 1 fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and documentation, (from FMS Survey dated 3-19-13) the facility failed to provided interior finish materials that meets LSC(00) 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient practice could effect all 87 residents. Findings include: During the facility tour on 2-10-15 between 8:00-10:00AM it was observed that carpet has been applied to the corridor walls on both levels, within 12 inches of the floor. This observation was cited by Federal Surveyor (BW) on 3-19-13. At the time of POC on 5-28-13, the facility had corrected this condition throughout the "C" wing, and plans to continue as carpet is replaced at normal intervals. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. ***** Annual Waiver Recommended ***	K 014	Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division)	
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	AW at K38	2/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(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 038	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and documentation (from FMS Survey dated 3-19-13) the facility failed to provided proper means of egress from the basement storage area under the "A" wing, in accordance with LSC(00) section 19-2-1. This deficient practice could effect all occupants (undermined number) that would need to evacuate this area in an emergency. Note: residents are not allowed in this area. Findings include: During the facility tour on 2-10-15 between 8:00-10:00AM it was observed that the storage area in the basement, under the "A" wing, only has one exit. This area is approximately 7, 290 square feet in size. Rooms over 2,500 square feet require two remote exits. This observation was cited by Federal Surveyor (BW) on 3-19-13 as a part of an FMS. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. **Annual Waiver Recommended***	K 038	Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division)	
K 067 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	AW at K67	2/27/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/10/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	**1201 8TH STREET SOUTH** **VIRGINIA, MN 55792**

(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 067	Continued From page 3	K 067		
	This STANDARD is not met as evidenced by: Based on observation, interview, and documentation (from FMS Survey dated 3-19-13) the facility failed to install heating and ventilation in accordance with LSC(00) section 19-5.2.1 and NFPA 90A 19.5.2.2. This deficient practice could effect all residents. Findings include: During the facility tour on 2-10-15 between 8:00-10:00AM it was observed and confirmed by interview, with the Director of Maintenance (RC) the the corridor is being used as a return air plenum in the "A & B" wings. This observation was cited by Federal Surveyor (BW) on 3-19-13. Interview with the Director of Maintenance (RC) indicated that the facility has not pursued a plan of correction based on the estimated cost of the project. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. ***Annual Waiver Recommended***		Waiver requested (CMS-2786R to be mailed to MN State Fire Marshall Division)	
K 103 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3	K 103	AW at K103	2/27/15
	This STANDARD is not met as evidenced by: Based on observation, interview, and		Waiver requested (CMS-2786R to be	

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

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	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**02/10/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	**1201 8TH STREET SOUTH** **VIRGINIA, MN 55792**

(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 103	Continued From page 4 documentation (from FMS Survey dated 3-19-13) the facility failed to install non-combustible framing, above the ceiling, in two locations. The building was originally constructed as non-combustible Type II(111) per LSC(00) 19.1.6.3. This deficient practice could effect 30 of the 83 residents. Findings include: During the facility tour on 2-10-15 between 8:00-10:00AM it was observed that in two areas above the ceiling in tub rooms of "A & B" wings limited combustible framing material has been used. This observation was cited by Federal Surveyor (BW) on 3-19-13. Based on interview with the facility Director of Maintenance (RC), this condition still exists. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. ***Annual Waiver Recommended***	K 103	mailed to MN State Fire Marshall Division)	

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Friday, February 27, 2015 12:51 PM
To:	rochi_lsc@cms.hhs.gov
Cc:	jeffrey.juntunen@state.mn.us; 'cheri.high@bhshealth.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	St Michaels Health & Rehab Center (245283) K14, K38, K67 & K103 Annual Waiver Requests - Previously Approved - No Changes

This is to inform you that St Michaels Health & Rehab is again requesting annual waivers for K14, K38, K67 & K103. The exit date was 2-1-15. exit date was 02/10/2015

I am recommending that CMS approve these waiver requests.

Patrick Sheehan, Fire Safety Supervisor

Office: 651-201-7205 Cell: 651-470-4416

Health Care & Corrections Fire Inspections

Minnesota State Fire Marshal Division Est. 1905

445 Minnesota St., Suite 145, St Paul, MN 55101-5145

FAX: 651-215-0525

Web: fire.state.mn.us

2000 CODE

Name of Facility

St. Michael's Health and Rehabilitation Center 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
~~K84~~ K014	An annual/continuing waiver is being requested for K014

A. Compliance with this provision will cause an unreasonable hardship because:

1. The most recent cost estimate dated 4-19-13 for removing and replacing the carpet cove on the upper and lower floors is approximately $14000. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves.
2. Removal of the carpeting without replacement of some type of wall covering would make it aesthetically unappealing and could cause injury to residents due to rough surfaces.
3. The carpeting in the Gardens and Meadows wings and lower level is older and is due to be replaced in 2016. The Foundation is currently attempting to raise funds for flooring but do not have adequate funds at this time.
4. The Minnesota Department of Public Safety, State Fire Marshall's Division has allowed installation of carpeting on walls up to a height of 12 inches when the building is fully sprinkled and the carpeting has a Class I rating, based on the Radiant Panel Test for carpeting. These conditions are met at this facility.

B. There would be no adverse effect on the building occupants safety because:

1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13.
2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system.
3. The Building is equipped with corridor smoke detection.
4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors.
5. The facility is smoke free and signs to that effect are prominently posted at all major entrances.
6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers).
7. The building fire alarm system is monitored to provide automatic fire department notification.
8. Fire Safety Training is provided for all employees annually and during orientation for all new hires.
9. Fire Drills are conducted at least quarterly on each shift.
10. This annual/continuing waiver has been approved in the past.

[signature] 2-25-15

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 2-27-15

Name of Facility

St. Michael's Health and Rehabilitation Center 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
~~K84~~ K038	An annual/continuing waiver is being requested for K038 A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 4-8-13 for complying with a second means of egress from this wing is over $113,000.00. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves. 2. There are concerns that penetrations of load bearing walls to install a second means of egress could adversely affect the structural integrity of the building. B. There would be no adverse effect on the building occupants safety because: 1. Residents do not have access to this area. 2. Not more than two staff members occupy the area at any given time and then only for short periods of time (less than 15 minutes) to stock or retrieve supplies. 3. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 4. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 5. The Building is equipped with corridor smoke detection. 6. This area is equipped with smoke detection. 7. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 8. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 9. The building fire alarm system is monitored to provide automatic fire department notification. 10. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 11. Fire Drills are conducted at least quarterly on each shift. 12. The facility will decrease the combustible load of the space and monitor the area to keep combustible load reasonable for the storage space. [signature] 2-25-15

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature) [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 2-27-15

Name of Facility

St. Michael's Health and Rehabilitation Center 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
~~K84~~ K067	An annual/continuing waiver is being requested for K067 A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 4-10-13 for a complying ducted HVAC system is over $130000.00 excluding the required wiring. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves. 2. There are concerns that penetrations of load bearing walls to install required duct work could adversely affect the structural integrity of the building. 3. Installation of a ducted system may require asbestos abatement which would increase the costs. 4. LSC (00), Sec. 9.2.1 gives AHJ the authority to allow existing HVAC systems that do not comply with NFPA 90A to be continued in service. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. 10. This annual/continuing waiver has been approved in the past. [signature] 2-25-15

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 2-27-15

Name of Facility — **2000 CODE**

St. Michael's Health and Rehabilitation Center 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
~~K84~~ K103	An annual/continuing waiver is being requested for K103. A. Compliance with this provision will cause an unreasonable hardship because: 1. The cost of removing the wood framing and replacing the ceilings at the Garden-Wing and Meadows-Wing tub rooms is estimated at roughly $10,000. 2. NFPA 101(00), Sec. 4.6.3 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical. St. Michael's Health & Rehab Center feels that it would be impractical to remove/replace the combustible wood framing at the ceilings because while not in literal compliance with the Code, the combustible wood framing at the ceilings does not represent a significant threat to the safety of the staff and residents and correction of this deficiency would cause the need for disproportionate effort, expense and disruption of services with little or no increase in life safety. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. [signature] 2-25-15

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 2-27-15

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 25, 2015

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5283025

Dear Ms. High:

The above facility was surveyed on February 9, 2015 through February 12, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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.

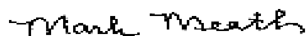
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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 Chris Campbell at (218) 302-6151 or email: chris.campbell@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.

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

Sincerely,



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

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00582	A. BUILDING: ______ B. WING ______	02/12/2015

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(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
2 000	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 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 February 9th, 10th, 11th and 12th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute 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.	2 000		

Minnesota Department of Health

POC NOT FINAL

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(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
2 000	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 did not ensure care and services were provided as directed by the care plan to reduce the risk of pressure ulcers for 1 of 3 residents (R29) who were reviewed for pressure ulcers. Findings include: R29 was admitted to the facility with a stage three pressure ulcer (full thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle are not exposed) that healed on 2/5/15. R29 was not provided a Roho cushion (an air filled pressure reducing cushion) in the recliner as directed by the care plan. R29's Clinical Diagnoses Report 2/12/15, indicated R29's diagnoses included type two diabetes, a gluteal pressure ulcer and debility.	2 565	Corrected	3/24/15

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2 565	Continued From page 3 R29's Potential Alteration in Skin Integrity care plan edited 2/5/15, indicated R29 had a history of pressure ulcers and was at risk for further breakdown. R29 preferred to sleep in a recliner and had been for a long time. The care plan directed R29 was to have a Roho cushion in the wheelchair and the recliner alternating between the wheelchair and the recliner when in use. During continuous observation on 2/11/15, from 7:35 a.m. to 8:40 a.m. R29 was observed sleeping in the recliner. R29's Roho cushion remained in the wheelchair and was not on the recliner. On 2/11/15, at 1:30 p.m. nursing assistant (NA)-A stated R29 slept in the recliner and not the bed. The Roho cushion was to be placed in the recliner at night and put in the wheelchair before R29 got into the wheelchair. NA-A verified the Roho cushion was not in the recliner when she got R29 up that morning. On 2/11/15, at 1:41 p.m. registered nurse (RN)-A stated the Roho cushion was to be placed in the recliner before R29 sat in the recliner. On 2/11/15, at 2:30 p.m. R29's buttocks were observed with RN-A. The recently healed pressure ulcer on R29's buttock remained healed and no other open areas were observed. Suggested Method of Correction: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of	2 565		

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2 565	Continued From page 4 care. Time Period for Correction: 21 days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to assess 1 of 1 resident (R44) reviewed for table height while eating. Findings include: On 2/9/15, at 5:14 p.m. R44 was observed at a dining room table, seated in a low wheelchair with the table at his shoulder level. R44's arms rested horizontally-straight across the table, and his plate was at his collarbone level. R44's diagnoses included dementia, and osteoarthrosis, left shoulder. R44's quarterly minimum data set (MDS) dated 12/30/14 identified R44 was cognitively impaired. In addition the MDS stated R44 needed supervision with eating (oversight, encouragement or cueing).	2 830	Corrected	3/24/15

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2 830	Continued From page 5 The Dietician (D)-A, responsible for dietary staff and facility quality assurance, was interviewed on 2/12/15, at 1:16 p.m. D-A stated that R44 was moved from Table 18 to Table 4 about a month ago. D-A could not find any notes concerning the rationale for a change in tables for R44. D-A also stated the move and table height were not care planned for R44. According to D-A, the facility's Restorative Aide (RA)-A is also involved with decisions concerning the residents' dining positioning. During interview on 2/12/15, at 1:29 p.m., RA-A stated the facility did not assess R44's positioning at the dining table and the high table could be an issue for R44. RA-A stated that R44's overall condition was declining so R44 was moved from the independent side of the dining room to the assistance-side of the dining room. RA-A also stated R44 leaned forward more in his wheelchair and that this could be an issue at a higher table. Suggested Method of Correction: The director of nursing or designee, could review and revice policies and procedures related to positioning during dining, assessments, monitoring and care, and could provide staff education related to the care of resident related to positioning during dining. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. Time Period for Correction: 21 days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the	2 900		3/24/15

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2 900	Continued From page 6 comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure care and services were provided to reduce the risk of pressure ulcers for 1 of 3 residents (R29) reviewed for pressure ulcers. Findings include: R29 was admitted to the facility with a stage three pressure ulcer (full thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle are not exposed) that healed on 2/5/15. R29 was not provided a Roho cushion (an air filled pressure reducing cushion) in the recliner as directed by the care plan. R29's Clinical Diagnoses Report 2/12/15, indicated R29's diagnoses included type two diabetes, a gluteal pressure ulcer and debility. The admission Minimum Data Set (MDS) dated	2 900	Corrected.	

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2 900	Continued From page 7 12/23/14, indicated R29 had moderate cognitive impairment, had no behaviors or rejection of cares. R29 required extensive assistance of one staff with bed mobility and transferring. R29 was at risk for pressure ulcers and required pressure relieving devices on the bed and chairs. A Skin-Wound Documentation dated 12/16/14, indicated R29 had a 9 centimeter (cm) by 4 cm area between the gluteal folds of the buttocks that had a 1 cm open open area on the lower portion. Pressure ulcer measurements dated 12/24/14, indicated R29 had five pressure ulcers. At that time R29 stated she had pain in the area of the pressure ulcers. R29 was issued a Roho cushion for the wheelchair and the recliner. R29 would lay in the bed for 30 minutes to one hour two times a day to off load. Pressure ulcer measurements dated 1/7/15, indicated R29's pressure ulcer was decreasing in size. On 1/15/15, R29's pressure ulcer was healing with pink tissue present. The pressure ulcer was not open. On 2/5/15, the wound documentation indicated R29's buttocks were healed. R29's Potential Alteration in Skin Integrity care plan edited 2/5/15, indicated R29 had a history of pressure ulcers and was at risk for further breakdown. R29 preferred to sleep in a recliner and had been doing so for a long time. The care plan directed R29 was to have a Roho cushion in the wheelchair and the recliner alternating between the wheelchair and the recliner when in use. During continuous observation on 2/11/15, from 7:35 a.m. to 8:40 a.m. R29 was observed sleeping in the recliner. R29's Roho cushion remained in the wheelchair and was not on the recliner seat.	2 900		

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2 900	Continued From page 8 On 2/11/15, at 1:30 p.m. nursing assistant (NA)-A stated R29 slept in the recliner and not the bed. The Roho cushion was to be placed in the recliner at night and put in the wheelchair before R29 got into the wheelchair. NA-A verified the Roho cushion was not in the recliner when she got R29 up that morning. On 2/11/15, at 1:41 p.m. registered nurse (RN)-A stated the Roho cushion was to be placed in the recliner before R29 sat in the recliner. On 2/11/15, at 2:30 p.m. R29's buttocks were observed with RN-A. The recently healed pressure ulcer on R29's buttock remained healed and no open areas were observed. Suggested Method of Correction: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. Time Period for Correction: 21 days	2 900		
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	21426		3/24/15

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21426	Continued From page 9 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure employee evaluations for tuberculosis (TB) included all the components specified in the facility policy and procedure for implementation of a two-step tuberculin skin test (TST), for 3 of 5 new employees. In addition, the facility failed to ensure resident TST's were completed for 1 of 5 residents reviewed. Findings include: EMPLOYEES: The Tuberculosis Screening and Mantoux Administration policy approved 10/22/12 indicated Step One of a Two-Step Mantoux was performed on all newly hired personnel prior to orientation on the floor or resident contact. A Second Step Mantoux was to be completed 14 days later. Review of nursing assistant (NA)-B's personnel record indicated a hire date of 1/6/15 and a first step skin test not completed until 3 weeks later, on 1/27/15.	21426	Corrected.	

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21426	Continued From page 10 Review of NA-C's personnel record revealed a hire date of 11/21/14 and a first step skin test not completed until 1/30/15. Review of dietary aide (DA)-A's personnel record indicated a hire date of 11/6/14. DA-A completed the first step skin test according to facility procedure, but a second step skin test, given on 11/28/14 was never read. Review of DA-B's personnel record indicated a rehire date of 12/30/14. A symptom screen was completed but not dated. A first step skin test was administered on 1/28/13 and the date of reading was not identified. A second step skin test was administered on 2/19/13, 8 days late and was never read. RESIDENTS: The facility policy on Tuberculosis Screening and Mantoux Administration specified that newly admitted residents would receive their first step Mantoux skin test within 72 hours of admission. The policy also specified if the Mantoux could be documented within 3 months prior to admission, a repeat was not required. R157 was admitted on 1/28/15. Record review indicated a TB history/symptom screening was completed on 1/28/15. This screening indicated that R157 had been coughing for more than 3 weeks. The form specified if TB symptoms are present, promptly refer resident for a chest x-ray and full medical examination. The facility did not have evidence of a completed x-ray. Review of R157's medication administration history revealed R157 "refused at this time" a first step skin test on 1/29/15. No further action was taken. In an interview with registered nurse (RN)-C and RN-D on 2/11/15, at 12:54 p.m. identified this information should have been given to an RN and acted upon. On 2/11/15, at approximately 3:00 p.m., RN-D provided documentation that R157 had a negative	21426		

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21426	Continued From page 11 second-step Mantoux skin test at another facility, dated 8/27/14. Suggested Method of Correction: The director of nursing or designee could review and update systems for employee and resident tuberculosis screenings. The director of nursing or designee could educate all appropriate staff. The director of nursing or designee could monitor to ensure ongoing compliance with tuberculosis policy and procedures. Time period for Correction: 21 days	21426		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report	21980		3/24/15

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21980	Continued From page 12 as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of mistreatment for 1 of 3 resident cases (R153) reviewed for mistreatment. Findings include: Review of R153's admission Minimum Data Set [MDS], dated 1/22/15, revealed R153 was cognitively intact and experienced no symptoms of psychosis. R153 required extensive assistance	21980	Corrected.	

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21980	Continued From page 13	21980		

of two staff to transfer, physical help of one staff for bathing and extensive assistance from one staff for mobility in wheelchair. R153 was noted as experiencing pain almost constantly at a very high level that interfered with her ability to sleep and limited participation in daily activities.

During interview on 2/9/15, at 6:33 p.m. R153 reported she had been mistreated by nursing assistant, (NA)-Z, while being assisted with a shower. R153 reported NA-Z was not thorough in helping her wash and rinse her hair, was verbally curt with her and used her injured leg to pull her in the shower chair to the safety bars. R153 elaborated that NA-Z had told her she would either have to wait for someone to come and help move R153 over to the shower safety bars or lift her leg off the floor. R153 reported she told NA-Z her leg was injured and she was not able to lift her leg of the floor. R153 described her leg as a "piece of meat, very tender" and had no control over her leg. R153 explained NA-Z told her there were not enough people to help move her so she grabbed her foot and pulled her across the room in her shower chair to the safety grab bars. The bars were approximately 10 feet away. R153 reported this caused intense pain and reported she felt "like I am going to die" R153 added there were no foot pedals on the shower chair, like there were in her wheelchair. R153 reported she told a nurse, whose name she did not recall, and then talked to the nurse manager, (RN)-C about her concern and possibly another manager, whose name she did not recall.

On 2/11/15 at 9:14 a.m. RN-C reported she had spoke with R153 about staff being rough with her surgical leg in the shower room. RN-C reported she had been on leave from work during the time it was initially reported by R153's family, but knew

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21980	Continued From page 14 it was reported to the administrator and a formal complaint was filed. A review of a Customer Concern Feedback Form, dated 1/17/15, revealed R153's family member, (F)-A reported to staff concerns that "this woman [NA-Z] was short and curt with her [R153]. She roughly washed her hair. She only washed the top of her head. She quickly rinsed her head. [R153] required to be more thoroughly rinsed and the aide responded rudely telling her that it was already rinsed. After the shower she grabbed [R153] by her left ankle (her bad leg) and drug her across the room. This was extremely painful." A note written by a nurse, [RN]-Z read "Confirmed with [F-A] that described aide is [NA-Z]. Confirmed pulled solely by leg (not one hand on leg, one on chair)." A review of the Investigative Report, submitted to the state agency on 1/23/15, and accompanying word documents, included a review of R153's medical record, a written statement from NA-Z, an interview with R153 and F-A and documented interviews with staff working at the time of the incident (NA-Y, NA-X and LPN-Z). R153 confirmed statements from F-A, stating "Aide was curt and unaccommodating. Said she cannot lift affected limb. Aide grabbed and pulled her across shower room floor by leg causing extreme pain." Only NA-Z was able to account for how R153 was moved in the shower chair to the safety bars and included in her written statement, undated "After shower was completed and she was dressed and ready to transfer into chair, I asked if she wanted to go to the bars so she would have something to hold on to or did she want to hold on to 2 of us. She wanted to utilize the bar so we took it very slow I was guiding her foot as she could not pick up her feet. I then put the call light on and [NA-X]	21980		

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21980	Continued From page 15 came in to help with the transfer." The statement from NA-Z also included that NA-Y helped take R153 to the shower room in the shower chair, which was consistent with the statement from NA-Y. No interviews were done with other residents who received care from NA-Z. During interview with the administrator on 2/12/14 at approximately 11:00 a.m., the administrator confirmed no other residents cared for by NA-Z were interviewed regarding their care experiences or to determine if other residents had experienced rough treatment. The administrator reported she did not ask NA-Z to demonstrate how she moved R153 to the safety bars in the shower room on her own, when she had needed assistance of NA-Y to move her in the shower chair from the room to the shower room. The administrator reported she did not do so because "nothing was adding up to what [R153] said based on other interviews." The Abuse Prevention Plan and Policy, last revised 12/22/14, directed staff "The investigation will be well documented and will focus on whether the abuse or neglect occurred and to what extent the causative factors and what interventions were provided to prevent further injury. It should be promptly concluded and include interviews with all persons having information concerning the incident. Internal Investigation Goals are to: I. Conduct clinical examination for signs of injury. II. Conduct and document interviews of staff and residents that include actual words of interviewees. III. Evaluation of potential/actual causative/risk factors (as applicable) : Related resident Care Plan/Assessments, Assignment Sheet for resident, Staffing schedule for day of incident IV. Determine and implement interventions to prevent further injury. V.	21980		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00582	A. BUILDING: ____ B. WING ____	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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21980	Continued From page 16 Re-assess related function (ADL [activities of daily living] Safety risk etc) VI Update Care Plan and NAR [nursing assistant] Assignment as appropriate VII. Determine if abuse/neglect/maltreatment occurred and to what extent." Suggested Method for Correction: The administrator or designee could review and update policies related to vulnerable adult abuse and neglect. The administrator or designee could educate all facility staff. The administrator or designee could develop monitoring systems to ensure ongoing compliance is attained and maintained. Time Period for Correction: 21 days	21980		