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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VE0F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00787

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **178977500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BRIGID'S AT HI-PARK**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

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 **04/04/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	65			
(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 :
Susanne Reuss, Unit Supervisor — 04/06/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Susan N. Leppke, Program Specialist — 04/06/2012 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/9/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on February 5, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On April 4, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey completed on February 5, 2012, effective March 26, 2012. Therefore, remedies will not be imposed. See attached CMS-2567B forms for the results of the April 4, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 6, 2012 CMS Certification Number (CCN):245355

Mr. Michael Schultz, Administrator
St Brigid's At Hi-Park
213 Pioneer Road
Red Wing, Minnesota 55066

Dear Mr. Schultz:

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 26, 2012 the above facility is recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Susan N Leppke

Susan N. Leppke, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4121 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 6, 2012

Mr. Michael Schultz, Administrator
St Brigid's At Hi-Park
213 Pioneer Road
Red Wing, Minnesota 55066

RE: Project Number S5355022

Dear Mr. Schultz:

On March 1, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 4, 2012, 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 15, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 26, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2012, effective March 26, 2012 and therefore remedies outlined in our letter to you dated March 1, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Susanne Reuss

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5355r12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245355	A. Building B. Wing	4/4/2012

Name of Facility	Street Address, City, State, Zip Code
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/26/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/26/2012**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **03/26/2012**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/26/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/SNL	4/6/2012	16022	04/04/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/15/2012

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

ID: VE0F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00787

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **178977500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BRIGID'S AT HI-PARK**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

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 **02/15/2012** (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 IMR**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	65			
(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):

At the time of the standard survey completed on February 5, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Sheryl Reed, HFE NE II 03/13/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 04/06/2012 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
POSTED 4/9/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 8812

March 1, 2012

Mr. Michael Schultz, Administrator
St Brigid's At Hi-Park
213 Pioneer Road
Red Wing, Minnesota 55066

RE: Project Number S5355022

Dear Mr. Schultz:

On February 15, 2012, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. 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;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss
Minnesota Department of Health
PO Box 64900
St Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

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 26, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 15, 2012 (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 15, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Susanne Reuss

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5355s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245355	A. BUILDING _____ B. WING _____	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	RECEIVED MAR 12 2012 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
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	F 225	It continues to be the policy of St. Brigid's at Hi-Park to report potential vulnerable adult situations timely to the appropriate agencies. Resident 25: The IDT reviewed the care plan and NAR care card and updated as appropriate. Regarding R68: The facility provided the technical college with the Abuse Prevention Plan with the exception that it will be a part of the training for the student NAR's. The staff person involved was immediately educated and has had further education assigned to her regarding the Abuse Prevention Plan. All staff members are required to complete Vulnerable Adult/Abuse Prevention Plan training via online Silverchair learning system and mandatory annual in services.	03/26/12

3/13/12 SER

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/ADMINISTRATOR — (X6) DATE: 3/9/12

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
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ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

(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 225	Continued From page 1 State survey and certification agency). 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 make a timely report to the state agency (SA) for 2 of 6 residents (R25 and R55) reviewed for allegation of abuse, and failed to immediately report to the Administrator and thoroughly assess an allegation of rough handling during cares for 1 of 6 residents (68) reviewed. Findings include: R25 experienced a fall and the incident was not reported to the state agency until three days after occurrence. R25 diagnoses included muscle weakness and congestive heart failure. Care plan for R25, dated 4/5/11 was reviewed. The care plan directed staff "(R25) to be transferred (with) gait belt at all times also use gait belt (with) all ambulating."	F 225	Continued F225 Regarding R55, immediate education was delivered to staff regarding how resident likes her legs to be lifted, the care cards were adjusted to this fact. Further education will be done by 03/16/12 to all Licensed nursing staff and NAR's, regarding R55's repositioning preferences. Repositioning Interviews/Abuse Prevention Plan audits will be conducted with R55 to ensure compliance, 3 times per week for the first quarter of rotating shifts. All staff members will receive a copy of the Abuse Prevention plan, crime reporting poster, and a chain of command that identifies who to call and how to make a timely report regarding abuse incidents. Each staff will sign a verification form that they have read and understand the documents and reporting requirements and timelines. On 03/08/12 the Ombudsman conducted a mandatory all staff in-service regarding Resident Rights and Dignity. By 03/22/12 Licensed Nursing staff will receive training from the DON on vulnerable adult elements that are reportable The facility IDT will review newly opened Matrix events at daily stand up meetings to ensure all events have been reviewed for reportability. The Director of Social Services will interview 3 staff per week regarding their role in the Abuse Prevention Plan.	

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F 225	Continued From page 2 Event report dated 5/13/11 was reviewed. Event report revealed the following: "At 2015 (R25) was ambulating back and was starting to turn to sit back in recliner, when s/he states s/he lost his/her balance and fell unto rightside/back area." An incident report, dated 5/16/11, states: "LPN (licensed practical nurse) was walking the resident to her reclining chair in the residents room. The resident went to sit down in his/her chair but missed the chair and fell to the floor. Resident was not wearing a gait belt. The resident's care plan states that a gait belt will be used for all transfers." The date of incident occurrence was listed as 5/13/11. At 4:30 p.m. on 2/15/12, interview with the director of nursing (DON) revealed that she was told by the LPN on 5/13/11 that the LPN was not using the gait belt for the transfer that occurred during the course of the fall. The DON confirmed that the incident was not reported to the state agency until 5/16/11. R25 was allegedly treated roughly by staff and the facilty failed to report to the state agency until the day after learning about the incident. R25 was identifed by the facilility as being at risk for falls with interventions including use of personal alarm. An incident report, dated 1/20/12, included allegations from a student nurse that "(R25) was folding clothes in the lounge, s/he was standing and the personal alarm was activated. (R25) became agitated by the alarm so s/he removed it	F 225	Continued F225 The results of interviews will be reported to Quality Council for 3 months and thereafter as needed. Responsible party: Director of Social Services	

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F 225	Continued From page 3	F 225		

from the shirt. St. Brigid's NAR (nursing assistant) entered the lounge and informed the resident that s/he needed to be sitting down. The NAR "forcefully" removed the alarm from (R25's) hand. As the NAR was removing the alarm from (R25's) hand, the NAR "slapped" (R25's) wrist." The date the alleged incident occurred was on 1/16/12. The student nurse did not notify her nursing instructor of the incident until 1/19/12.

Interview with social service director (SSD) at 11:50 a.m. on 2/14/12 revealed the nursing instructor notified the facility of the alleged abuse of R25 around supper time on 1/19/12. SSD explained that while the facility started an internal investigation of the alleged incident on 1/19/12, the report to the SA was not made until 1/20/12.

The facility failed to report, investigate and implement prevention measures for R55 who experienced bruising on the legs due to rough transfers.

R68, alert and oriented, had diagnoses including paralysis agitans, fracture of the femur (closed), late effects acute poliomyelititis, muscle weakness, venous thrombosis and hypertension.

At 10:15 a.m. on 2/13/12 R68 participated in a standardized interview with surveyor. R68 reported some staff were occassionally rougher than others during transfers. R68 explained that there were bruises on the legs from being transfered by staff. R68 further explained that this happens when staff lift legs with their thumb on top of the leg instead of using their hands to lift legs from the bottom, touching only the calfs. R68 reported that a nursing assistant had been

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F 225	Continued From page 4 informed of these concerns on an earlier date. At 8:30 a.m. on 2/14/12, SSD explained that she had not previously been made aware of concerns of bruising on R68's legs due to transfers. The SSD and surveyor reviewed event history for the period of 3/1/11 through 2/14/12. There were no events related to bruises from lifting R68's legs. SSD explained that concerns related to bruising should be documented in the event history and showed an example from 6/24/11 regarding bruises on R68's foot related to a belt buckle on a wheelchair being too tight. Progress note written by wound care nurse dated 2/14/12 at 8:49 a.m. notes " 2 small fading yellow bruises on back of left leg. Measurement of 1 x 1 centimeter each." During an interview on 9:02 a.m. on 2/14/12, NAR-A reported observing bruises on R68's legs sometime within the last few weeks. NAR-A could not recall the exact date when these bruises were observed. NAR-A reported the concerns to a nurse but could not recall the nurse's name. During an interview at 11:00 a.m. on 2/15/12, LPN-B reported a nursing assistant had reported bruises on R68's legs a few months ago but could not remember the exact date. At this time, LPN-B verified two dime sized bruises on the top of R68's legs. R68 reported to LPN-B that the bruises occurred during transfers. LPN-B reported she then asked R68 about preferences in how R68 would like to be transferred. LPN-B explained that she passed this information along to the nursing assistants on duty for the shift she was working and the next. LPN-B acknowledged	F 225		

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F 225	Continued From page 5 that she did not inform the clinical manager (CM), DON or administrator about the bruising. LPN-B explained that she did not document the bruises in R68's progress notes or complete an incident report. LPN-B reported that she did not inform the clinical manager of R68's transfering preferences or update the care plan with these preferences. LPN-B explained that this was due to R68 being capable of directing staff in how to provide cares. During interview at 10:10 a.m. on 2/15/12, SSD explained that nursing staff would be expected to report bruises on residents to the CM or charge nurse on duty who would then initiate an investigation along with the DON, SSD, wound care nurse and administrator. During interview at 1:15 p.m. on 2/15/12, DON explained that nursing staff would be expected to report bruises on residents to the DON who would then initiate an investigation along with the DON, SSD and administrator. Abuse Prevention Plan dated 1/2012 directed staff to maintain a proactive approach for identifying individual risk factors that may constitute or contribute to abuse and negelct. This included: identification and management of individual resident risk factors through the assessment and care planning process and development of intervention strategies to prevent abuse. Staff were directed that the care planning process was to include identification of specific factors that make the resident susceptible to abuse as well as documentation of a goal and specific measures to minimze the risks. Staff were directed to report abuse immediately to a supervisor who would immediately notify the	F 225		

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F 225	Continued From page 6 administrator, DON and SSD. The policy listed the administrator, DON and SSD as primarily responsible for the prompt (within 24 hours of discovery) review, investigation and reporting of all suspected cases of maltreatment/abuse/neglect/vulnerability to the state agency.	F 225		03/26/12
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 ensure policies were implemented for reporting allegations of mistreatment to the designated state agency, promptly, for 2 of 6 residents reviewed for allegations of neglect/abuse (R25, R55) and failed to, immediatley, notify the administrator and implement policies related to investigation of rough handling during cares for 1 of 6 residents (R68) reviewed. Findings include: R25 experienced a fall and the incident was not reported to the state agency until 3 days after the occurrence. R25 had diagnoses including muscle weakness and congestive heart failure. Care plan for R25, dated 4/5/11 was reviewed and directed staff	F 226	It continues to be the policy of St. Brigid's at Hi-Park to report potential vulnerable adult situations timely to the appropriate agencies. Resident 25: The IDT reviewed the care plan and NAR care card and updated as appropriate. Regarding R68: The facility provided the technical college with the Abuse Prevention Plan with the exception that it will be a part of the training for the student NAR's. The staff person involved was immediately educated and has had further education assigned to her regarding the Abuse Prevention Plan. All staff members are required to complete Vulnerable Adult/Abuse Prevention Plan training via online Silverchair learning system and mandatory annual in services. Regarding R55, immediate education was delivered to staff regarding how resident likes her legs to be lifted, the care cards were adjusted to this fact. Further education will be done by 03/16/12 to all Licensed nursing staff and NAR's, regarding R55's repositioning preferences. Repositioning Interviews/Abuse Prevention Plan audits	

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F 226	Continued From page 7 "(R25) to be transferred (with) gait belt at all times, also use gait belt (with) all ambulating. An Event report dated 5/13/11 was reviewed. The Event report revealed the following: "At 2015 (R25) was ambulating back and was starting to turn to sit back in recliner, when s/he states s/he lost his/her balance and fell unto rightside/back area." At 2:15pm on 2/15/12, interview with director of nursing (DON) revealed the facilities abuse prevention policy directed staff to notify the state agency of allegations of neglect/abuse without delay. At 4:30p.m. on 2/15/12, interview with the DON revealed she had been informed on 5/13/11 of the gait belt not being used during the transfer resulting in R55's fall. The DON confirmed that the incident was not reported to the state agency until 5/16/11. R55 was identified of being at risk for falls with interventions including use of personal alarm. The facility failed to report an allegation of rough treatment by staff until the day after being informed of the incident. An incident report, dated 1/20/12, included allegations from a student nurse that "(R55) was folding clothes in the lounge, s/he was standing and her personal alarm was activated. (R55) became agitated by the alarm so s/he removed it from the shirt. St. Brigid's NAR (nursing assistant) entered the lounge and informed the resident that s/he needed to be sitting down. The NAR	F 226	Continued F226 will be conducted with R55 to ensure compliance, 3 times per week for the first quarter of rotating shifts. All staff members will receive a copy of the Abuse Prevention plan, crime reporting poster, and a chain of command that identifies who to call and how to make a timely report regarding abuse incidents. Each staff will sign a verification form that they have read and understand the documents and reporting requirements and timelines. On 03/08/12 the Ombudsman conducted a mandatory all staff in-service regarding Resident Rights and Dignity. By 03/22/12 Licensed Nursing staff will receive training from the DON on vulnerable adult elements that are reportable The facility IDT will review newly opened Matrix events at daily stand up meetings to ensure all events have been reviewed for reportability. The Director of Social Services will interview 3 staff per week regarding their role in the Abuse Prevention Plan. The results of interviews will be reported to Quality Council for 3 months and thereafter as needed. Responsible party: Director of Social Services	

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F 226	Continued From page 8 "forcefully" removed the alarm from (R55's) hand. As the NAR was removing the alarm from (R55's) hand, the NAR "slapped" (R55's) wrist." The date the alleged incident occurred was on 1/16/12. The student did not notify the nursing instructor of the incident until 1/19/12. Interview with social service director (SSD) at 11:50 a.m on 2/14/12, revealed that the nursing instructor notified the facility of the alleged abuse of R55 around supper time on 1/19/12. SSD explained that while the facility started an internal investigation of the alleged incident on 1/19/12, the report to the SA was not made until 1/20/12. At 10:10 a.m. on 2/15/12 SSD explained that she believed the facility had up to 24 hours to make a report to the state agency. SSD explained that typically an internal investigation occurs before reporting to the state agency. At 1:28 p.m. on 2/15/12 the administrator explained that the facility takes up to 12 hours to conduct an internal investigation prior to reporting allegations of abuse to the state agency. The facility failed to identify and develop prevention measures for R68 who had bruises on her legs due to transfers. R68 diagnoses included paralysis agitans, fracture of the femur (closed), late effects acute poliomyelititis, muscle weakness, venous thrombosis and hypertension. At 10:15 a.m. on 2/13/12, R68 participated in a standardized interview with surveyor. R68 reported occassional rough treatment by staff and	F 226		

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F 226	Continued From page 9	F 226		

explained that there were bruises on his/her legs from being transfered by staff. R68 reported that s/he had informed a nursing assistant of these concerns.

At 8:30 a.m. on 2/14/12, SSD and surveyor reviewed event history for the period of 3/1/11 through 2/14/12. There were no events related to bruises from lifting R68's legs. SSD explained that concerns related to bruising should be documented in the event history and showed an example from 6/24/11 regarding bruises on R68's foot related to a belt buckle on a wheelchair being too tight.

During an interview at 9:02 a.m. on 2/14/12, NAR-A reported she had observed bruises on R68's legs. NAR-A could not recall when these bruises had been observed but believed it was a few weeks ago. NAR-A reported that these concerns were reported to a nurse. NAR-A could not recall the nurse to whom she reported bruises on R68's legs.

During an interview at 11:00 a.m. on 2/15/12, LPN-B reported that a nursing assistant had reported observing bruises on R68's legs a few months ago but could not remember the exact date. At that time LPN-B verified two dime sized bruises on the top of R68's legs. R68 reported to LPN-B that the bruises occurred during transfers. LPN-B reported she then asked R68 about preferences in how R68 would like to be transferred. LPN-B explained that she passed this information along to the nursing assistants on duty for the shift she was working and the next. LPN-B acknowledged that she did not inform the clinical manager (CM), DON or administrator

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F 226	Continued From page 10	F 226		

about the bruising. LPN-B explained that she did not document the bruises in R68's progress notes or complete an incident report. LPN-B reported that she did not inform the clinical manager of R68's transfering preferences or update the care plan with these preferences. LPN-B explained that this was due to the belief that R68 was capable of directing staff in how to provide cares.

During interview at 10:10 p.m. on 2/15/12, SSD explained that nursing staff would be expected to report bruises on residents to the CM or charge nurse on duty who would then initiate an investigation along with the DON, SSD, wound care nurse and administrator.

During interview at 1:15 p.m. on 2/15/12, DON explained that nursing staff would be expected to report bruises on residents to the DON who would then initiate an investigation along with the DON, SSD and administrator.

Abuse Prevention Plan dated 1/2012 directed staff to maintain a proactive approach for identifying individual risk factors that may constitute or contribute to abuse and negelct. This included: identification and management of individual resident risk factors through the assessment and care planning process and development of intervention strategies to prevent abuse. Staff were directed that the care planning process was to include identification of specific factors that make the resident susceptible to abuse as well as documentation of a goal and specific measures to minimze the risks. Staff were directed to report abuse immediately to a supervisor who would immediately notify the administrator, DON and SSD. The policy listed

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F 226	Continued From page 11 the administrator, DON and SSD as primarily responsible for the prompt (within 24 hours of discovery) review, investigation and reporting of all suspected cases of maltreatment/abuse/neglect/vulnerability to the state agency.	F 226		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure gastrostomy (GT) placement was accurately checked for 1 of 1 (R44) observation of GT medications being given. Findings include: Licensed practical nurse (LPN-A) failed to check the placement of an enteral (gastrostomy) feeding tube correctly prior to administrating medications to R 44. At 6:14 p.m. on 2/12/12, LPN-A dispensed the resident's liquid medication into small plastic cups and indicated the resident received 60 milliliter (ml) water flush before and after the medications.	F 322	1-LPN-A told the DON about the observation from the surveyors regarding medication administration via a G-tube. Education regarding G-tube policy and procedure was immediately given and reviewed with LPN-A on 2/12/12 as surveyors were in the building. 2-Licensed staff in-services are scheduled on 03/15/12 at 6:30am and 2:30pm where correct G-tube placement and medication administration will be discussed and reviewed. 3-The Nursing Supervisors will be doing random audits regarding proper medication administration via the G-tube to demonstrate accuracy. The audits will be done weekly for the first month, observing two day and evening medication passes, beginning 03/19/12. Then audits will move to bi-monthly for the second month and then randomly every month following. 4-The DON/Designee will monitor/review audits monthly to ensure compliance.	03/26/12

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F 322	Continued From page 12 LPN-A drew approximately 10 ml's of water into the syringe. LPN-A gently pushed the water into the G-tube while listening with a stethoscope. LPN-A indicated she was checking placement while listening to the gurgle of water. LPN-A then instilled 60 ml of water into the GT before and after administering two liquid medications. LPN-A indicated others will check placement another way, however, this was the method she preferred. The current physician orders, printed 2/15/12, indicated the resident was to receive all nourishment and medications through the G tube. The physician orders indicated the resident received certagen 15 ml via tube at 6:00 p.m. and keppra 500 mg (5 ml) per G-tube twice a day. Physician orders indicated R 44 was NPO (nothing by mouth) and received osmolite tube feeding 1.2, 60 cc/hour over 12 hours. The 12/2002 policy and procedure for enteral feeding- medications, indicated to check and measure for residual gastric contents before checking patency with 1 ounce of room temperature water. At 2:30 p.m. on 2/15/12, when interviewed, the Director of Nursing verified the G-tube placement should not be checked by instilling water.	F 322		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION 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	F 356	-Staffing Coordinator or designee will post daily Nurse Staffing Information -Nurse Staffing Information will include: Date, Census, Shift staffing levels, including actual hours, facility name.	03/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245355	A. BUILDING _____ B. WING _____	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

(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 356	Continued From page 13 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 documentation review the facility did not ensure the total number of hours, for nursing staff who were working, was posted before each shift and the posting over the weekend was not current. This had the potential to affect all 65 residents residing in the facility and visitors. Findings include:	F 356	Continued F356 -Staffing levels for the weekend will be posted on Friday afternoon by Staffing Coordinator or designee. -Charge Nurse for the weekend will update sheet as charges occur. (Staff or census) -This will be monitored by Human Resources or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245355	A. BUILDING _____ B. WING _____	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

(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 356	Continued From page 14 On entrance to the facility at 11:30 a.m. on Sunday, 2/12/12, the staffing posting was dated 2/9/12. The posting was 3 days old, did not list the total number and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. At 11:00 a.m. on 2/14/12, interview with the staffing coordinator verified the postings did not include the actual hours or total hours worked by registered nurses, licensed practical nurses or certified nursing aides. The staffing coordinator indicated that on Fridays she posts the sheets for the weekend, but had been on vacation and consequently the weekend schedule was not posted. She also indicated that the staff posting on the weekends is not updated daily to reflect the current resident censes of the day or staff schedule changes.	F 356		

ST. BRIGID'S
AT HI-PARK
Benedictine Health System

March 9, 2012

Susanne Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900

Dear Ms. Reuss,

We are submitting to you today our plan of correction. Our date of completion has been set for March 26, 2012.

If you have any questions or concerns please feel free to contact me at (651) 388-1234 or micheal.schultz@bhshealth.org.

Respectfully,

Michael Schultz
CEO/Administrator

C: File

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
	245355	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Brigids at Hi Park was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. St. Brigids at Hi Park is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1977 and was determined to be of Type III(211) construction. In 1986, addition was constructed to the West Wing that was determined to be of Type III(211) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 58 at the time of the survey.	K 000		

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

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