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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XU59

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00763

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245524**

2.STATE VENDOR OR MEDICAID NO.
(L2) **825540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLE SISTERS OF THE POOR**
(L4) **330 EXCHANGE STREET SOUTH**
(L5) **SAINT PAUL, MN** (L6) **55102**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/31/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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)
12/31

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

12.Total Facility Beds **73** (L18)

13.Total Certified Beds **73** (L17)

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

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

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

*Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40	33		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 01/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/08/2017 (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
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
01/24/2017
(L32)

32. DETERMINATION OF APPROVAL DATE
01/24/2017
(L33)

Posted 02/09/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245524
February 8, 2017

Sr. Mary Elizabeth Anderson, Administrator
Little Sisters of the Poor
330 Exchange Street South
Saint Paul, MN 55102

Dear Sr. Anderson:

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 the above facility is certified for or recommended for:

73 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 73 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K351.

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 8, 2017

Sr. Mary Elizabeth Anderson, Administrator
Little Sisters of the Poor
330 Exchange Street South
Saint Paul, MN 55102

RE: Project Number S5524026

Dear Sr. Anderson:

On December 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 15, 2016. 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 January 31, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 6, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 15, 2016, effective January 6, 2017 and therefore remedies outlined in our letter to you dated December 28, 2016, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245524 Y1	A. Building B. Wing Y2	1/31/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0334	Correction	ID Prefix F0356	Correction
Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	01/06/2017	LSC	01/06/2017	LSC	01/06/2017
ID Prefix F0371	Correction	ID Prefix F0428	Correction	ID Prefix F0465	Correction
Reg. # 483.60(i)(1)-(3)	Completed	Reg. # 483.45(c)(1)(3)-(5)	Completed	Reg. # 483.90(h)(5)	Completed
LSC	01/06/2017	LSC	01/06/2017	LSC	01/06/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 02/08/2017	SIGNATURE OF SURVEYOR 16022	DATE 01/31/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/15/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XU59

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00763

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(L1) **245524**

2.STATE VENDOR OR MEDICAID NO.
(L2) **825540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLE SISTERS OF THE POOR**
(L4) **330 EXCHANGE STREET SOUTH**
(L5) **SAINT PAUL, MN** (L6) **55102**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/15/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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)
12/31

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

12.Total Facility Beds **73** (L18)

13.Total Certified Beds **73** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40	33		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Cynthia Wentkiewicz, HFE NE II — 01/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/23/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 01/24/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 28, 2016

Sr. Mary Elizabeth Anderson, Administrator
Little Sisters of the Poor
330 Exchange Street South
Saint Paul, MN 55102

RE: Project Number S5524026

Dear Sr. Anderson:

On December 15, 2016, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 January 24, 2017, 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 January 24, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 15, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

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
	245524	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey was conducted on December 12, 13, 14, and 15, 2016. Little Sisters of the Poor is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

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F 280	Continued From page 1 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 280		

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medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to revise the care plan to include falls for 1 of 3 residents (R50) who was reviewed for accident.

Findings include:

R50 occurrence report sheets indicated R50 had multiple falls dated 7/4/16 and 11/17/16.

Care Plan: Problem: "...FALLS: 7/4/16, 11/17/16 FX Right pelvis sustained ...Fall: 11/17/16 Fracture right pelvis. Scheduled pain meds: ES Tylenol. Resident became nauseated/vomiting from Norco and Tramadol. Hospital 11/23/16." However, the care plan lacked goals and interventions.

The Incident Report dated 11/17/16, read, "Resident was heard screaming, then she was found lying on her back, on the floor in the hallway, between room 415 and 412, head by the wall, leg straight, both hands supporting the back of head, the can [cane] struck in the crotch. A&O

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[alert and oriented] per norm [normal]. 'I was pushing the wheelchair in front of me [with my can [cane] hanging to the back of the W/C [wheel chair], the can [cane] fell and I triped [sic] on it. I fell on my right side, I did not hit my head anywhere.' VS [vital signs] and neuro checked. No s/s [signs or symptoms] of injure noted. Resident able to move all extremnities [sic]. C/O [complain of] stiffness to right hip but says it is not out of the oridinary [sic]. She was lifted from the floor by Hoyer lift and assist of 3 and assisted to bed ..."

The Fall Assessment done on 11/17/16, read, "Resident unwitnessed fall w [with]/sustained pelvic fracture. Resident is not able to bear weight without assistance at this time. Transfers assist of one. Orthostatic BPs [blood pressures] done with assistance laying 139/50 P64, Standing 142/58 P58, 112/56 P68. Tramadol for pain added to her medications as of 11/22/16."

R50's Care Area Assessment (CAA) dated 11/28/16, indicated, "Problem: CAA triggered for fall due to actual fall w/major sustained injury [right pubic rami fracture] 11/17/16. [R50] was in hallway doing her normal daily activity when fall occurred. [R50] is normally (I) [independent] with walking w/a device, has had increased problems with prosthesis over the past few months and she has been using the W/C more to get around."

On 12/15/16, at 11:50 a.m. registered nurse (RN)-B verified R50's fall care plan lacked goals and interventions and stated, RN-B would discuss with director of nursing (DON) about it because she knew after a fall, the interdisciplinary team (IDT) always met to discuss about what exactly happen. IDT would look at what needed to be

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F 280	Continued From page 4 done for goal and interventions to prevent falls from occurring again. On 12/15/16, at 11:56 a.m. DON confirmed R50's fall care plan lacked goals and interventions and indicated, "I can see that is not updated in the care plan. We spoke to [R50] about it and [R50] but it is not in the care plan. My expectation is the fall goal and interventions should be care plan." Policy and procedure titled PROCEDURE FOR FALLS with revised date 7/16, read, "9. Update the care plan with the date of the fall and any other factors that are pertinent. Place an intervention on the CP [care plan]." Policy and procedure titled CARE PLAN dated 10/10, revealed, "5. Care plans are reviewed and discussed individually. B. Approaches are written clearly to be understood by all and include specific department responsible for approaches. Approaches must reflect Interdisciplinary Team involvement. C. Concerns, problems, needs and/or strengths have a corresponding goal. The format for a goal is who, what, how, and when. Goals are resident oriented, specific problem-oriented goals that are, realistic, measureable, and directed toward the highest practicable function."	F 280		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 334		

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each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is

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medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

This REQUIREMENT is not met as evidenced by:

Based on interview and document review, the facility failed to ensure the medical record included documentation that the resident or representative was provided education about the benefits and potential side effects of pneumococcal immunization after refusal for 1 of 5 residents (R4) reviewed for pneumococcal immunization.

Findings include:

R4 was admitted to the facility on 9/28/16. Immunization records revealed R4 had refused the Prevnar 13 pneumococcal vaccine, but did not provide evidence that education of benefits and potential side effects had been given to R4.

On 12/15/16, at 1:44 p.m., the director of nursing

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F 334	Continued From page 7 (DON) confirmed that R4 had refused the vaccine, and said staff should document when risks and benefits were given. The DON said she would try to find documentation of risks and benefits in the medical record. No documentation was provided. On 12/15/16, at 3:13 p.m., the assistant director of nursing (ADON) explained that she spoke to R4 about risks and benefits, but did not chart the conversation in the medical record. The ADON said risks and benefits should be documented in the notes section of the immunizations tab in the patient medical record. Review of the Immunizations: Pneumococcal Vaccines (PPSV23 and PCV13) policy, last revised 2/2016, revealed the requirement to provide the resident with the current Vaccine Information Statements (VIS) which include benefits and potential side effects, and to document the date of the VIS in the resident's medical record.	F 334		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		

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F 356	Continued From page 8 resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post an accurate resident census. This had the potential to affect	F 356		

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the entire facility.

Findings include:

Upon entrance to the facility on 12/12/16, at 11:30 a.m., facility staff said the current resident census was 70. During an initial tour of the facility on 12/12/16, at 12:59 p.m., the resident census posted by the facility showed 69 residents were in the building during the 7:00 a.m. - 3:30 p.m. shift.

When asked about the discrepant resident census on 12/12/16, at 1:13 p.m., the director of nursing (DON) said the current census was actually 68 because two residents had been discharged to a transitional care facility. The DON explained one resident discharged on 12/6/16, and the other on 12/9/16. The DON said she was having someone update the posted resident census.

Observation on 12/13/16, at 8:18 a.m. confirmed the facility updated the posting from 12/12/16. A line had been drawn through the previous census of 69, and 68 was written next to it along with a note about the discharge to a transitional care unit.

On 12/15/16, at 9:40 a.m., human resources staff (HR-2) said she was in charge of updating the staff and resident census for each shift, and that she posted the census as close to the beginning of each shift as possible. HR-2 confirmed that she updated the census posted on 12/12/16, and explained that if someone notified her of a change, she would update the form and sometimes make a note about why the number changed.

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F 356	Continued From page 10 A Weekly Census Report was run on 12/15/16, at 2:06 p.m. for the resident census on 12/5/16 through 12/15/16. Comparison between the Weekly Census Report and the posted resident census revealed discrepancies on the following dates: 12/5/16, 12/6/16, 12/7/16, 12/8/16, 12/10/16, 12/11/16, and 12/13/16.	F 356		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment	F 371		

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sanitation procedures that would minimize the possibility of food borne illness in the main kitchen. This had the potential to affect all 68 residents in the facility, who were served food out of the kitchen. In addition, the facility failed to follow food safety procedures in 2 of 5 kitchenettes having the potential to affect all 68 residents residing in the facility.

Findings include:

During the tour of the kitchen on 12/12/16, at 1:00 p.m. the following sanitation problems were observed and confirmed by the dietary manager (DM) and sous chef (SC).

- a deep fryer located next to the six burner stove/grill had heavy food debris on the fryer shelf, the sides of the fryer and in the oil. The outside right side of the fryer had heavy brown, greasy substance down the entire side of the unit as well on the left side of the six burner stove/grill. The floor below and behind both units contained drippings of brown, greasy buildup of food debris. The DM stated the fryer was used "last week and had not been cleaned yet."

- Six burner stove/grill with two ovens located below the unit had blackened/greasy burnt residue on the inside of the oven door and on the bottoms of each oven. On and around all five stove knobs there was a heavy buildup of a brown substance. DM and SC verified the ovens and knobs were dirty and needed to be cleaned.

- The fourth floor refrigerator/freezer was observed to contain food items that were either not covered, labeled and/or dated. In the refrigerator, there was a large uncovered plastic

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bowl of ice with the ice scoop sitting directly in the ice. In addition, there were two pastries on a plastic plate, a large bowl of mixed fresh fruit, both covered, but not labeled nor dated. In the freezer there were four cups with a scoop of chocolate ice cream on a tray, uncovered, not labeled nor dated.

- The second floor refrigerator/freezer was observed to contain food items that were either expired, opened not dated or not covered. In the refrigerator there was an unlabeled, opened eight ounce can of Ensure nutritional supplement (approximately 1/4 full) with a piece of tape over the opening, an unopened thawed, four ounce Mighty Shake carton was not labeled nor dated, two eight ounce skim milk cartons with expiration date of 12/10/16 and two 64 ounce skim milk plastic jugs (one unopened, one opened, approximately 1/2 full) with expiration date of 12/8/16.

During interview on 12/12/16, at 1:20 p.m. DM stated he did not know where the items came from, verified the items should not have been in the refrigerator and removed them.

On 12/13/16, at 12:19 p.m. another uncovered plastic bowl of ice with the ice scoop sitting directly in the ice was observed. Registered nurse (RN)-C stated the ice was supposed to be covered and the "ice scoop is often in the ice."

During a follow-up kitchen tour on 12/15/16, at 11:40 a.m. the following sanitation concern was observed and verified by the DM.

- the six stovetop burners on the stove/grill had a heavy buildup of a greasy black substance on/in

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F 371	Continued From page 13 all corners of each of the six burner grates and approximately 3-4 inches high on the entire backsplash of the stove. During interview on 12/15/16, at 11:47 a.m. the DM stated the stove top was cleaned last week, but the "carbon was not removed." DM stated they needed to use a steel brush and that the stove top and burners are cleaned weekly. DM verified they do not have a sign off sheet for any of the cleaning responsibilities, the "porter' was responsible to clean the equipment, not the cooks. DM stated they had a cleaning checklist, not necessarily a cleaning policy. In addition, DM stated "ultimately we are responsible for the floor refrigerators." Review of the Little Sisters of the Poor/Holy Family Residence Cleaning Checklist, dated 12/15/16, listed weekly cleaning responsibilities that included the stove top and burners and to polish all stainless steel surfaces and monthly responsibilities that included cleaning the side-by-side ovens. The cleaning checklist lacked direction for cleaning and assigned responsibility for the floor refrigerators/freezers.	F 371		
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not	F 428		

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F 428	Continued From page 14 limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action	F 428		

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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 428	Continued From page 15 to protect the resident. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not ensure that a licensed pharmacist reviewed the medication regimen (MR) at least monthly for 1 of 5 residents (R32) reviewed for unnecessary medications. In addition, 3 other residents' (R14, R23, R58) MR was not reviewed monthly. Findings include: R32's diagnoses included dementia, major depression and diabetes indicated on the Admission Record dated 12/15/16. R14's diagnoses included chronic kidney disease, diabetes and adjustment disorder with depression indicated on the Admission Record dated 12/15/16. R23's diagnoses included heart failure, hypertension and chronic kidney disease indicated on the Admission Record dated 12/15/16. R58's diagnoses included Alzheimer's disease, hypertension and heart disease indicated on the Admission Record dated 12/15/16. After review of R32's, R14's, R23's and R58's medical record, all four records lacked evidence of documentation of the consulting pharmacist's medication review in the month of October, 2016. Review of the former Consultant Pharmacist (CP) Activity Report dated 10/31/16, indicated 68 resident records were reviewed.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245524	A. BUILDING _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

(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 428	Continued From page 16	F 428		

Review of the Little Sisters of the Poor Record of Drug Regimen Review Report dated 10/31/16, indicated 68 residents' medical records were reviewed on either 10/18/16 or 10/27/16, however the medical records of R32, R14, R23 and R58 were not reviewed.

Review of the Daily Census dated 10/27/16, indicated the daily census was 72 at the time of the Consultant Pharmacist Medical Review.

Review of email communication from the CP dated 10/31/16, indicated the end of month October reports for the entire facility were attached and "let me know if there are any questions or concerns - as you know, I had some Point Click access issues. There ended up being 4 residents I was not able to access, but we will make sure to get them November."

During interview on 12/14/2016, at 3:02 p.m., the the director of nursing (DON) stated the pharmacist that completed the medication review at the time is no longer employed by the facility. DON verified there were no October medication reviews completed by the CP for all four residents (R32, R14, R23 and R58) because she was having point click care access issues on the day of the medication review.

During interview on 12/15/16, at 8:51 a.m. the DON stated she call the CP who stated she had completed the reviews but there was no documentation found in their records.

Review of the Merwin LTC (long term care) Pharmacy Consultant Pharmacist Duties dated 1/27/15, indicated the CP was responsible for

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LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

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F 428	Continued From page 17 providing the required services in accordance with local, state and federal laws and regulations, facility policies and procedures and community standards of professional practice. The services included, reviewing the medication regimen of each resident and documenting the review and findings and submitting a written report of findings and recommendations resulting from the review of medication regimen and nursing documentation records to the attending physician and/or DON.	F 428		
F 465 SS=E	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure the environment was maintained in a safe and comfortable manner for 4 of 10 residents (R14, R13, R40, R63) reviewed for environmental concerns. Findings include: On 12/15/16, at 10:11 a.m. during environmental tour with the chief maintenance engineer (CME), the following concerns were noted.	F 465		

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F 465	Continued From page 18	F 465		

R14's bathroom commode was observed with a broken plastic hole missing from the front right arm rest measuring approximately one inch by one and one-half inches. In addition, there were two slight cracks along the front and back inside edges of the left plastic arm rest.

On 12/15/16, at 10:11 a.m. CME stated he was not aware of the broken commode. CME approached registered nurse (RN)-A who indicated she was not aware of the broken commode, would attach a yellow repair slip, and take it down to the shop for repair.

On 12/15/16, at 10:49 a.m. CME stated they have a list of items they check every day. Maintenance staff does walking rounds and computerized monitor rounds. They check boiler water temperatures on the computer daily. They also have thermometers on heating equipment which they check visually every day. In addition, they also do monthly, quarterly, semi-annual and annual checks. CME stated room temperatures are not checked daily, but they check heat source air handlers every day which is part of daily rounds. CME stated when floor staff have problems or concerns, they complete a yellow repair slip for any items which need repair. CME indicated all units have yellow repair slips they complete as necessary. CME further stated if any staff have a critical issue, they call maintenance for repair.

On 12/15/16, at 10:59 a.m. a yellow repair slip was observed hanging on the board outside CME's office door. CME stated he removes the yellow slip, performs indicated repairs and files repair slips in CME's office file drawer.

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F 465	Continued From page 19	F 465		

On 12/12/16, at 6:30 p.m. R13 indicated room was usually cold because it had two windows. R13 indicated she drew the window blinds which helped. On 12/15/16, at 10:15 a.m. CME entered R13's room to check the temperature, which read 69 degrees. CME checked the radiator control and adjusted the fan to blow more room air.

On 12/12/16, at 3:16 p.m. R40 indicated room was not warm enough and would tell the nurse to adjust it. On 12/15/16, at 10:20 a.m. CME entered room and checked the temperature which read 69.4 degrees. CME turned the fan blower higher and the heat to 75 degrees. He asked R40 to call him with any requests.

On 12/12/16, at 2:30 p.m. R63 indicated room was cold because R63 slept next to a window and would add extra blankets. On 12/15/16, at 10:25 a.m. R63 stated it was always cold when near the window. CME checked the room temperature which read 73 degrees and turned the fan blower up.

On 12/15/16, at 10:30 a.m. CME stated he was not aware of room temperature concerns, stated residents should inform staff when they need room temperature adjustments and stated each room had a temperature control. CME further stated he would coordinate with staff and residents to ensure rooms were comfortable.

On 12/15/16, at 1:50 p.m. CME stated the facility was currently in the process of adding an electronic repair maintenance system.

Facility's undated Work Requisition Policy revealed: "Work/Repair requisitions are available at all nursing stations and in the first floor copy

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	245524	A. BUILDING _____ B. WING _____	12/15/2016

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F 465	Continued From page 20 room... Please fill out all information to include the date and location of the item needing attention... Requisitions will be taken to the shop area and hung up with the back side showing. Maintenance staff will prioritize the requests based upon the below schedule... Any Priority level 5 should initiate a phone call to the maintenance staff... Maintenance will keep record of the completed requisitions in the engineering office."	F 465		

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	245524	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/14/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY At the time of this survey, LITTLE SISTERS OF THE POOR was found to be in compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and National Fire Protection Association (NFPA) Standard 101 - 2012 edition, Chapter 19 Existing Health Care. This 5-story building constructed in 1977 was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a capacity of 73 beds. At the time of survey the census was 69. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
December 28, 2016

Sr. Mary Elizabeth Anderson, Administrator
Little Sisters of the Poor
330 Exchange Street South
Saint Paul, MN 55102

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5524026

Dear Sr. Anderson:

The above facility was surveyed on December 12, 2016 through December 15, 2016 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
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
	00763	A. BUILDING: _____ B. WING _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December12 through December 15, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include falls for 1 of 3 residents (R50) who was reviewed for accident. Findings include: R50 occurrence report sheets indicated R50 had multiple falls dated 7/4/16 and 11/17/16. Care Plan: Problem: "...FALLS: 7/4/16, 11/17/16 FX Right pelvis sustained ...Fall: 11/17/16 Fracture right pelvis. Scheduled pain meds: ES Tylenol. Resident became nauseated/vomiting	2 570		

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2 570	Continued From page 3 from Norco and Tramadol. Hospital 11/23/16." However, the care plan lacked goals and interventions. The Incident Report dated 11/17/16, read, "Resident was heard screaming, then she was found lying on her back, on the floor in the hallway, between room 415 and 412, head by the wall, leg straight, both hands supporting the back of head, the can [cane] struck in the crotch. A&O [alert and oriented] per norm [normal]. 'I was pushing the wheelchair in front of me [with my can [cane] hanging to the back of the W/C [wheel chair], the can [cane] fell and I triped [sic] on it. I fell on my right side, I did not hit my head anywhere.' VS [vital signs] and neuro checked. No s/s [signs or symptoms] of injure noted. Resident able to move all extremnities [sic]. C/O [complain of] stiffness to right hip but says it is not out of the oridinary [sic]. She was lifted from the floor by Hoyer lift and assist of 3 and assisted to bed ..." The Fall Assessment done on 11/17/16, read, "Resident unwitnessed fall w [with]/sustained pelvic fracture. Resident is not able to bear weight without assistance at this time. Transfers assist of one. Orthostatic BPs [blood pressures] done with assistance laying 139/50 P64, Standing 142/58 P58, 112/56 P68. Tramadol for pain added to her medications as of 1/22/16." R50's Care Area Assessment (CAA) dated 11/28/16, indicated, "Problem: CAA triggered for fall due to actual fall w/major sustained injury [right pubic rami fracture] 11/17/16. [R50] was in hallway doing her normal daily activity when fall occurred. [R50] is normally (I) [independent] with walking w/a device, has had increased problems with prosthesis over the past few months and she	2 570		

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2 570	Continued From page 4 has been using the W/C more to get around." On 12/15/16, at 11:50 a.m. registered nurse (RN)-B verified R50's fall care plan lacked goals and interventions and stated, RN-B would discuss with director of nursing (DON) about it because she knew after a fall, the interdisciplinary team (IDT) always met to discuss about what exactly happen. IDT would look at what needed to be done for goal and interventions to prevent falls from occurring again. On 12/15/16, at 11:56 a.m. DON confirmed R50's fall care plan lacked goals and interventions and indicated, "I can see that is not updated in the care plan. We spoke to [R50] about it and [R50] but it is not in the care plan. My expectation is the fall goal and interventions should be care plan." Policy and procedure titled PROCEDURE FOR FALLS with revised date 7/16, read, "9. Update the care plan with the date of the fall and any other factors that are pertinent. Place an intervention on the CP [care plan]." Policy and procedure titled CARE PLAN dated 10/10, revealed, "5. Care plans are reviewed and discussed individually. B. Approaches are written clearly to be understood by all and include specific department responsible for approaches. Approaches must reflect Interdisciplinary Team involvement. C. Concerns, problems, needs and/or strengths have a corresponding goal. The format for a goal is who, what, how, and when. Goals are resident oriented, specific problem-oriented goals that are, realistic, measureable, and directed toward the highest practicable function." SUGGESTED METHOD OF CORRECTION: The	2 570		

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LITTLE SISTERS OF THE POOR	330 EXCHANGE STREET SOUTH SAINT PAUL, MN 55102

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2 570	Continued From page 5 director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness in the main kitchen. This had the potential to affect all 68 residents in the facility, who were served food out of the kitchen. In addition, the facility failed to follow food safety procedures in 2 of 5 kitchenettes having the potential to affect all 68 residents residing in the facility. Findings include: During the tour of the kitchen on 12/12/16, at 1:00 p.m. the following sanitation problems were observed and confirmed by the dietary manager (DM) and sous chef (SC).	21015		

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21015	Continued From page 6 - a deep fryer located next to the six burner stove/grill had heavy food debris on the fryer shelf, the sides of the fryer and in the oil. The outside right side of the fryer had heavy brown, greasy substance down the entire side of the unit as well on the left side of the six burner stove/grill. The floor below and behind both units contained drippings of brown, greasy buildup of food debris. The DM stated the fryer was used "last week and had not been cleaned yet." - Six burner stove/grill with two ovens located below the unit had blackened/greasy burnt residue on the inside of the oven door and on the bottoms of each oven. On and around all five stove knobs there was a heavy buildup of a brown substance. DM and SC verified the ovens and knobs were dirty and needed to be cleaned. - The fourth floor refrigerator/freezer was observed to contain food items that were either not covered, labeled and/or dated. In addition, there were two pastries on a plastic plate, a large bowl of mixed fresh fruit, both covered, but not labeled nor dated. In the freezer there were four cups with a scoop of chocolate ice cream on a tray, uncovered, not labeled nor dated. - The second floor refrigerator/freezer was observed to contain food items that were either expired, opened not dated or not covered. In the refrigerator there was an unlabeled, opened eight ounce can of Ensure nutritional supplement (approximately 1/4 full) with a piece of tape over the opening, an unopened thawed, four ounce Mighty Shake carton was not labeled nor dated, two eight ounce skim milk cartons with expiration date of 12/10/16 and two 64 ounce skim milk plastic jugs (one unopened, one opened,	21015		

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21015	Continued From page 7 approximately 1/2 full) with expiration date of 12/8/16. During interview on 12/12/16, at 1:20 p.m. DM stated he did not know where the items came from, verified the items should not have been in the refrigerator and removed them. During a follow-up kitchen tour on 12/15/16, at 11:40 a.m. the following sanitation concern was observed and verified by the DM. - the six stovetop burners on the stove/grill had a heavy buildup of a greasy black substance on/in all corners of each of the six burner grates and approximately 3-4 inches high on the entire backsplash of the stove. During interview on 12/15/16, at 11:47 a.m. the DM stated the stove top was cleaned last week, but the "carbon was not removed." DM stated they needed to use a steel brush and that the stove top and burners are cleaned weekly. DM verified they do not have a sign off sheet for any of the cleaning responsibilities, the "porter' was responsible to clean the equipment, not the cooks. DM stated they had a cleaning checklist, not necessarily a cleaning policy. In addition, DM stated "ultimately we are responsible for the floor refrigerators." Review of the Little Sisters of the Poor/Holy Family Residence Cleaning Checklist, dated 12/15/16, listed weekly cleaning responsibilities that included the stove top and burners and to polish all stainless steel surfaces and monthly responsibilities that included cleaning the side-by-side ovens. The cleaning checklist lacked direction for cleaning and assigned responsibility for the floor refrigerators/freezers.	21015		

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21015	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21075	MN Rule 4658.0645 Ice Ice must be stored and handled in a sanitary manner. Stored ice must be kept in an enclosed container. If the container is not mechanically cooled, it must be cleaned at least daily and more often if needed. If an ice scoop is used, the scoop must be stored separately to prevent the handle from contact with the ice. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness in the main kitchen. In addition, the facility failed to follow food safety procedures in 2 of 5 kitchenettes having the potential to affect all 68 residents residing in the facility. Findings include: During the tour of the kitchen on 12/12/16, at 1:00	21075		

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21075	Continued From page 9 p.m. the following sanitation problems were observed and confirmed by the dietary manager (DM) and sous chef (SC). - The fourth floor refrigerator/freezer was observed to contain a large uncovered plastic bowl of ice with the ice scoop sitting directly in the ice. On 12/13/16, at 12:19 p.m. another uncovered plastic bowl of ice with the ice scoop sitting directly in the ice was observed. Registered nurse (RN)-C stated the ice was supposed to be covered and the "ice scoop is often in the ice." During a follow-up kitchen tour on 12/15/16, at 11:40 a.m. the following sanitation concern was observed and verified by the DM. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure safe and appropriate dietary services. The administrator or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21075		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		

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21426	Continued From page 10 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was performed for 2 of 5 employees (E1 and E2) reviewed for TB screening before having contact with residents. Findings include: E2's hire date was 8/3/16. E2 had a first step tuberculin skin test (TST) from a previous employer on 6/15/16 that was negative with 0 millimeters of induration. E2 did not have a second step TST On 12/15/16 at 3:36 p.m., the assistant director of nursing (ADON) confirmed E2 had not received the two step TST or TB blood test to date, and confirmed that E2 did have contact with residents on the job. The ADON said employees were supposed to have TB screening done before they	21426		

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21426	Continued From page 11 started working, and that E2's screening fell through the cracks. The ADON said she became aware of the problem on 12/15/16 after she looked for TB blood test results and learned E2 never had a TB blood test. E1's hire date was 6/29/16. E1 had a first step TST on 6/23/16 that was negative with 0 millimeters of induration. E1 did not have a second step TST. E1 had a TB blood test on 11/16/16 that was negative. On 12/15/16 at 3:30 p.m., the ADON confirmed E1 did not have a second step TST because E1 was on leave shortly after being hired and missed it. The ADON confirmed and that E1 had a TB blood test after hire, on 11/16/16. At 3:56 p.m., human resources staff (HR2) confirmed that E1 was on leave after being hired. HR2 explained that E1 returned to work and had contact with residents starting 9/6/16. The Tuberculosis Program-Employee policy, last revised 3/12, required employees of the Little Sisters of the Poor to be screened "prior to employment to decrease the risk of the introduction of Tuberculosis into the facility." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review	21530		

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21530	Continued From page 12 A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 13 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not ensure that a licensed pharmacist reviewed the medication regimen (MR) at least monthly for 1 of 5 residents (R32) reviewed for unnecessary medications. In addition, 3 other residents' (R14, R23, R58) MR was not reviewed monthly. Findings include: R32's diagnoses included dementia, major depression and diabetes indicated on the Admission Record dated 12/15/16. R14's diagnoses included chronic kidney disease, diabetes and adjustment disorder with depression indicated on the Admission Record dated 12/15/16. R23's diagnoses included heart failure, hypertension and chronic kidney disease indicated on the Admission Record dated 12/15/16. R58's diagnoses included Alzheimer's disease, hypertension and heart disease indicated on the Admission Record dated 12/15/16. After review of R32's, R14's, R23's and R58's medical record, all four records lacked evidence of documentation of the consulting pharmacist's medication review in the month of October, 2016. Review of the former Consultant Pharmacist (CP) Activity Report dated 10/31/16, indicated 68 resident records were reviewed.	21530		

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21530	Continued From page 14 Review of the Little Sisters of the Poor Record of Drug Regimen Review Report dated 10/31/16, indicated 68 residents' medical records were reviewed on either 10/18/16 or 10/27/16, however the medical records of R32, R14, R23 and R58 were not reviewed. Review of the Daily Census dated 10/27/16, indicated the daily census was 72 at the time of the Consultant Pharmacist Medical Review. Review of email communication from the CP dated 10/31/16, indicated the end of month October reports for the entire facility were attached and "let me know if there are any questions or concerns - as you know, I had some Point Click access issues. There ended up being 4 residents I was not able to access, but we will make sure to get them November." During interview on 12/14/2016, at 3:02 p.m., the the director of nursing (DON) stated the pharmacist that completed the medication review at the time is no longer employed by the facility. DON verified there were no October medication reviews completed by the CP for all four residents (R32, R14, R23 and R58) because she was having point click care access issues on the day of the medication review. During interview on 12/15/16, at 8:51 a.m. the DON stated she call the CP who stated she had completed the reviews but there was no documentation found in their records. Review of the Merwin LTC (long term care) Pharmacy Consultant Pharmacist Duties dated 1/27/15, indicated the CP was responsible for providing the required services in accordance with local, state and federal laws and regulations,	21530		

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21530	Continued From page 15 facility policies and procedures and community standards of professional practice. The services included, reviewing the medication regimen of each resident and documenting the review and findings and submitting a written report of findings and recommendations resulting from the review of medication regimen and nursing documentation records to the attending physician and/or DON. SUGGESTED METHOD OF CORRECTION: The administrator, DON and CP, could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The DON or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Forty (40) days.	21530		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure the environment was maintained in a safe and comfortable	21685		

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21685	Continued From page 16	21685		

manner for 10 of 10 residents (R14, R57, R19, R11, R25, R28, R48, R13, R40, R63) reviewed for environmental concerns. This had the potential to affect all 68 residents residing in the facility.

Findings include:
On 12/15/16, at 10:11 a.m. during environmental tour with the chief maintenance engineer (CME), the following concerns were noted.
R14's bathroom commode was observed with a broken plastic hole missing from the front right arm rest measuring approximately one inch by one and one-half inches. In addition, there were two slight cracks along the front and back inside edges of the left plastic arm rest.

On 12/15/16, at 10:11 a.m. CME stated he was not aware of the broken commode. CME approached registered nurse (RN)-A who indicated she was not aware of the broken commode, would attach a yellow repair slip, and take it down to the shop for repair.

On 12/15/16, at 10:49 a.m. CME stated they have a list of items they check every day. Maintenance staff does walking rounds and computerized monitor rounds. They check boiler water temperatures on the computer daily. They also have thermometers on heating equipment which they check visually every day. In addition, they also do monthly, quarterly, semi-annual and annual checks. CME stated room temperatures are not checked daily, but they check heat source air handlers every day which is part of daily rounds. CME stated when floor staff have problems or concerns, they complete a yellow repair slip for any items which need repair. CME indicated all units have yellow repair slips they complete as necessary. CME further stated if any

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21685	Continued From page 17 staff have a critical issue, they call maintenance for repair. On 12/15/16, at 10:59 a.m. a yellow repair slip was observed hanging on the board outside CME's office door. CME stated he removes the yellow slip, performs indicated repairs and files repair slips in CME's office file drawer. On 12/12/16, at 6:30 p.m. R13 indicated room was usually cold because it had two windows. R13 indicated she drew the window blinds which helped. On 12/15/16, at 10:15 a.m. CME entered R13 ' s room to check the temperature, which read 69 degrees. CME checked the radiator control and adjusted the fan to blow more room air. On 12/12/16, at 3:16 p.m. R40 indicated room was not warm enough and would tell the nurse to adjust it. On 12/15/16, at 10:20 a.m. CME entered room and checked the temperature which read 69.4 degrees. CME turned the fan blower higher and the heat to 75 degrees. He asked R40 to call him with any requests. On 12/12/16, at 2:30 p.m. R63 indicated room was cold because R63 slept next to a window and would add extra blankets. On 12/15/16, at 10:25 a.m. R63 stated it was always cold when near the window. CME checked the room temperature which read 73 degrees and turned the fan blower up. On 12/15/16, at 10:30 a.m. CME stated he was not aware of room temperature concerns, stated residents should inform staff when they need room temperature adjustments and stated each room had a temperature control. CME further stated he would coordinate with staff and	21685		

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21685	Continued From page 18 residents to ensure rooms were comfortable. On 12/15/16, at 1:50 p.m. CME stated the facility was currently in the process of adding an electronic repair maintenance system. Facility's undated Work Requisition Policy revealed: "Work/Repair requisitions are available at all nursing stations and in the first floor copy room... Please fill out all information to include the date and location of the item needing attention... Requisitions will be taken to the shop area and hung up with the back side showing. Maintenance staff will prioritize the requests based upon the below schedule... Any Priority level 5 should initiate a phone call to the maintenance staff... Maintenance will keep record of the completed requisitions in the engineering office." SUGGESTED METHOD FOR CORRECTION: The Maintenance Director could develop a quality assurance system to ensure that areas of the facility that need repair are reported immediately and repairs done accordingly. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21685		