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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WZ32

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245327**
2.STATE VENDOR OR MEDICAID NO.
(L2) **448415000**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE HEALTH CENTER**
(L4) **312 EAST GEORGE ST PO BOX 136**
(L5) **IVANHOE, MN** (L6) **56142**

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 **1/24/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **25** (L18)
13.Total Certified Beds **25** (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:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Elisabeth Silkey Unit Supervisor 01/24/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/28/2020 (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
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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 28, 2020

CMS Certification Number (CCN): 245327

Administrator
Divine Providence Health Center
312 East George Street PO Box 136
Ivanhoe, MN 56142

Dear Administrator:

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 January 6, 2020 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 25 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 28, 2020

Administrator
Divine Providence Health Center
312 East George Street PO Box 136
Ivanhoe, MN 56142

RE: CCN: 245327
Cycle Start Date: December 11, 2019

Dear Administrator:

On January 24, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WZ32

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245327**

2.STATE VENDOR OR MEDICAID NO.
(L2) **448415000**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE HEALTH CENTER**
(L4) **312 EAST GEORGE ST PO BOX 136**
(L5) **IVANHOE, MN** (L6) **56142**

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 **12/11/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Erin Johnson-Crosby HFE NE II 01/15/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/17/2020 (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)

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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 31, 2019

Administrator
Divine Providence Health Center
312 East George St. PO Box 136
Ivanhoe, MN 56142

RE: CCN: 245327
Cycle Start Date: December 11, 2019

Dear Administrator:

On December 11, 2019, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 March 11, 2020 (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).

In addition, if substantial compliance with the regulations is not verified by June 11, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	**312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/9/19 through 12/11/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/9/19 though 12/11/19, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was NOT in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		1/6/20

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

Electronically Signed | 01/07/2020

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
	245327	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

(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 686	Continued From page 1 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow policy and procedure, hospital discharge orders, notify the primary physician of initiation or changes to treatment, and appropriately assess and monitor 1 of 1 residents (R11), who was identified to be at high-risk for pressure ulcers and developed recurring Stage 2 pressure ulcers. Findings include: R11's 10/8/19, hospital Discharge Orders and Summary identified facility staff were to perform wound care per facility protocol and monitor R11's skin closely for skin breakdown due to immobility. R11 had a pressure ulcer on the middle of her coccyx (tailbone) at that time. The wound bed was surrounded by tissue pink with redness measuring 2.5 centimeters (cm) in diameter. There was no wound drainage. The wound dressing was dry and intact with a Mepilex (non-surgical dressing). R11's 10/8/19, baseline care plan identified R11 was cognitively intact. She required assistance of two staff for bed mobility, transfers, toileting and did not ambulate. She was incontinent of bowel and bladder and used a bed pan for toileting. The pressure ulcer was identified as a slit on the	F 686	Corrective action as it applies to others: Policy was reviewed and updated on December 12, 2019. The policy will be reviewed on an annual basis. Training was help with all the nursing staff on January 6, 2020 to review the policy and procedures and correct process and documents. Immediate corrective action: The Director of Nursing, Amy Jelen when made aware of the concern on R11 immediately went to discuss the concern with the charge LPN and a wound checklist was completed. Then Amy reviewed the results of the wound checklist and then checked all the documents for this resident and added to the notes to have nursing check and measure the areas, and measure weekly as well as assess the areas twice a day and use the z guard product. R11’s provider was also communicated to of the areas and the measurements. The areas of cocern for R11 are healed and closed as of 1/6/19 and the provider has been communicated to of this as well. R11’s care plan has also been updated to include repositioning every 2 hours and with any transferring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

(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 686	Continued From page 2 coccyx at that time. Review of R11's 10/9/19, nursing order identified staff were to monitor the foam dressing on her buttocks and change at least every five days and as needed (PRN). Staff were to ensure it was kept in place until no redness was noted. Nursing could initiate treatment and then notify provider within 24 hours. R11's 10/14/19, admission Minimum Data Set (MDS), identified she had intact cognition. R11 was at risk for pressure ulcers, and had no current pressure ulcers. Staff were to apply a preventative non-surgical dressing to R11's coccyx. R11 had diagnoses of morbid obesity, peripheral neuropathy (numbness in extremities), and spinal stenosis (narrowing of spinal column), requiring total dependence with two staff for transfers and locomotion on and off the unit, extensive assist of two staff for bed mobility, dressing and toileting. R11's 10/21/19, Care Area Assessment (CAA), identified R11 was at risk for pressure ulcers related to incontinence and immobility. On admission to the facility, she had not had any open area on her coccyx. Staff were using a foam dressing to the area for protection. She had a cushion in her wheelchair and an air mattress on her bed to prevent pressure ulcers from forming or worsening. R11's 10/14/19, care plan identified a risk for pressure ulcers due to inactivity and being unable to leave one's chair (chair fast). Staff were to consider physical therapy for conditioning and a wheel chair assessment, pressure reduction cushion in wheelchair, air mattress on bed, and a	F 686	that offloading occurs for 2 minutes. The Director of Nursing communicated with the nursing staff of the pressure ulcers on the resident's coccyx. The nursing team was instructed to follow the steps on the wound care process checklist: 1. Measure the wound and document the measurements on the wound sheet. 2. Document a progress notes in the resident's chart on the wound. 3. Complete the wound notification sheet. 4. Contact the Dr. of the change in the pressure ulcer and treatment. 5. Enter the MD order for wound care in the TAR. 6. Enter order for weekly wound measuring in the TAR. 7. Update the resident's care plan with the problem and the interventions. The facility is partnering with Avera Tyler and their certified wound nurse to work with the resident's at Divine Providence for any wounds that they indicate with the wound care process checklist. The Nursing team has also identified that all residents who are non-weight bearing are considered at risk for pressure ulcers and so they will have care plans updated to include a 2 hour repositioning schedules. Continued monitoring to prevent recurrence: The Director of Nursing, Amy Jelen will conduct weekly audits on the wound care process, which will include but is not limited to charting, TAR entries for measurements, MD notifications, with residents who have current pressure ulcers. She will complete the weekly audits for 1 month and then move to bi	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

(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 686	Continued From page 3 skin assessment and inspection every shift with close attention to her heels. Staff were to teach or assist her in doing frequent small shifts of her body weight. Interview on 12/09/19 at 1:22 p.m., with R11 identified she had a pressure ulcer on her buttocks before she entered the facility. The staff try to get her off her buttocks every two hours, but at night staff only turn and reposition her twice. Observation on 12/10/19 at 8:07 a.m., with nursing assistants (NA)-A and NA-C performing personal care to R11 identified R11 had two slit-like open areas on her coccyx. A barrier cream was applied. NA-C indicated one of the open areas had been present before, but not the other. That was new. Interview on 12/10/19 at 8:41 a.m., with registered nurse (RN)-B identified the last she was aware, R11's coccyx was pink. She had not seen the wound for a while. She had not worked as a charge nurse for a few weeks so she has not seen the area. The charge nurse should look at R11's skin weekly if no concerns or daily if there were skin concerns. Interview on 12/10/19 at 2:51 p.m., with RN-A identified staff were to apply a barrier cream to R11's coccyx area. She had not observed the area recently. The nurse aides were to let nursing staff know if there was a concern. If R11's coccyx area had opened, she would expect nursing be notified immediately. Further interview with R11 on 12/10/19 at 3:09 p.m., identified nursing had not looked at her buttocks for more than a week. R11 felt the area	F 686	weekly for 3 months. The Director of Nursing will present the audit documents and results to the QA team in the monthly meetings.	

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	245327	A. BUILDING _____ B. WING _____	12/11/2019

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F 686	Continued From page 4	F 686		

had been open for more than a week as she has had increased pain when she sat down, which usually indicated an opened area. R11 identified she informed RN-B yesterday about her buttocks, but she did not come and look at the area. She had told the aides and the staff were aware the area was open.

R11's 11/4/19, nursing progress note identified R11 had a pressure ulcer on her buttocks that measured 4 cm X 1.6 cm.

Review of R11's October 2019, Treatment Flowsheet identified on 10/21/19, R11's coccyx was left open to air (OTA). In November, 2019, R11's Treatment Flowsheet identified the dressing was changed on 11/1/19, 11/3/19, 11/10/19, 11/12/19, and 11/14/19. On 11/15/19 the order was changed to as needed (PRN). There was no mention the provider was notified or contributed to the changes to the treatment of R11's pressure ulcer.

Review of R11's current, November 2019, physician orders did not include treatment orders for a wound on her coccyx area.

Review of R11's 11/15/19, the nursing order identified the order was changed to PRN and was not documented as observed until 12/11/19. There was no documentation to support the physician was notified of the need to alter or change treatment.

R11's 11/21/19, nursing progress notes identified coccyx area was healed and open to air (OTA). R11's progress notes had not included any mention of R11's coccyx area since 11/21/19.

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F 686	Continued From page 5 Interview on 12/10/19 at 3:13 p.m., with NA-B identified he last observed R11's coccyx was on 12/9/19. The area was open, but he did not report the open area to nursing. During shift report, staff were advised to apply barrier cream to the area. He understood the nurses were aware of the opening on R11's coccyx. NA-B agreed he should have reported to open wound to nursing staff. Interview on 12/10/19 at 3:30 p.m., RN-B identified there was not a specific staff who monitored wounds. R11 was admitted with a slit on the coccyx area, but it had been closed when the dressing was removed the night of her admission. Staff should have requested an order from the R11's primary physician for treatment. Nurses were to have monitored the area on R11's bath days. The nurse aides were responsible to notify the charge nurse any time there was a skin change. The nurse was responsible to notify the provider with wound changes and the need to alter or modify therapy. RN-B confirmed there was no provider notification on 11/15/19, when the nursing order was changed to PRN. Review of the progress notes identified there was no communication to the provider regarding R11's coccyx area since her admission. Observation and interview on 12/10/19 at 3:58 p.m., with the director of nurses (DON), RN-B and the Administrator (A), identified R11 had a slit opening to coccyx that was observed. The DON identified two pressure ulcers, one at the top of the coccyx, measured 1.5 cm x .4 cm and the other on the lower coccyx, measured 2 cm x .5 cm. RN-B identified the two areas were Stage 2 pressure ulcers with area as new. The DON expected the area should have been measured weekly and checked daily as R11 was more at	F 686		

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F 686	Continued From page 6	F 686		

risk for pressure ulcers, due to a history of pressure ulcers in that area. If staff find an open area it should be entered on the Treatment Administration Record (TAR) so it is monitored daily. Facility policy was to notify the resident's physician if treatment was initiated, changed or was discontinued.

Interview on 12/10/19 at 4:14 p.m., with the administrator (A) identified wound care was a concern. Staff were currently working on solutions to fix the concern, which included employing a nurse that is certified in wound care.

Interview on 12/11/19 7:08 a.m., with RN-C identified barrier cream was to be applied to R11's coccyx. The last time she observed the area was a week ago and it was slightly open. At a recent nursing shift change report, barrier cream was to be applied to R11's coccyx. There was no mention in the shift change report the area was open. She had not had a chance to look at it while working last night.

Interview on 12/11/19 7:11 a.m., with NA-A identified the coccyx area has been an ongoing issue since R11 was admitted. The area would open and then close. It had been open for about two weeks and the nurses were notified.

Review of the June 2017, Skin Condition Identification and Prevention Program, identified a resident who enters the facility without a pressure sore will not develop pressure sores unless the individual's clinical condition demonstrates they were unavoidable. A resident having a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from

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F 686	Continued From page 7 developing. Daily monitoring included evaluation of the ulcer, evaluation of status of dressing, status of surrounding ulcer, presence of possible complication and presence of pain. There was to be evidence of healing within 2-4 weeks of intervention. If no signs of healing within 2-4 weeks, a re-assessment was to occur. Physician involvement was listed as necessary, but to be done monthly at a minimum. The policy made no mention the physician should be actively involved when initiating, changing, or need to alter therapy occurred.	F 686		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Divine Providence Health Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2020

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

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K 000	Continued From page 1 "IF OPTING TO USE EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED" By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Divine Providence Health Center is a one-story building, constructed in 1967. It has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an outpatient medical clinic and an assisted living facility by 2-hour fire wall assemblies, with opening protective's consisting of labeled, self-closing, positive latching 90-minute fire-rated door assemblies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with battery-operated	K 000		

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K 000	Continued From page 2 smoke alarms. The facility has a capacity of 25 beds and had a census of 18 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 343 SS=F	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1). This deficient practice could	K 343	Corrective action as it applies to others: Policy was reviewed and updated on December 12,2019. The policy will be reviewed on an annual basis. Immediate corrective action: The fire alarm test was competed and the DACT was documented that it was functioning during the shift. This was completed on December 31, 2019. Continued monitoring to prevent recurrence: The Plant Manager, Darren	12/31/19

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K 343	Continued From page 3 effect 18 of the 18 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 12/10/2019, it was revealed during documentation review, ithat the DACT was not being documented as functioning during the 2nd shift and 3rd shift. This deficient practice was verified by the Facility Maintenance Director.	K 343	Harris will conduct monthly fire alarms and also the DACT system. When it is the evening or overnight test, he will test the DACT system the next morning and document that it passed the test. The plant manager will present the monthly test documents to the QA monthly meetings.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system	K 353	Corrective action as it applies to others: Policy was reviewed and updated on	12/13/19

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K 353	Continued From page 4 in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 18 out of 18 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 10:00 PM and 2:00 PM on 12/12/19, during the inspection, it was discovered that the pressure gauge on fire sprinkler system has not been changed out within the last 5 years. This deficient practice was verified by the Facility Maintenance Director.	K 353	December 12,2019. The policy will be reviewed on an annual basis. Immediate corrective action: The Plant Manager, Darren Harris notified the building sprinkler vendor on December,13,2019. and made them aware of the issue that the sprinkler in the basement was missing its inspection tag. They will be on site to change out the pressure gauge and place a new tag on the sprinkler on March,2020. Continued monitoring to prevent recurrence: The Plant Manager, Darren Harris will conduct monthly checks to make sure that all the sprinklers have the required tags and information on them by the building sprinkler vendor. The plant manager will present the monthly audit documents to the QA monthly meetings.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		12/10/19

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K 920	Continued From page 5 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could effect 18 of the 18 residents Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920	Corrective action as it applies to others: Policy was reviewed and updated on December 12,2019. The policy will be reviewed on an annual basis. Immediate corrective action: The Plant Manager, Darren Harris immediately removed the extension cord from the de-humidifier on December 10,2019. Continued monitoring to prevent recurrence: The Plant Manager, Darren	

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K 920	Continued From page 6 (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 12/10/2019,during the inspection, an extension cord was observed being used as a substitute for fixed wiring in the storage room on the lower level. This deficient practice was verified by the Facility Maintenance Director.	K 920	Harris will conduct monthly checks to make sure that no extension cords are being used in the facility. The plant manager will present the monthly audit documents to the QA monthly meetings.	