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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XPXI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00955

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245233**

2.STATE VENDOR OR MEDICAID NO.
(L2) **633543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT ANNE EXTENDED HEALTHCARE**
(L4) **1347 WEST BROADWAY**
(L5) **WINONA, MN** (L6) **55987**

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 **04/08/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(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 :
Gary Nederhoff, Unit Supervisor 04/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/22/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1983
(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 5/31/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2013
(L33)

DETERMINATION APPROVAL

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

A Post Certification Revisit (PCR) by review of the plan of correction was completed by the Department of Health and on April 3, 2013, a PCR was completed by the Department of Public Safety. Based on the plan of correction the facility corrected the deficiencies issued pursuant to the February 21, 2013 standard survey, effective April 2, 2013. Refer to the CMS 2567b forms for both health and life safety code.

Effective April 2, 2013, the facility is certified for 109 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5233

May 22, 2013

Mr. Rand Gettler, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

Dear Mr. Gettler:

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 April 2, 2013 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

April 8, 2013

Mr. Rand Gettler, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

RE: Project Number S5233023

Dear Mr. Gettler:

On March 5, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 21, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 3, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 2, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 21, 2013, effective April 2, 2013 and therefore remedies outlined in our letter to you dated March 5, 2013, 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 related to this letter.

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File 5233r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245233	A. Building B. Wing	4/8/2013

Name of Facility	Street Address, City, State, Zip Code
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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 **F0226** Reg. # **483.13(c)** LSC	Correction Completed **04/02/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/02/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/02/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/02/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/02/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/02/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/02/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/02/2013**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **04/02/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GPN	04/08/2013	10160	04/08/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/21/2013			

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
245233	A. Building B. Wing **01 - MAIN BUILDING 01**	4/3/2013

Name of Facility	Street Address, City, State, Zip Code
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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	Correction Completed **04/02/2013**	ID Prefix	Correction Completed **04/02/2013**	ID Prefix	Correction Completed **04/02/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0045		LSC K0052	
ID Prefix	Correction Completed **04/02/2013**	ID Prefix	Correction Completed **04/02/2013**	ID Prefix	Correction Completed **02/25/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0054		LSC K0062		LSC K0144	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	04/08/2013	25822	04/03/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/21/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XPXI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00955

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245233**

2.STATE VENDOR OR MEDICAID NO.
(L2) **633543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT ANNE EXTENDED HEALTHCARE**
(L4) **1347 WEST BROADWAY**
(L5) **WINONA, MN** (L6) **55987**

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 **02/21/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(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 March 22, 2013 standard surveysurvey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NEII 03/22/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/05/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1983
(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 4/9/2013 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 # 7011 2000 0002 5148 9707

March 5, 2013

Mr. Rand Gettler, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

RE: Project Number S5233023

Dear Mr. Gettler:

On February 21, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby 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:

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

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

<u>Remedies</u> - 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:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive SE
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731

Fax: (507) 206-2711

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 April 2, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 2, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 21, 2013 (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 21, 2013 (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,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING _____ B. WING _____	02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**F226 SS = C** Facility has systems in place to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of residents property. Facility policy regarding Abuse Prevention Plan was reviewed, updated and is appropriate. All staff educated on the policy and procedure for reporting abuse, mistreatment, neglect and misappropriation of residents property. Monitoring of all Vulnerable Adult reports will be conducted on a quarterly basis to be sure staff are reporting immediately to Common Entry Point and the Administrator. Director of Nursing or their designee is responsible for monitoring of this plan of correction. Completion Date: ~~4/8/13~~ 4/2/13 JPM	
F 226 SS=C	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 document review and interview, the facility failed to develop a vulnerable adult policy that met the reporting requirements for abuse prohibition, this had the potential to affect 98 of 98 residents living in the facility. Findings include: The Vulnerable Adult/Maltreatment prevention plan & reporting policy lacked clear instruction to report allegations of abuse/neglect/etc. immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (this includes the office of health facility complaints-OHFC). Review of three resident allegations for the past year it	F 226	3-22-13 JPM	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Renee Hetts | TITLE: CEO | (X6) DATE: 3/18/13

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

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F 226	Continued From page 1 had been noted that all three allegations had been reported immediately to the administrator and OHFC. During review of the Abuse Prevention Plan policy revised 2/12/13 revealed, "After safe guarding the resident, report the information to their supervisor. The supervisor in turn must immediately report all suspected maltreatment to either or both the Social Worker or the Director of Nursing. The Social Worker will process the report." The Key Component #6: REPORT and INVESTIGATE section of the policy explained the online reporting process via the website but did not address how soon after becoming aware of a potential vulnerable adult incident the online report must be completed. The Definitions section of the policy revealed, "In accordance with federal requirements, the following definitions delineate what is to be reported to Minnesota Department of Health within 24 hours of the incident's discovery." During an interview on 2/20/13 at 2:14 p.m., the acting director of nursing stated the facility had to make an initial report to the Office of Health Facility complaints within twenty-four of an incident. The acting director of nursing verified the abuse prevention plan policy indicated the facility had to make an initial report within twenty-four hours of the incident's discovery. During an interview on 2/22/13 at 9:47 a.m., social services-A verified the abuse prevention plan policy revealed the facility had to make an initial report within twenty-four hours of the	F 226		

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F 226	Continued From page 2 incident's discovery.	F 226	**F279 SS = D**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a plan of care for 3 of 33 residents (R72, R128 and R109) reviewed for bruising, restraints, positioning, and unnecessary medications. Findings include: R72's care plan did not address chronic bruising.	F 279	Facility has systems in place to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. This includes measurable objective and timed goals to meet residents medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Facility policy regarding developing and revising care plans was reviewed, updated and found to be appropriate. Resident's plans of care will include appropriate interventions for all identified care needs. Plans of care will be updated as needed per resident's health changes and needs. Care Plan problems and approaches for R72 was reviewed and updated to include chronic bruising. Care Plan problems and approaches for R128 was reviewed and updated to include bruising and fragile skin due to Coumadin use as well as risk factors for impaired skin integrity. Care plan problems and approaches were reviewed and updated for R109 to include use of side rails.	

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F 279	Continued From page 3 R72 was readmitted from the hospital on 12/6/12. R72's annual Minimum Data Set (MDS) dated 1/8/13, identified resident as cognitively intact and required extensive assistance with two plus staff for bed mobility, transfers, dressing and toileting needs. During observation on 2/19/13 at 11:13 a.m., R72 had bruising noted on the entire left hand and across the back of the right hand. During nursing note review on 12/7/12 at 12:55 a.m., identified bruising on left hand and forearm with no other bruising noted. During R72's care plan review with problem start date of 3/5/09, the care plan had not identified bruising. During an interview on 2/20/13 at 6:38 p.m., licensed practical nurse (LPN)-A indicated R72 had a skin condition and R72's hands always have the bluish purplish color. LPN-A verified the skin condition was not on the care plan and should have been on the care plan. During interview on 2/21/13 at 8:03 a.m., registered nurse (RN)-C indicated bruising was a chronic problem for R72. RN-C verified bruising disorder had not been on the care plan and confirmed should have been on the care plan. During interview on 2/21/13 at 8:27 a.m., the acting director of nursing (ADON) verified R72 had always had the dark skin discoloration. The ADON indicated the dark discoloration was not a new problem for R72 and should have been in the care plan. R128 failed to have a comprehensive care plan	F 279	Licensed Nursing staff and staff that complete care plans will review the updated policy for Careplan Development and Revisions. Licensed Nursing staff will be educated on the updated policy and procedure for keeping the plan of care current and when to update plan of care due to changes in resident conditions or treatments. Monitoring of care plans will be completed on a quarterly basis. Director of Nursing or their designee is responsible for monitoring of this plan of correction. Completion Date: ~~4/8/13~~ 4/2/13 dPN	

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F 279	Continued From page 4 developed to identify skin conditions and risk factors for impaired skin integrity related to bruising and fragile skin. R128 was admitted to the facility on 7/24/12, for rehabilitation following an above knee amputation. Diagnoses included venous thrombosis, obesity, peripheral vascular disease and edema. The quarterly Minimum Data Set (MDS) dated 1/22/13, had identified R128 as alert and oriented. The MDS indicated R128 required extensive assist with dressing, independent with all other activities of daily living. R128's physician orders dated 2/6/13 identified the use of 5 milligrams (MG) of Coumadin (an anticoagulant) daily at bedtime. Review of progress note dated 2/10/13, revealed a bruise was noted on R128's right arm. The note indicated R128 reported she had the bruise for a few days. During interview on 2/21/13, at 9:05 a.m. R128 stated her skin was thin and fragile, and she had a history of bruising related to Coumadin use and bumping her arms. R128's care plan dated 7/24/12 identified potential for alteration in skin integrity related to diagnoses including obesity, and peripheral vascular disease. The care plan lacked identification of risk factors for impaired skin integrity related to bruising, fragile skin and the use of Coumadin. On 2/21/13, at 9:24 a.m. the acting director of nursing (ADON) stated nursing staff were to monitor skin and to report any new bruising.	F 279		

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F 279	Continued From page 5 ADON verified R128's care plan lacked identification of skin issues related to bruising, fragile skin and the use of Coumadin. ADON stated she would expect the CP to include risk factors related to the use of Coumadin. R109's care plan did not include the use of side rails as a positioning device. R109's diagnoses included dementia and weakness. Review of the Restraints/Adaptive Equipment Side Rail assessment dated 7/13/12, indicated R109 utilized side rails to assist with transfers and bed mobility. Review of R109's current comprehensive care plan, did not include the use of side rails. During observation on 2/20/13, at 11:11 a.m. R109's bed was observed to be equipped with bilateral half rails affixed to the bed. On 2/21/13, at 9:10 a.m. NA-E was interviewed. NA-E verified R109 had used side rails for bed positioning. NA-E stated, "When we turn him he holds onto the rails." During interview on 2/21/13, at 9:24 a.m. the ADON confirmed R109 utilized bilateral side rails for bed positioning, and further confirmed the side rails were not identified on the care plan. ADON stated she would expect to see current interventions on the CP. The facilities Care Plan Development and Revision Policy and Procedure dated 9/1/10, identified " The care planning process is multi-disciplinary and is an on-going, evaluative	F 279		

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F 279	Continued From page 6 and evolving; the care plan document is updated and reflective of the resident's changing needs." The policy and procedure included "The Saint Anne Assessment nurse, having reviewed the assessments of the various clinical disciplines develops the Temporary Admission Care Plan addressing areas of Self-care ability, Mobility needs, Elimination needs, Nutrition needs, Mood adjustment to facility" and further included "As time progresses, this care plan is updated, modified to reflect changes in resident condition, new orders, resolutions of past issues. These changes are made in the paper copy of the care plan, dated and signed. Unit staff is made aware of the changes in resident needs and new approaches that have been added."	F 279	**F280 SS = D** Facility has systems in place to ensure each resident is able to participate in the plan of care and its revision. A comprehensive care plan is developed within 7 days of the completed of the comprehensive assessment and is prepared by an interdisciplinary team. The plan of care is periodically reviewed and revised by an interdisciplinary team. Facility policy regarding updating care plan was reviewed, updated and found to be appropriate. Resident's plans of care will include appropriate health interventions for all identified care needs. Plans of care will be updated as needed per resident's health changes and needs. Licensed nursing staff and staff completing care plans will review the updated policy for Careplan Development and Revisions. Licensed Nursing staff will be educated on the updated policy and procedure for keeping the plan of care current and when to update plan of care due to changes in resident conditions or treatments.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the comprehensive care plan to reflect changes in residents health interventions for 3 of 4 residents (R109, R154 and R159) reviewed for repositioning and pain management. Findings include: R109's written care plan was not updated to reflect his current transfer status. R109 was admitted to the facility on 4/16/12, with diagnoses that included dementia, weakness and history of falls. On 2/20/13, at 3:05 p.m. R109 was observed sitting in a recliner chair with legs in the up position in the fourth floor solarium. At 4:10 p.m. two nursing assistants (NA) were observed to approach R109 and assisted him to transfer to his wheel chair with a gait belt and walker. During review of R109's care plan (CP) dated 4/18/12, it was revealed R109 had a potential/actual alteration in mobility and potential for injury related to declining condition. The CP directed staff to use an EZ stand (a mechanical transfer device) and the assist of one or two staff for transfers. On 2/21/13, at 9:10 a.m. NA-E was interviewed. NA-E stated R109 was transferred with the use of	F 280	Care Plan problems and approaches for R109 was reviewed and updated to include current transfer status. Care Plan problems and approaches for R154 was reviewed and updated to include phantom limb pain. Care Plan problems and approaches for R159 was reviewed and updated to include pain control. Monitoring of care plans will be completed on a quarterly basis. Director of Nursing or their designee is responsible for monitoring of this plan of correction. Completion Date: ~~4/8/13~~ 4/2/13 JSPN	

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F 280	Continued From page 8 the EZ stand "depending on the time of day, sometimes we use the gait belt with two assist." During interview with the acting director of nursing (ADON) on 2/21/13, at 9:24 a.m. it was verified R109's care plan directed staff to use the EZ stand for transfers. ADON stated she would expect to see current interventions on the CP. R154 lacked revision of the plan of care with identified phantom pain. R154 was admitted to the facility 11/19/12 for rehabilitation following a right leg amputation (below the knee amputation - BKA.) On 2/20/13 at 11:38 a.m. R154 was interviewed. R154 stated they were experiencing discomfort without relief of phantom leg pain that R154 rated at a 5-6 out of 10 (where 10 is the worst pain and 0 is no pain) at current time. R154's clinical record was reviewed. A pain assessment dated 11/26/12 identified frequent phantom pain and that R154 felt aching in right ankle and shin. The quarterly pain assessment dated 2/12/13 indicated no changes to plan of care at this time. The care plan dated 11/20/12 located in the medical record was reviewed. During an interview on 2/20/13 at 3:55 p.m. the health unit coordinator indicated the care plan located in the medical record was the most current care plan. This care plan identified a problem of pain related to " recent right BKA, chronic pain." And the care plan had a goal with a target date of 12/20/12 of " Will have no c/o (complaints of)	F 280		

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F 280	Continued From page 9 pain on a daily basis by next review." The plan of care did not address the phantom leg pain R154 had been or was currently experiencing. During an interview on 2/21/13 at 9:00 a.m. RN-A stated R154 was due for another pain assessment and that the phantom pain was something that recurred recently for R154. During an interview on 2/21/13 at 8:55 a.m. RN-A stated she had not up-dated R154 ' s care plan to include the phantom leg pain. During an interview on 2/13/12 at 9:54 a.m. the acting director of nursing (ADON) stated care plans were to be up-dated when the event happened and could be updated by anyone. R159 lacked a revision of the plan of care for pain control. R159 was admitted on 12/12/12 for rehabilitation after removal of hardware of an artificial knee. On 1/24/13 the nurse practitioner noted R159 had esophageal candidiasis. Interdisciplinary notes of 2/5/13 indicated R159 had gall bladder surgery. R159 was interviewed and observed on 2/20/13 at 11:12 a.m. R159 stated experienced pain that averaged 3 to 4 out of ten and would ask for pain medication at a level of 5. R159 stated that the oxycodone and ice helped manage the pain and was taking Prilosec twice a day but still had heartburn. R159 added that now yeast was found in esophagus and that the burning was still there even though the gall bladder had been removed. During an interview on 2/20/13 at 3:55 p.m. the	F 280		

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F 280	Continued From page 10 health unit coordinator indicated the care plan located in the medical record dated 12/12/13 was the most current care plan. The care plan identified a problem of " potential for pain R/T [related to] recent explanation [sp] of left TKA [total knee arthroscopy] and DJD [degenerative joint disease]." A goal target for 2/12/13 was for the resident to have no complaints of pain. The care plan did not identify a problem, goal, or interventions related to epigastric pain. A care plan intervention dated 12/12/12 directed " heat to painful area" but the interventions did not list cold as a non-pharmacological intervention used for pain relief. During an interview on 2/20/13 at 4:00 p.m. RN-A stated that care plans were reviewed monthly and that R159's care plan had not yet come up for review. Facility policies provided by the director of nursing were reviewed. The policy entitled Care Plan Development and Revision dated 9/1/10 directed " 4. As time a progress, this care plan is updated, modified to reflect changes in resident condition, new orders, and resolutions of past issues. These changes are made in the paper copy of the care plan, dated and signed. Unit staff is made aware of the changes in resident needs and new approaches that have been added."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide hydration needs according to the care plan for 1 of 2 residents (R69) reviewed for hydration. Findings include: R69 was not offered fluids during cares and fluids had not been available in the room according to the care plan. R69's care plan with a problem date of 2/3/09 indicated R69 had a potential for fluid volume deficit related to diuretic use and directed staff to offer fluids when toileting and keep fluids at bedside. During interview with resident on 2/19/13 at 11:24 a.m., R69 indicated they had not received/offered fluids between meals. There was no glass of water observed in the room during the interview. During observation on 2/20/13 at 6:47 p.m., nursing assistant (NA)-A provided assistance with bedtime cares but had not offered R69 fluids nor had there been a glass of water present in room. During interview on 2/21/13 at 7:38 a.m., registered nurse (RN)-C indicted volunteers pass water some days to the resident's room otherwise the staff was responsible for making sure water was passed and present to the resident rooms. RN-C indicated there was a list of residents that do not get or want water in there room but RN-C verified R69 was on the list not to get water in the	F 282	**F282 SS=D** Facility has systems in place to ensure services are provided or arranged by qualified persons in accordance with each resident's written plan of care. Facility policy regarding updating care plans was reviewed, updated and found to be appropriate. Facility policy regarding hydration was reviewed and found to be appropriate. Resident's plans of care will include appropriate health interventions for all identified care needs. Plans of care will be updated as needed per resident's health changes and needs. Licensed Nursing staff and staff completing care plans will review the updated policy for Care plan Development and Revisions. Nursing staff will be educated on the updated policy and procedure keeping the plan of care current, when to update plan of care due to changes in resident conditions or treatments and following the plan of care. Care Plan problems and approaches for R69 was reviewed and updated to include current hydration interventions. Monitoring of care plans will be completed on a quarterly basis.	

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(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 282	Continued From page 12 room. RN-C confirmed it was the expectation R69 was offered water with cares according to care plan. During observation on 2/21/13 at 9:15 a.m., NA-A provided morning cares for R69 and had not offered fluids. During interview on 2/21/13 at 9:38 a.m., NA-A confirmed they had not offered R69 fluids during cares and indicated should have asked R69 if they wanted a drink but forgot. During interview on 2/21/13 at 8:36 a.m., the acting director of nursing expected staff to offer fluids with cares.	F 282	Director of Nursing or their designee is responsible for monitoring of this plan of correction. Completion Date: ~~4/8/13~~ 4/2/13 ABM	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and treat acute moderate to severe pain following a fall for 1 of 1 resident (R42) reviewed for pain. Findings include:	F 309	**F309 SS=D** Facility has systems in place to ensure residents receives necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Facility policy regarding pain assessment, intervention and use of PRN medications was reviewed, updated and found to be appropriate Resident's plans of care will include appropriate health interventions for all identified care needs. Plans of care will be updated as needed per resident's health changes and needs. Licensed Nursing staff will review the updated policy for Pain Assessment, Intervention and use of PRN Medications. Licensed Nursing staff will be educated on the updated policy and procedure for monitoring residents pain and completing	

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	245233	A. BUILDING _____ B. WING _____	02/21/2013

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F 309	Continued From page 13 R42 experienced ongoing acute moderate to severe neck and head pain following a fall on 11/24/12 at 7:49 p.m. R42 was admitted to the facility 11/10/10 and had diagnoses that included congestive heart failure, dementia, and acute pain due to trauma. The annual Minimum Data Set dated 10/16/12 indicated the resident had a BIMS (Brief Interview for Mental Status) of 10 (moderately impaired), occasional moderate pain that did not limit function, and no past history of falls. According to an incident report dated 11/24/12, R42 experienced a fall from a standing position to the floor landing on face on 11/24/12 at 7:49 p.m. The incident report described the R42 to have a bruise and open cut on forehead and also a bruise on the nasal bridge of the nose. Also R42 complained of moderate pain located in head/neck area. The physician was contacted on 11/24/12 at 10:02 p.m. and no new orders received. R42 was observed on 11/26/12 at 3:29 p.m. and noted to have a resolving hematoma on forehead that was the diameter of baseball. Also a bruise was observed across the bridge of the nose and extended under both eyes. R42 was holding head with her hands and heard moaning and saying that her head hurt. R42 was sitting with head and neck bent forward while seated in a straight back wheelchair. Again at 5:15 p.m. on 11/26/12, R42 was observed with head and neck bent forward while sitting in a straight back wheelchair at the dining room table and a pillow placed behind her neck.	F 309	additional observations to monitor effectiveness of pain regimes. Care Plan problems and approaches for R42 was reviewed and updated to include current pain interventions. Staff will be educated on reviewing the plan of care so they are aware of interventions available for resident per plan of care. Monitoring of pain observations and residents reports of pain will be completed on a monthly basis. Director of Nursing or designee is responsible for monitoring this plan of correction. Completion date: ~~4/8/13~~ 4/2/13 APN	

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F 309	Continued From page 14 During an interview on 11/27/12 at 5:45 p.m. licensed practical nurse (LPN)-B stated R42 had fallen a few days prior and had a "massive" headache. During an interview on 11/27/12 at 7:40 p.m. nursing assistant (NA)-B stated she was concerned because R42 was sitting with head and neck bent forward and lying in bed in this same position. NA-B stated this was a new position for R42 since the fall as she had not done it before the fall incident. During an interview on 11/28/12 at 8:30 a.m. licensed practical nurse (LPN)-A stated R42 was able to hold neck and head in an upright position before the fall (fall occurred on 11/24/12) and since the fall R42 had kept her head and neck in a forward bent position for comfort. On 11/24/12 at11:00 p.m. the nurse document R42 was lying in bed and complained of severe head pain and neck pain. The nurse practitioner (NP) was notified and instructed staff to continue to monitor the resident and update her with any changes. Ice was applied. On 11/25/12 at 2:49 p.m. the resident complained of head and neck pain. The resident indicated it was hard to straighten head. Neurological checks were done and within normal limits. On 11/26/12 at 2:49 p.m. the nurse documented R42 complained of neck pain with activities of daily living and with movement while in the wheelchair. The documentation indicated R42 stated, "I need a neck brace." On 11/27/12 three nursing notes indicated the resident had complained of head and neck pain, was moaning out with pain, and that R42 required	F 309		

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F 309	Continued From page 15 assist of two staff to walk to the bathroom. The note indicated R42 ' s head leaned down and tilted to the right side. When asked to lift head up, R42 stated could not due to pain. Resident required being fed by staff due to position of head. The day shift notes indicated the resident was seen by the NP "d/t [due to] increased pain and soreness in neck and head from recent fall" and a medication change (NP ordered Hydrocodone-acetaminophen one tab four times per day for pain due to trauma) and occupational therapy orders was completed. On 11/27/12 at 9:18 p.m. nursing documentation indicated the resident requested to lie down at 3:30 p.m. and did not want to get up for supper due to pain in head and neck. R42 did get up at 600 p.m. and was observed to hold head in hands the entire time at the dinner table and complaining of pain in neck and head. After dinner R42 went back to bed and had difficulty with bedtime cares due to resident holding head and not wanting any cares done due to pain. Lortab (pain medication) given at 8:00 p.m. and the medication was effective. On 11/28/12 at 5:12 a.m. the nursing notes indicated "Resident resting when checked on periodically throughout the night, but when attempted to move [R42] to change position and give [R42] a drink of water [R42] was clearly still in a lot of pain, not wanting to be touched, calling out " Oh it hurts too much." Review of the medication administration record revealed the resident received two tablets of Tylenol 325 mg four times a day for ankle pain (order dated 11/19/12) and had an order for	F 309		

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F 309	Continued From page 16 Tylenol 325 mg 2 tabs once a day as needed. After the acute pain developed following the fall on 11/24/12 at 7:49 p.m. R42 had received only two as needed doses of Tylenol for pain between 11/25/12 at 12:37 a.m. through 11/27/12 at 5:10 a.m. The last dose of the schedule Tylenol was documented as given prior to 1:30 p.m. on 11/27/12. LPN-B stated a new order for Lortab had been received on 11/27/12 but at 7:45 p.m. stated the Lortab had not yet been given. When LPN-B had been interviewed on 11/28/12 at 8:30 a.m. on 11/28/12, LPN-A stated the Lortab had first been given at 7:47 p.m. on 11/27/12 even though it was ordered eleven hours previously. The care plan provided 11/28/12 had a problem dated 11/27/12 that stated, " Has a history of complaints of right ankle bone pain. Recent fall on 11/24/12 with complaints of pain to head and neck. " The care listed 2 interventions/approached specific to head and neck pain. Interventions included: 1. dated 11/27/12 " Administer medications: Lortab. Evaluate/record/report effectiveness and any adverse side effects. " 2. dated 11/27/12 " PT [physical therapy] to eval [evaluate] and treat for neck pain." The care plan had 3 interventions dated 8/2/12 that related to the care of the ankle. In addition the care plan had 6 interventions/approaches dated 5/3/12 that directed staff to encourage resident to discuss pain and request pain medication; evaluate effectiveness of interventions and adverse side effect, monitor and adjust if ineffective; monitor and record any complaints of pain and monitor any non-verbal signs of pain; use non-medicated pain relief measures including application heat/cold. No further care plan was found related	F 309		

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F 309	Continued From page 17 to pain or management of hematoma and pain in head and neck. The physical therapy assessment done the same day it was ordered by the physician on 11/27/12 was reviewed. The initial assessment indicated that prior to the fall the resident was able to transfer and walk with contact guard assistance due to unsteadiness during transfer. The assessment indicated that R42 ' s current level was moderate assistance requiring 50% physical assistance. The assessment noted the " patient completes all functional transfers and ambulation with head held in severe flexion." During an interview on 11/28/12 at 11:25 a.m. the physical therapy aid stated R42 was seen by the therapist the day before and the physical therapy notes of 11/27/12 indicated R42 was in severe pain. During an interview with the physical therapist (PT) on 11/28/12 at 11:55 a.m. the PT indicated she felt R42 had a contusion and stiff neck muscles from the fall that were causing the pain and that it may take up to 4 weeks to get the pain and stiffness resolved. The director of nursing was interviewed on 11/29/12 at 12:50 p.m. and stated the staff had not followed the care plan for use of heat/ice for neck/head pain and pain management was not assessed for pain relief following the fall.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to provide supervision when assessed to need assistance to use the elevator safely for 1 of 2 residents (R63) who require supervision when on the elevator for safety. Findings Include: R63 was admitted on 7/12/11 with diagnoses that included but were not limited Parkinson's, dementia, depressive disorder, hypertension and psychophysical visual disturbance. The quarterly Minimum Data Set (MDS) dated 1/9/13, revealed R63 required extensive assist with bed mobility and personal hygiene, transfers, dressing, toilet use and locomotion on and off the unit. R13 had cognitively intact cognition, with a brief interview for mental status (BIMS) score of 14. During an interview on 2/22/13 at 8:37 a.m., the trained medication assistant (TMA)-A stated residents were escorted by staff members on the elevators unless the resident was determined to be independent with use of the elevator. TMA-A stated R63 would require staff assistance for use of the elevator. During an observation on 2/22/13 at 8:43 a.m., R63 was observed to be on the elevator alone when the doors of the elevator opened on the third floor. R63 attempted to propel himself using his feet to exit the elevator. R63 was unable to	F 323	**F323 SS=D** Facility has systems in place to ensure residents environment remains free of accident hazards and each resident receives adequate supervision and assistance devices to prevent accidents. Facility policy regarding resident safety in using the elevator independently was written. Resident's plan of care will include appropriate health interventions for all identified care needs. Plans of care will be updated as needed per resident's health changes and needs. Licensed Nursing and Therapy staff will review the updated policy for resident safety in using the elevator independently Licensed Nursing and Therapy staff will be educated on the updated policy and procedure for resident safety in using the elevator independently. Care Plan problems and approaches for R63 was reviewed and updated to include current supervision required for elevator safety. Nursing Staff will be educated on reviewing the plan of care so they are	

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F 323	Continued From page 19 exit the elevator independently. This writer had moved the hold button on the elevator to give R63 time to exit elevator independently. R63 was assisted by nursing assistant (NA)-D off the elevator after the buzzer started sounding on the elevator alerting staff to a concern. During an interview on 2/22/13 at 9:09 a.m., the acting director of nursing (ADON) stated staff members should be escorting residents to and from the dining room when they use the elevators especially if a resident is unable to get off the elevator themselves. The ADON stated if a resident was determined to be independent they could be placed on the elevator and staff would push the button for the floor needed. The ADON stated there was not a specific assessment used to determine a resident's safe use of the elevator. The ADON stated the decision was made based on knowing the residents and R63 had a very difficult time on the elevator and should be escorted. The ADON stated the concern related to R63 using the elevator independently would include not being able to get off the elevator before the doors would start closing. The ADON verified R63 should not be alone on the elevator and stated R63 definitely needed to be escorted. The ADON verified the facility did not have a policy related to residents' safe use of the elevators.	F 323	aware of interventions for residents per plan of care. Evaluation of residents safety for use of elevator alone will be completed on a quarterly and annual basis, as well as with and significant status change. Monitoring of evaluation of residents safety for use of elevator alone will be reviewed on quarterly basis. Director of Nursing or designee is responsible for monitoring this plan of correction. Completion date: ~~4/8/13~~ 4/2/13 JSPM	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

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F 431	Continued From page 20 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were disposed of in a timely manner when discontinued in two of four medication storage rooms and failed to ensure medications were stored in a sanitary manner in 2 of 2 medication carts located on fourth floor.	F 431	**F431 SS=E** Facility has systems in place to ensure medications are disposed of in a timely manner when discontinued and endure medications are stored in a sanitary manner in medication carts. Facility policy regarding destruction of medications, returning medications for credit and Medication Cart Cleaning were reviewed, updated and found to be appropriate Resident's medications will be removed timely when discontinued, changed, etc. Medication carts will be cleaned after each medication pass on the exterior and on a weekly basis on the interior at a minimum. Licensed Nursing staff will review the updated policies for destruction of medications, returning of medications for credit and medication cart cleaning. Licensed Nursing staff will be educated on the updated policy and procedure for destruction of medications, returning medications for credit and medication cart cleaning. Changed medications for R77 were destroyed. Expired medications for R112 were destroyed.	

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F 431	Continued From page 21 Findings include: The medication storage room was observed on 2/20/13 at 7:15 p.m. with licensed practical nurse (LPN)-D. The designated discontinued medication storage was on the top shelf of a locked cupboard that also contained extra medications still used. LPN-D stated the medications were destroyed by the pharmacists and some pharmacies were slower than others. The following medications were found not destroyed timely: R77 had warfin 2 mg tablets (anticoagulant) stored. The medication label indicated the prescription had been dispensed on 4/30/12. Review of the medical records indicated the physician order for warfin 2 mg had been changed on 1/26/12. R112 had resperidone (antipsychotic) tablets stored. The medication label indicated the prescription for as needed medications, expired on 1-13-13. R37 had Tramadol (pain) tablets stored. The medication label indicated the prescription had been dispensed 8/26/12. Review of the physician orders indicated the Tramadol had been discontinued 9/27/12. R95 had Aranesp Injectable (medication to improve hemoglobin) syringes stored in the cupboard. The label indicated the medication was dispensed on 11/29/12 and was to be refrigerated. R95 was discharged on 12/11/12.	F 431	Discontinued medications for R37 were destroyed. Discharged medications for R95 were destroyed. Discontinued medications for R57 were destroyed. Expired medications for R21 were destroyed. Expired medications for R52 were destroyed. Discharged medications for R128 were destroyed. Expired medications for R25 were destroyed. Expired medications for R35 were destroyed. Monitoring of medication cart cleaning and destruction of medications, returning medications for credit will be completed on a monthly basis. Director of Nursing or designee is responsible for monitoring this plan of correction. Completion date: ~~4/8/13~~ 4/2/13 -SPN	

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F 431	Continued From page 22 R57 had Tamiflu (antiviral) tablets stored. The label indicated the medication was dispensed on 1/20/13. LPN-D stated the medication was discontinued related to allergies. R21 had Nitro stat and Tylenol suppositories stored. R21 expired 1/21/13. LPN-C (floor team leader) was interviewed on 2/21/12 at 7:30 a.m. and indicated the medications were to be destroyed by nursing unless they were controlled medications which are to be destroyed by the pharmacist. LPN-C stated she was unaware of time line for destruction. The facility policy entitled Disposition and Destruction of Medications dated 7/14/10 was reviewed and directed "2. Any medication which are unused due to discharge, dose change, death of resident, WITH THE EXCEPTION OF open over the counter bottles, refrigerated items, injectable and control substances can be returned in a bag to Weber-Judd who will appropriately dispose of these medications for SAW." "3. If a resident is discharged, dies or the physician's order for a controlled substance discontinued permanently, any remaining controlled substances must be destroyed. Facilities in this instance must follow forms and instructions provided by the Minnesota Board of Pharmacy. The destruction of these medications must be witnessed by a pharmacist OR a registered nurse" The policy/procedure did not identify a time line related to the destruction of medications. During observation in the fourth floor Nursing Unit medication room on 2/21/13, at 9:45 a.m. with	F 431		

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F 431	Continued From page 23 registered nurse (RN)-A it was noted that expired medications were available for resident use. The medications were stored in a locked cupboard where stock and individual resident medications were stored until needed for use. During the observation RN-A verified findings and stated the medication needed to be destroyed or sent back to the pharmacy. Medications expired, but available for use included: R52 had Atropine drops, that had expired on 1/28/13. Atropine is used to treat multiple disorders to include cardiac, respiratory, and gastrointestinal. R128 had Zantac 150mg tablets that had expired on 7/2013. Zantac is used to treat and prevent ulcers in the stomach and intestines. Review of medication information list titled MEDS 4th Locked Cupboard indicated the medication had been placed in the locked cupboard on 8/1/12. R25 had Seroquel 25mg tablets that had expired on 1/2013. Seroquel is used to treat symptoms of schizophrenia and bipolar disorder. Review of medication information list titled MEDS 4th Locked Cupboard indicated the medication had been placed in the locked cupboard on 1/31/13. R35 had Nitro stat 0.4 mg tablets used to pprevent or relieve a sudden attack of angina (chest pain.) Asmanex inhalation used to treat asthma, and Foradil inhalation used to relaxes muscles in the airways to improve breathing. All three medications had expired on 1/18/13.	F 431		

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F 431	Continued From page 24 The acting director of nursing (ADON) was interviewed on 2/21/13 at 9:55 a.m. ADON indicated the expectation was for medications were to be destroyed within 1-2 weeks after discontinued, discharge, or death. She added the length of time the medications remained on 5th floor storage, was unacceptable.	F 431	**F441 SS=F** Facility has systems in place to ensure an infection control program is maintained. Facility policies regarding Infection Control Program, Hand Hygiene and Perineal Care for the Incontinent Resident was reviewed, updated and found to be appropriate. Infection Control nurse will track, trend and analyze the data obtained related to infections. Nursing Staff will follow the procedure for peri care and hand washing. All staff will review the updated policies for the infection control program and hand hygiene. Nursing staff will review the updated policy for perineal care for the incontinent resident. Licensed Nursing staff will be educated on the updated policies and procedures for Infection Control, when to complete an infection event. Nursing staff will be educated on the updated policy for Perineal Care for the Incontinent Resident and Hand Hygiene. Monitoring of Infection Control tracking, trending and analyzing data will be completed on a quarterly basis.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		

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F 441	Continued From page 25 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure that the infection control program included tracking, trending, and analysis of data related to infections. This had the potential to affect all 98 residents currently residing in the facility. In addition the facility failed to ensure infection control practices of gloving and washing hands were maintained by staff during personal cares for 2 of 2 residents (R69, R40) observed during personal cares. Findings include: The facilities infection control line listings of Resident Infections occurring in the facility and Monthly Infection Summary reports, were reviewed with the director of nursing (DON) on 2/21/13 at 11:00 a.m., During interview, the DON indicated the registered nurse (RN) infection program director was on leave. The DON and assistant director of nursing (ADON) verified they were unable to find any information related to the analysis of the data collected. During an interview on 2/21/12 at 12:00 Noon, the director of nursing stated that she had a telephone conversation with the registered nurse	F 441	Monitoring of staff performing peri care for an incontinent resident and hand washing will be completed on a monthly basis. Director of Nursing or designee is responsible for monitoring this plan of correction. Completion date: ~~4/8/13~~ 4/2/13 KPN	

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F 441	Continued From page 26 (RN) infection program director. The RN told the DON that she had not document trends and analysis of data. Gloves were not changed by staff after being soiled during perineal cares for R69 and R40. R69 had perineal care done and during the observation on 2/20/13 at 6:47 p.m., nursing assistant (NA)-C put on gloves and prepared basin of water in the bathroom, NA-C removed R69's shirt and placed in the laundry bag, NA-C washed and dried R69's face, proceeded to wash and dry ears, washed and dried under arms, offered lotion and resident refused. NA-C put on R69's purple polo shirt. NA-C transferred R69 into bed, shoes were removed. Without removing soiled gloves NA-C provided resident with perineal care as follows: removed soiled incontinent product and washed and dried front perineal area and continued to wash buttocks. NA-C offered R69 powder and resident agreed. NA-C grabbed powder container with soiled gloves and applied powder to perineal area. NA-C opened up drawer, removed socks with grippers and put on R69. NA-C placed R69's call light on resident's chest and then proceeded to turn on water faucet in bathroom to rinse out basin and then removed their soiled gloves. NA-B had not changed her gloves at any time during this observation even when they were soiled after completing perineal cares. During interview on 2/20/13 at 7:13 p.m., NA-C verified they had not changed gloves after providing perineal care and should have.	F 441		

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F 441	Continued From page 27 R40 had perineal care done and during observation on 2/21/13 at 6:53 a.m., NA-B had prepared basin of water in the bathroom and gathered washcloth and towel. NA-B washed and dried R40's eyes and face and removed soiled gown. R40's chest was washed and dried and NA-B applied deodorant. NA-B assisted R40 with putting on shirt. NA-B removed soiled incontinent product and perineal care was done. NA-B pulled out trash bag to put soiled washcloth in and picked up basin with soiled water and dumped the water into the toilet. After rinsing the basin NA-B removed soiled gloves. NA-B had not changed gloves at any time during the observation and especially following the soiling of gloves after competing perineal cares. During interview on 2/21/13 at 7:11 a.m., NA-B verified that gloves were not changed after providing perineal care and proceeded to touch the basin and faucet in the room. During interview on 2/21/13 at 8:39 a.m., the acting director of nursing (ADON) would expect staff to take off the gloves after perineal care and if staff needs to continue cares they would need to put on new gloves. During Perineal Care for the incontinent Resident policy review dated 5/1/06, the policy directed staff to provide perineal care, place all linens in a used laundry hamper, and wash basin and store in resident's room, clean up other supplies used. Remove gloves and wash hands. During interview on 2/21/13 at 10:36 a.m., the ADON verified the policy was not accurate and the gloves should have been changed	F 441		

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F 441 F 520 SS=E	Continued From page 28 immediately after perineal care was done. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or	F 441 F 520	**F520 SS=E** Facility has systems in place to ensure it maintains a quality assessment and assurance committee consisting of the director of nursing services, the medical direction and at least three other facility staff members. Meetings are to be held at least quarterly to identify issues and develop and implement appropriate plans of action to correct identified quality deficiencies. Facility policy regarding Quality Assurance and Assessment Committee was reviewed, updated and found to be appropriate. Quality Assurance and Assessment Committee will conduct ongoing quality assessment and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility is aware of. Quality Assurance and Assessment Committee has a process for in depth analysis, improvement activities and sanction plans to address deficient practices in care planning and infection control monitoring and surveillance. All staff will review the updated policy for Quality Assurance and Assessment Committee. Quality Assurance and Assessment Committee will review the	

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F 520	Continued From page 29 should have been aware of that had the potential to adversely affect all 98 residents in the facility. Findings include: The facility QA program lacked a process for in depth analysis, improvement activities and action plans to address deficient practices in care planning or infection control monitoring and surveillance. The director of nursing (DON) reported during interview on 2/21/13, at 12:00 noon the QA committee did have the required minimum membership and quarterly meetings. On 2/21/12 at 1:00 p.m. the director of nursing provided information of an action plans that was developed during the March 2012 QA meeting. The action plan identified staff in-servicing to provide education on individualized care plans for resident's experiencing pain. The care plan was to be reviewed quarterly and as needed if there was a change in resident's pain. During an interview on 2/21/13 at 11:15 a.m. the director of nursing indicated that she had been employed since September 2012 and had recognized a problem with care planning and had provided staff in-service education at that time. During staff interviews on February 20, and 21, 2013 registered nurses and acting director of nursing verified the care plans were not being updated when there were changes to resident interventions. During an interview on 2/21/12 at 11:15 a.m. the DON stated the facility did have a RN infection	F 520	updated policy and procedure for conduct ongoing quality assessment and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey. Quality Assurance and Assessment Committee will be education on the process for in depth analysis, improvement activities and action plans to address deficient practices in care planning and infection control monitoring and surveillance. QAA Committee was educated on all deficiencies obtained during the recent state survey and tentative action plans were discussed on 3/13/13. Plan of Correction and actions items will be reviewed at the next meeting as well as quarterly thereafter until the QAAC deems it unnecessary. Director of Nursing or designee is responsible for monitoring this plan of correction. Completion date: ~~4/8/13~~ 4/2/13 JDN	

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F 520	Continued From page 30 control program director that kept record of resident infections and the statistics and reported at QA meetings; however, no surveillance analysis or trending had been documented.	F 520		

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Saint. Anne Extended Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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	K 000	POC ok TB 3-20-13 RECEIVED MAR 18 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 04.02.2013

EXIT: 02.21.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rural Health	CEO	3/15/13

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@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. Saint Anne Extended Healthcare Center is a 6-story building with no basement. The facility was constructed in 1962 and was determined to be of Type II(222) construction. The facility is fully sprinkled and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 97 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 029	**K029** We will have Alltrades company take down the bi-fold door and construct a sheetrock	

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K 029	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 97 residents. Findings include: On facility tour between 8:20 AM and 11:20 PM on 02/21/2013, observation revealed that the following was found: 1. Ground level - medical storage (room over 50 square feet) has a bi-fold door on the east wall. a. no automatic closer b. no smoke-resisting partitions 2. Ground level - storage room # 37 (over 50 square feet) has open penetrations around pipes	K 029	wall to maintain a smoke barrier. The maintenance staff will fill the penetrations around the pipes in rooms 2 and 37. This will be completed by 4/2/2013.	

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K 029	Continued From page 3 3. Ground level - storage room # 2 (over 50 square feet) has open penetrations around pipes and cables on the south wall. These deficient practices were confirmed by the Facility Maintenance Director (TS) at the time of discovery.	K 029		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility failed to provide continuous illumination of exit access corridors in accordance with LSC Sections 19.2.8 and 7.8 . This deficient practice could affect all of the 25 out of 97 residents, as well as an undeterminable number of staff and visitors, if an evacuation was hindered due to an unilluminated exit access corridor. Findings include: On facility tour between 8:20 AM and 11:20 PM on 02/21/2013, revealed that the light switches on the corridor wall in all the exit access corridors controlled all the lights on the 4th floor. An interview with the Facility Maintenance	K 045	**K045** We will have electrician rewire the lighting to maintain continuous lighting in the halls. This will be completed by 4/2/2013.	

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K 045	Continued From page 4 Director revealed all resident room halls have overhead lights controlled by switches on the wall. With all light switches turned off, the exit access corridors did not have the required level of continuous illumination as required by LSC Section 19.2.8 and 7.8.1. NOTE: All floors did to be checked for this deficiency. This deficient practice was confirmed by the Facility Maintenance Director (TS) at the time of discovery.	K 045		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, 2-3.5.1 and 3-9.4.2.	K 052		

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K 052	Continued From page 5 Findings include: On facility tour between 8:20 AM and 11:20 PM on 02/21/2013, observation that the following was found: 1. 4th floor - smoke detector # 27 with-in 3 feet of air supply / return vents NOTE: Check the entire facility for this deficiency 2. Penthouse - elevator equipment room, does not have heat detectors with-in 2 feet of sprinkler heads These deficient practices were confirmed by the Facility Maintenance Director (TS) at the time of discovery.	K 052	**K052** 1. The smoke detectors were moved by maintenance staff so that they are at least 3 feet from air supply; done on 2/22/2013. 2. The heat detectors will be installed in the elevator equipment room by Trans-Alarm, Inc. before 4/2/2013.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1 and 7-5.2.2. The deficient practice could affect all 97 residents. Findings include:	K 054		

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K 054	Continued From page 6 On facility tour between 8:20 AM and 11:20 PM on 02/21/2013, the review of the annual fire alarm system inspection / test report and the following was found: 1. Not all the information was provided on the annual report form from Trans Alarm dated 06/15/2012 2. No bi-annual smoke detector sensitivity test report available for review These deficient practices were confirmed by the Facility Maintenance Director (TS) at the time of discovery.	K 054	**K054** 1. Plant Operations Director will make sure we receive the form 7-52.2 completely filled out from Trans-Alarm by 4/2/2013. 2. Will have the biannual smoke detector sensitivity report available for review.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-1, 2-2.1.1, 5-3.3 and 5-3.3.2. This deficient practice could affect all 97 residents. Findings include:	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062	Continued From page 7 On facility tour between 8:20 AM and 11:20 PM on 02/21/2013, observation and review of the annual fire sprinkler inspection report from General Fire Protection revealed that the following was found: 1. Annual inspection report dated 7/25/2012, there was a note stating the annual fire pump test was stopped because of low suction pressure (7 psi). There was no fire pump report with graph attached. 2. 1st floor - kitchen dishwashing area has several corroded fire sprinkler heads These deficient practices were confirmed by the Facility Maintenance Director (TS) at the time of discovery.	K 062	**K062** 1. Plant Operations Director will get the fire pump report from General Sprinkler Company that was done but not completed on 7/25/2012 and have them back to complete the test before 4/2/2013. 2. The heat detectors will be installed in the elevator equipment room by Trans-Alarm, Inc. before 4/2/2013.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110	K 144		

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K 144	Continued From page 8 Chapter 6-4.1. The deficient practice could affect all 97 residents. Findings include: On facility tour between 8:20 AM and 11:20 PM on 02/21/2013, the documentation review of the weekly inspection logs (February 2012 to February 2013) for the diesel emergency generator revealed that a weekly operational inspection was missed for the week of 05/26/2012. This deficient practice was confirmed by the Facility Maintenance Director (TS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	**K144** We will set up electronic calendar so maintenance staff receives an e-mail for a reminder to do the weekly inspection. Completed by 2/25/2013.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9707

March 5, 2013

Mr. Rand Gettler, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, Minnesota 55987

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5233023

Dear Mr. Gettler:

The above facility was surveyed on February 19, 2013 through February 21, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive SE, Rochester, Minnesota 55904-5506. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: _____ B. WING _____	02/21/2013

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 19, 20 and 21, 2013 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings	

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	2 000	which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by:	2 255		

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2 255	Continued From page 2 Based on interview and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of that had the potential to adversely affect all 98 residents in the facility. Findings include: The facility QA program lacked a process for in depth analysis, improvement activities and action plans to address deficient practices in care planning or infection control monitoring and surveillance. The director of nursing (DON) reported during interview on 2/21/13, at 12:00 noon the QA committee did have the required minimum membership and quarterly meetings. On 2/21/12 at 1:00 p.m. the director of nursing provided information of an action plans that was developed during the March 2012 QA meeting. The action plan identified staff in-servicing to provide education on individualized care plans for resident's experiencing pain. The care plan was to be reviewed quarterly and as needed if there was a change in resident's pain. During an interview on 2/21/13 at 11:15 a.m. the director of nursing indicated that she had been employed since September 2012 and had recognized a problem with care planning and had provided staff in-service education at that time. During staff interviews on February 20, and 21, 2013 registered nurses and acting director of nursing verified the care plans were not being updated when there were changes to resident	2 255		

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2 255	Continued From page 3 interventions. During an interview on 2/21/12 at 11:15 a.m. the DON stated the facility did have a RN infection control program director that kept record of resident infections and the statistics and reported at QA meetings; however, no surveillance analysis or trending had been documented. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, medical director and consulting pharmacist, could review and revise the facility's system used to identify quality of care concerns, develop and implement action plans to correct the identified quality issues, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a plan of care	2 560		

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2 560	Continued From page 4 for 3 of 33 residents (R72, R128 and R109) reviewed for bruising, restraints, positioning, and unnecessary medications. Findings include: R72's care plan did not address chronic bruising. R72 was readmitted from the hospital on 12/6/12. R72's annual Minimum Data Set (MDS) dated 1/8/13, identified resident as cognitively intact and required extensive assistance with two plus staff for bed mobility, transfers, dressing and toileting needs. During observation on 2/19/13 at 11:13 a.m., R72 had bruising noted on the entire left hand and across the back of the right hand. During nursing note review on 12/7/12 at 12:55 a.m., identified bruising on left hand and forearm with no other bruising noted. During R72's care plan review with problem start date of 3/5/09, the care plan had not identified bruising. During an interview on 2/20/13 at 6:38 p.m., licensed practical nurse (LPN)-A indicated R72 had a skin condition and R72's hands always have the bluish purplish color. LPN-A verified the skin condition was not on the care plan and should have been on the care plan. During interview on 2/21/13 at 8:03 a.m., registered nurse (RN)-C indicated bruising was a chronic problem for R72. RN-C verified bruising disorder had not been on the care plan and confirmed should have been on the care plan. During interview on 2/21/13 at 8:27 a.m., the acting director of nursing (ADON) verified R72	2 560		

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2 560	Continued From page 5 had always had the dark skin discoloration. The ADON indicated the dark discoloration was not a new problem for R72 and should have been in the care plan. R128 failed to have a comprehensive care plan developed to identify skin conditions and risk factors for impaired skin integrity related to bruising and fragile skin. R128 was admitted to the facility on 7/24/12, for rehabilitation following an above knee amputation. Diagnoses included venous thrombosis, obesity, peripheral vascular disease and edema. The quarterly Minimum Data Set (MDS) dated 1/22/13, had identified R128 as alert and oriented. The MDS indicated R128 required extensive assist with dressing, independent with all other activities of daily living. R128's physician orders dated 2/6/13 identified the use of 5 milligrams (MG) of Coumadin (an anticoagulant) daily at bedtime. Review of progress note dated 2/10/13, revealed a bruise was noted on R128's right arm. The note indicated R128 reported she had the bruise for a few days. During interview on 2/21/13, at 9:05 a.m. R128 stated her skin was thin and fragile, and she had a history of bruising related to Coumadin use and bumping her arms. R128's care plan dated 7/24/12 identified potential for alteration in skin integrity related to diagnoses including obesity, and peripheral vascular disease. The care plan lacked identification of risk factors for impaired skin integrity related to bruising, fragile skin and the use of Coumadin.	2 560		

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2 560	Continued From page 6 On 2/21/13, at 9:24 a.m. the acting director of nursing (ADON) stated nursing staff were to monitor skin and to report any new bruising. ADON verified R128's care plan lacked identification of skin issues related to bruising, fragile skin and the use of Coumadin. ADON stated she would expect the CP to include risk factors related to the use of Coumadin. R109's care plan did not include the use of side rails as a positioning device. R109's diagnoses included dementia and weakness. Review of the Restraints/Adaptive Equipment Side Rail assessment dated 7/13/12, indicated R109 utilized side rails to assist with transfers and bed mobility. Review of R109's current comprehensive care plan, did not include the use of side rails. During observation on 2/20/13, at 11:11 a.m. R109's bed was observed to be equipped with bilateral half rails affixed to the bed. On 2/21/13, at 9:10 a.m. NA-E was interviewed. NA-E verified R109 had used side rails for bed positioning. NA-E stated, "When we turn him he holds onto the rails." During interview on 2/21/13, at 9:24 a.m. the ADON confirmed R109 utilized bilateral side rails for bed positioning, and further confirmed the side rails were not identified on the care plan. ADON stated she would expect to see current interventions on the CP. The facilities Care Plan Development and Revision Policy and Procedure dated 9/1/10,	2 560		

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2 560	Continued From page 7 identified " The care planning process is multi-disciplinary and is an on-going, evaluative and evolving; the care plan document is updated and reflective of the resident's changing needs." The policy and procedure included "The Saint Anne Assessment nurse, having reviewed the assessments of the various clinical disciplines develops the Temporary Admission Care Plan addressing areas of Self-care ability, Mobility needs, Elimination needs, Nutrition needs, Mood adjustment to facility" and further included "As time progresses, this care plan is updated, modified to reflect changes in resident condition, new orders, resolutions of past issues. These changes are made in the paper copy of the care plan, dated and signed. Unit staff is made aware of the changes in resident needs and new approaches that have been added." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide hydration needs according to the care plan for 1 of 2 residents (R69) reviewed for hydration. Findings include: R69 was not offered fluids during cares and fluids had not been available in the room according to the care plan. R69's care plan with a problem date of 2/3/09 indicated R69 had a potential for fluid volume deficit related to diuretic use and directed staff to offer fluids when toileting and keep fluids at bedside. During interview with resident on 2/19/13 at 11:24 a.m., R69 indicated they had not received/offered fluids between meals. There was no glass of water observed in the room during the interview. During observation on 2/20/13 at 6:47 p.m., nursing assistant (NA)-A provided assistance with bedtime cares but had not offered R69 fluids nor had there been a glass of water present in room. During interview on 2/21/13 at 7:38 a.m., registered nurse (RN)-C indicted volunteers pass water some days to the resident's room otherwise the staff was responsible for making sure water was passed and present to the resident rooms. RN-C indicated there was a list of residents that do not get or want water in there room but RN-C verified R69 was on the list not to get water in the room. RN-C confirmed it was the expectation R69 was offered water with cares according to care plan.	2 565		

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2 565	Continued From page 9 During observation on 2/21/13 at 9:15 a.m., NA-A provided morning cares for R69 and had not offered fluids. During interview on 2/21/13 at 9:38 a.m., NA-A confirmed they had not offered R69 fluids during cares and indicated should have asked R69 if they wanted a drink but forgot. During interview on 2/21/13 at 8:36 a.m., the acting director of nursing expected staff to offer fluids with cares. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570		

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	00955	A. BUILDING: _____ B. WING _____	02/21/2013

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2 570	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the comprehensive care plan to reflect changes in residents health interventions for 3 of 4 residents (R109, R154 and R159) reviewed for repositioning and pain management. Findings include: R109's written care plan was not updated to reflect his current transfer status. R109 was admitted to the facility on 4/16/12, with diagnoses that included dementia, weakness and history of falls. On 2/20/13, at 3:05 p.m. R109 was observed sitting in a recliner chair with legs in the up position in the fourth floor solarium. At 4:10 p.m. two nursing assistants (NA) were observed to approach R109 and assisted him to transfer to his wheel chair with a gait belt and walker. During review of R109's care plan (CP) dated 4/18/12, it was revealed R109 had a potential/actual alteration in mobility and potential for injury related to declining condition. The CP directed staff to use an EZ stand (a mechanical transfer device) and the assist of one or two staff for transfers. On 2/21/13, at 9:10 a.m. NA-E was interviewed. NA-E stated R109 was transferred with the use of the EZ stand "depending on the time of day, sometimes we use the gait belt with two assist." During interview with the acting director of nursing (ADON) on 2/21/13, at 9:24 a.m. it was verified	2 570		

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2 570	Continued From page 11 R109's care plan directed staff to use the EZ stand for transfers. ADON stated she would expect to see current interventions on the CP. R154 lacked revision of the plan of care with identified phantom pain. R154 was admitted to the facility 11/19/12 for rehabilitation following a right leg amputation (below the knee amputation - BKA.) On 2/20/13 at 11:38 a.m. R154 was interviewed. R154 stated they were experiencing discomfort without relief of phantom leg pain that R154 rated at a 5-6 out of 10 (where 10 is the worst pain and 0 is no pain) at current time. R154's clinical record was reviewed. A pain assessment dated 11/26/12 identified frequent phantom pain and that R154 felt aching in right ankle and shin. The quarterly pain assessment dated 2/12/13 indicated no changes to plan of care at this time. The care plan dated 11/20/12 located in the medical record was reviewed. During an interview on 2/20/13 at 3:55 p.m. the health unit coordinator indicated the care plan located in the medical record was the most current care plan. This care plan identified a problem of pain related to " recent right BKA, chronic pain." And the care plan had a goal with a target date of 12/20/12 of " Will have no c/o (complaints of) pain on a daily basis by next review." The plan of care did not address the phantom leg pain R154 had been or was currently experiencing. During an interview on 2/21/13 at 9:00 a.m. RN-A stated R154 was due for another pain assessment and that the phantom pain was	2 570		

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2 570	Continued From page 12 something that recurred recently for R154. During an interview on 2/21/13 at 8:55 a.m. RN-A stated she had not up-dated R154 ' s care plan to include the phantom leg pain. During an interview on 2/13/12 at 9:54 a.m. the acting director of nursing (ADON) stated care plans were to be up-dated when the event happened and could be updated by anyone. R159 lacked a revision of the plan of care for pain control. R159 was admitted on 12/12/12 for rehabilitation after removal of hardware of an artificial knee. On 1/24/13 the nurse practitioner noted R159 had esophageal candidiasis. Interdisciplinary notes of 2/5/13 indicated R159 had gall bladder surgery. R159 was interviewed and observed on 2/20/13 at 11:12 a.m. R159 stated experienced pain that averaged 3 to 4 out of ten and would ask for pain medication at a level of 5. R159 stated that the oxycodone and ice helped manage the pain and was taking Prilosec twice a day but still had heartburn. R159 added that now yeast was found in esophagus and that the burning was still there even though the gall bladder had been removed. During an interview on 2/20/13 at 3:55 p.m. the health unit coordinator indicated the care plan located in the medical record dated 12/12/13 was the most current care plan. The care plan identified a problem of " potential for pain R/T [related to] recent explanation [sp] of left TKA [total knee arthroscopy] and DJD [degenerative joint disease]." A goal target for 2/12/13 was for the resident to have no complaints of pain. The care plan did not identify a problem, goal, or	2 570		

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2 570	Continued From page 13 interventions related to epigastric pain. A care plan intervention dated 12/12/12 directed " heat to painful area" but the interventions did not list cold as a non-pharmacological intervention used for pain relief. During an interview on 2/20/13 at 4:00 p.m. RN-A stated that care plans were reviewed monthly and that R159's care plan had not yet come up for review. Facility policies provided by the director of nursing were reviewed. The policy entitled Care Plan Development and Revision dated 9/1/10 directed " 4. As time a progress, this care plan is updated, modified to reflect changes in resident condition, new orders, and resolutions of past issues. These changes are made in the paper copy of the care plan, dated and signed. Unit staff is made aware of the changes in resident needs and new approaches that have been added." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated and then providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		

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2 830	Continued From page 14 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and treat acute moderate to severe pain following a fall for 1 of 1 resident (R42) reviewed for pain. Findings include: R42 experienced ongoing acute moderate to severe neck and head pain following a fall on 11/24/12 at 7:49 p.m. R42 was admitted to the facility 11/10/10 and had diagnoses that included congestive heart failure, dementia, and acute pain due to trauma. The annual Minimum Data Set dated 10/16/12 indicated the resident had a BIMS (Brief Interview for Mental Status) of 10 (moderately impaired), occasional moderate pain that did not limit function, and no past history of falls. According to an incident report dated 11/24/12, R42 experienced a fall from a standing position to the floor landing on face on 11/24/12 at 7:49 p.m. The incident report described the R42 to have a bruise and open cut on forehead and also a bruise on the nasal bridge of the nose. Also R42	2 830		

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2 830	Continued From page 15 complained of moderate pain located in head/neck area. The physician was contacted on 11/24/12 at 10:02 p.m. and no new orders received. R42 was observed on 11/26/12 at 3:29 p.m. and noted to have a resolving hematoma on forehead that was the diameter of baseball. Also a bruise was observed across the bridge of the nose and extended under both eyes. R42 was holding head with her hands and heard moaning and saying that her head hurt. R42 was sitting with head and neck bent forward while seated in a straight back wheelchair. Again at 5:15 p.m. on 11/26/12, R42 was observed with head and neck bent forward while sitting in a straight back wheelchair at the dining room table and a pillow placed behind her neck. During an interview on 11/27/12 at 5:45 p.m. licensed practical nurse (LPN)-B stated R42 had fallen a few days prior and had a "massive" headache. During an interview on 11/27/12 at 7:40 p.m. nursing assistant (NA)-B stated she was concerned because R42 was sitting with head and neck bent forward and lying in bed in this same position. NA-B stated this was a new position for R42 since the fall as she had not done it before the fall incident. During an interview on 11/28/12 at 8:30 a.m. licensed practical nurse (LPN)-A stated R42 was able to hold neck and head in an upright position before the fall (fall occurred on 11/24/12) and since the fall R42 had kept her head and neck in a forward bent position for comfort. On 11/24/12 at11:00 p.m. the nurse document R42 was lying in bed and complained of severe head pain and neck pain. The nurse practitioner (NP) was notified and instructed staff to continue	2 830		

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2 830	Continued From page 16 to monitor the resident and update her with any changes. Ice was applied. On 11/25/12 at 2:49 p.m. the resident complained of head and neck pain. The resident indicated it was hard to straighten head. Neurological checks were done and within normal limits. On 11/26/12 at 2:49 p.m. the nurse documented R42 complained of neck pain with activities of daily living and with movement while in the wheelchair. The documentation indicated R42 stated, "I need a neck brace." On 11/27/12 three nursing notes indicated the resident had complained of head and neck pain, was moaning out with pain, and that R42 required assist of two staff to walk to the bathroom. The note indicated R42 ' s head leaned down and tilted to the right side. When asked to lift head up, R42 stated could not due to pain. Resident required being fed by staff due to position of head. The day shift notes indicated the resident was seen by the NP "d/t [due to] increased pain and soreness in neck and head from recent fall" and a medication change (NP ordered Hydrocodone-acetaminophen one tab four times per day for pain due to trauma) and occupational therapy orders was completed. On 11/27/12 at 9:18 p.m. nursing documentation indicated the resident requested to lie down at 3:30 p.m. and did not want to get up for supper due to pain in head and neck. R42 did get up at 600 p.m. and was observed to hold head in hands the entire time at the dinner table and complaining of pain in neck and head. After dinner R42 went back to bed and had difficulty with bedtime cares due to resident holding head and not wanting any cares done due to pain.	2 830		

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2 830	Continued From page 17 Lortab (pain medication) given at 8:00 p.m. and the medication was effective. On 11/28/12 at 5:12 a.m. the nursing notes indicated "Resident resting when checked on periodically throughout the night, but when attempted to move [R42] to change position and give [R42] a drink of water [R42] was clearly still in a lot of pain, not wanting to be touched, calling out " Oh it hurts too much." Review of the medication administration record revealed the resident received two tablets of Tylenol 325 mg four times a day for ankle pain (order dated 11/19/12) and had an order for Tylenol 325 mg 2 tabs once a day as needed. After the acute pain developed following the fall on 11/24/12 at 7:49 p.m. R42 had received only two as needed doses of Tylenol for pain between 11/25/12 at 12:37 a.m. through 11/27/12 at 5:10 a.m. The last dose of the schedule Tylenol was documented as given prior to 1:30 p.m. on 11/27/12. LPN-B stated a new order for Lortab had been received on 11/27/12 but at 7:45 p.m. stated the Lortab had not yet been given. When LPN-B had been interviewed on 11/28/12 at 8:30 a.m. on 11/28/12, LPN-A stated the Lortab had first been given at 7:47 p.m. on 11/27/12 even though it was ordered eleven hours previously. The care plan provided 11/28/12 had a problem dated 11/27/12 that stated, " Has a history of complaints of right ankle bone pain. Recent fall on 11/24/12 with complaints of pain to head and neck. " The care listed 2 interventions/approached specific to head and neck pain. Interventions included: 1. dated 11/27/12 " Administer medications: Lortab. Evaluate/record/report effectiveness and any adverse side effects. " 2. dated 11/27/12 " PT	2 830		

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2 830	Continued From page 18 [physical therapy] to eval [evaluate] and treat for neck pain." The care plan had 3 interventions dated 8/2/12 that related to the care of the ankle. In addition the care plan had 6 interventions/approaches dated 5/3/12 that directed staff to encourage resident to discuss pain and request pain medication; evaluate effectiveness of interventions and adverse side effect, monitor and adjust if ineffective; monitor and record any complaints of pain and monitor any non-verbal signs of pain; use non-medicated pain relief measures including application heat/cold. No further care plan was found related to pain or management of hematoma and pain in head and neck. The physical therapy assessment done the same day it was ordered by the physician on 11/27/12 was reviewed. The initial assessment indicated that prior to the fall the resident was able to transfer and walk with contact guard assistance due to unsteadiness during transfer. The assessment indicated that R42 ' s current level was moderate assistance requiring 50% physical assistance. The assessment noted the " patient completes all functional transfers and ambulation with head held in severe flexion." During an interview on 11/28/12 at 11:25 a.m. the physical therapy aid stated R42 was seen by the therapist the day before and the physical therapy notes of 11/27/12 indicated R42 was in severe pain. During an interview with the physical therapist (PT) on 11/28/12 at 11:55 a.m. the PT indicated she felt R42 had a contusion and stiff neck muscles from the fall that were causing the pain and that it may take up to 4 weeks to get the pain and stiffness resolved. The director of nursing was interviewed on 11/29/12 at 12:50 p.m. and stated the staff had	2 830		

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2 830	Continued From page 19 not followed the care plan for use of heat/ice for neck/head pain and pain management was not assessed for pain relief following the fall. F309 and F323 SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures for the pain management, including assessment, reassessment, management and monitoring effectiveness of care provided. In addition the director of nursing or her designee could develop policies and procedures related to resident supervision, including assessment and care planning related to elevator use. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		

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21375	Continued From page 20 by: Based on document review and interview, the facility failed to ensure that the infection control program included tracking, trending, and analysis of data related to infections. This had the potential to affect all 98 residents currently residing in the facility. In addition the facility failed to ensure infection control practices of gloving and washing hands were maintained by staff during personal cares for 2 of 2 residents (R69, R40) observed during personal cares. Findings include: The facilities infection control line listings of Resident Infections occurring in the facility and Monthly Infection Summary reports, were reviewed with the director of nursing (DON) on 2/21/13 at 11:00 a.m., During interview, the DON indicated the registered nurse (RN) infection program director was on leave. The DON and assistant director of nursing (ADON) verified they were unable to find any information related to the analysis of the data collected. During an interview on 2/21/12 at 12:00 Noon, the director of nursing stated that she had a telephone conversation with the registered nurse (RN) infection program director. The RN told the DON that she had not document trends and analysis of data. Gloves were not changed by staff after being soiled during perineal cares for R69 and R40. R69 had perineal care done and during the observation on 2/20/13 at 6:47 p.m., nursing assistant (NA)-C put on gloves and prepared basin of water in the bathroom, NA-C removed R69's shirt and placed in the laundry bag, NA-C washed and dried R69's face, proceeded to wash	21375		

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21375	Continued From page 21 and dry ears, washed and dried under arms, offered lotion and resident refused. NA-C put on R69's purple polo shirt. NA-C transferred R69 into bed, shoes were removed. Without removing soiled gloves NA-C provided resident with perineal care as follows: removed soiled incontinent product and washed and dried front perineal area and continued to wash buttocks. NA-C offered R69 powder and resident agreed. NA-C grabbed powder container with soiled gloves and applied powder to perineal area. NA-C opened up drawer, removed socks with grippers and put on R69. NA-C placed R69's call light on resident's chest and then proceeded to turn on water faucet in bathroom to rinse out basin and then removed their soiled gloves. NA-B had not changed her gloves at any time during this observation even when they were soiled after completing perineal cares. During interview on 2/20/13 at 7:13 p.m., NA-C verified they had not changed gloves after providing perineal care and should have. R40 had perineal care done and during observation on 2/21/13 at 6:53 a.m., NA-B had prepared basin of water in the bathroom and gathered washcloth and towel. NA-B washed and dried R40's eyes and face and removed soiled gown. R40's chest was washed and dried and NA-B applied deodorant. NA-B assisted R40 with putting on shirt. NA-B removed soiled incontinent product and perineal care was done. NA-B pulled out trash bag to put soiled washcloth in and picked up basin with soiled water and dumped the water into the toilet. After rinsing the basin NA-B removed soiled gloves. NA-B had not changed gloves at any time during the observation and especially following the soiling of	21375		

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21375	Continued From page 22 gloves after competing perineal cares. During interview on 2/21/13 at 7:11 a.m., NA-B verified that gloves were not changed after providing perineal care and proceeded to touch the basin and faucet in the room. During interview on 2/21/13 at 8:39 a.m., the acting director of nursing (ADON) would expect staff to take off the gloves after perineal care and if staff needs to continue cares they would need to put on new gloves. During Perineal Care for the incontinent Resident policy review dated 5/1/06, the policy directed staff to provide perineal care, place all linens in a used laundry hamper, and wash basin and store in resident's room, clean up other supplies used. Remove gloves and wash hands. During interview on 2/21/13 at 10:36 a.m., the ADON verified the policy was not accurate and the gloves should have been changed immediately after perineal care was done. SUGGESTED METHOD FOR CORRECTION: The director of nursing or her designee could review policy and procedures regarding the infection control program.. The director of nursing or her designee could educate staff on policy and procedures and develop a monitoring system to ensure compliance with surveillance analysis and trending was completed. In addition the director of nursing or designess could review or revise policies and procedures related to infection control techniques in regards to provision of personal cares/peri-cares and handwashing and/or glove use. The director of nursing or designee could provide staff training in regard to these policies and procedures and conduct audits to ensure the policies abnd	21375		

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	00955	A. BUILDING: _____ B. WING _____	02/21/2013

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21375	Continued From page 23 procedures are being followed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21375		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were disposed of in a timely manner when discontinued in two of four medication storage	21630		

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21630	Continued From page 24 rooms and failed to ensure medications were stored in a sanitary manner in 2 of 2 medication carts located on fourth floor. Findings include: The medication storage room was observed on 2/20/13 at 7:15 p.m. with licensed practical nurse (LPN)-D. The designated discontinued medication storage was on the top shelf of a locked cupboard that also contained extra medications still used. LPN-D stated the medications were destroyed by the pharmacists and some pharmacies were slower than others. The following medications were found not destroyed timely: R77 had warfin 2 mg tablets (anticoagulant) stored. The medication label indicated the prescription had been dispensed on 4/30/12. Review of the medical records indicated the physician order for warfin 2 mg had been changed on 1/26/12. R112 had resperidone (antipsychotic) tablets stored. The medication label indicated the prescription for as needed medications, expired on 1-13-13. R37 had Tramadol (pain) tablets stored. The medication label indicated the prescription had been dispensed 8/26/12. Review of the physician orders indicated the Tramadol had been discontinued 9/27/12. R95 had Aranesp Injectable (medication to improve hemoglobin) syringes stored in the cupboard. The label indicated the medication was dispensed on 11/29/12 and was to be	21630		

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21630	Continued From page 25 refrigerated. R95 was discharged on 12/11/12. R57 had Tamiflu (antiviral) tablets stored. The label indicated the medication was dispensed on 1/20/13. LPN-D stated the medication was discontinued related to allergies. R21 had Nitro stat and Tylenol suppositories stored. R21 expired 1/21/13. LPN-C (floor team leader) was interviewed on 2/21/12 at 7:30 a.m. and indicated the medications were to be destroyed by nursing unless they were controlled medications which are to be destroyed by the pharmacist. LPN-C stated she was unaware of time line for destruction. The facility policy entitled Disposition and Destruction of Medications dated 7/14/10 was reviewed and directed "2. Any medication which are unused due to discharge, dose change, death of resident, WITH THE EXCEPTION OF open over the counter bottles, refrigerated items, injectable and control substances can be returned in a bag to Weber-Judd who will appropriately dispose of these medications for SAW." "3. If a resident is discharged, dies or the physician's order for a controlled substance discontinued permanently, any remaining controlled substances must be destroyed. Facilities in this instance must follow forms and instructions provided by the Minnesota Board of Pharmacy. The destruction of these medications must be witnessed by a pharmacist OR a registered nurse" The policy/procedure did not identify a time line related to the destruction of medications. During observation in the fourth floor Nursing Unit medication room on 2/21/13, at 9:45 a.m. with	21630		

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21630	Continued From page 26 registered nurse (RN)-A it was noted that expired medications were available for resident use. The medications were stored in a locked cupboard where stock and individual resident medications were stored until needed for use. During the observation RN-A verified findings and stated the medication needed to be destroyed or sent back to the pharmacy. Medications expired, but available for use included: R52 had Atropine drops, that had expired on 1/28/13. Atropine is used to treat multiple disorders to include cardiac, respiratory, and gastrointestinal. R128 had Zantac 150mg tablets that had expired on 7/2013. Zantac is used to treat and prevent ulcers in the stomach and intestines. Review of medication information list titled MEDS 4th Locked Cupboard indicated the medication had been placed in the locked cupboard on 8/1/12. R25 had Seroquel 25mg tablets that had expired on 1/2013. Seroquel is used to treat symptoms of schizophrenia and bipolar disorder. Review of medication information list titled MEDS 4th Locked Cupboard indicated the medication had been placed in the locked cupboard on 1/31/13. R35 had Nitro stat 0.4 mg tablets used to pprevent or relieve a sudden attack of angina (chest pain.) Asmanex inhalation used to treat asthma, and Foradil inhalation used to relaxes muscles in the airways to improve breathing. All three medications had expired on 1/18/13. The acting director of nursing (ADON) was interviewed on 2/21/13 at 9:55 a.m. ADON	21630		

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21630	Continued From page 27 indicated the expectation was for medications were to be destroyed within 1-2 weeks after discontinued, discharge, or death. She added the length of time the medications remained on 5th floor storage, was unacceptable. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications that are discontinued related to change of orders, death, or discharge of the resident are stored and destroyed appropriately. In addition the director of nursing or her designee could develop a system for accountability until the medications can be destroyed per state and federal regulations. The director of nursing could monitor to ensure medications are destoyed in a timely fashion. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21630		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980		

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21980	Continued From page 28 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop a vulnerable adult policy	21980		

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21980	Continued From page 29 that met the reporting requirements for abuse prohibition, this had the potential to affect 98 of 98 residents living in the facility. Findings include: The Vulnerable Adult/Maltreatment prevention plan & reporting policy lacked clear instruction to report allegations of abuse/neglect/etc. immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (this includes the office of health facility complaints-OHFC). Review of three resident allegations for the past year it had been noted that all three allegations had been reported immediately to the administrator and OHFC. During review of the Abuse Prevention Plan policy revised 2/12/13 revealed, "After safe guarding the resident, report the information to their supervisor. The supervisor in turn must immediately report all suspected maltreatment to either or both the Social Worker or the Director of Nursing. The Social Worker will process the report." The Key Component #6: REPORT and INVESTIGATE section of the policy explained the online reporting process via the website but did not address how soon after becoming aware of a potential vulnerable adult incident the online report must be completed. The Definitions section of the policy revealed, "In accordance with federal requirements, the following definitions delineate what is to be reported to Minnesota Department of Health within 24 hours of the incident's discovery." During an interview on 2/20/13 at 2:14 p.m., the acting director of nursing stated the facility had to make an initial report to the Office of Health	21980		

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21980	Continued From page 30 Facility complaints within twenty-four of an incident. The acting director of nursing verified the abuse prevention plan policy indicated the facility had to make an initial report within twenty-four hours of the incident's discovery. During an interview on 2/22/13 at 9:47 a.m., social services-A verified the abuse prevention plan policy revealed the facility had to make an initial report within twenty-four hours of the incident's discovery. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could review and revise the facility Abuse Prevention Policy related to timing of reporting of potential resident maltreatment. The administrator of designee could educate staff related to the policyd and monitor to assure the facility is reporting the potential resident maltreatment timely. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		