Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 1, 2023

Administrator
Gundersen St Elizabeth's Care Center
1200 Fifth Grant Boulevard West
Wabasha, MN 55981

RE: CCN: 245487
Cycle Start Date: January 12, 2023

Dear Administrator:

On January 12, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 12, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 12, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING ______ B. WING ______	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN ST ELIZABETH'S CARE CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/9/23 through 1/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. 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 the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 1/9/23 through 1/12/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H54877336C (MN86341), however NO deficiencies were cited due to actions implemented by the facility prior to survey: AND The following complaints were found to be UNSUBSTANTIATED: H54877335C (MN86478), H54877337C (MN86858), H54877378C (MN90012) and H5487024C (MN82198). The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/09/2023

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

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F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete an assessment on an active, daily smoker, for independence and safety with smoking, handling and storing smoking paraphernalia for 1 of 1 residents (R31) reviewed for accidents . Findings include: According to R31's annual Minimum Data Set assessment dated 12/16/22, R31 was assessed as being cognitively intact, used a walker for ambulation and required assistance and cueing for hygiene purposes at the facility. R31's care plan dated 3/8/22 indicated related to	F 689	Smoking safety assessment completed 1/12/2023 on R31. Smoking safety assessment and care plan review for R31 will be completed on a quarterly basis or at time of a significant change in condition for the duration of time this resident is determined safe and independently able to and chooses to leave the facility campus to smoke. Social worker team and Director of Nursing are responsible for ensuring completion of this assessment. Administrator will review medical record to	2/9/23

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F 689	Continued From page 2 smoking: "resident wishes will be respected whilst periodically providing education alternatives to current tobacco use." No other interventions were listed. On 1/9/23, at 1:30 p.m. R31 was observed standing outside of the facility, across the street, smoking a cigarette. R31 was appropriately dressed for the weather, wore a bright orange vest and was using a special walker with hand brakes and lights. When interviewed on 1/9/23, at 3:36 p.m. R31 was observed in his room where he had his cigarettes, and stated he kept his lighter on him. His lighter was not observed. R31 stated he kept his door closed at all times and other residents did not enter his room. R31 stated his intent to continue smoking, but understood he was not able to smoke on the facility property. R31 stated he had never had a problem with his smoking, had not suffered any burns, or burned his clothing. R31 stated staff were aware he smoked, but did not know if an assessment had been done for safety. When interviewed on 1/10/23, at 1:46 p.m. a licensed practical nurse (LPN)-A stated R31 was a known smoker and had been determined to be safe to go off campus to smoke. LPN-A stated a smoking assessment was not done by the nurses, but LPN-A thought the director of nursing (DON) would have done such an assessment, but did not know where the assessment could be found. LPN-A stated R31's smoking plan should be listed in his care plan, but also stated she was not able to locate the information in the chart. When interviewed on 1/10/23, at 2:45 p.m. the	F 689	verify completion of smoking safety assessment plan during the lookback period for the next three quarterly MDSs. Facility is a smoke free building and campus and will continue to communicate this expectation with referring entities and prospective residents/representatives. Facility will decline to admit residents that are active smokers and proceed with resident discharge process if residents begin smoking after admission if situation arises in future. Interim steps prior to completion of discharge process of resident identified as smoking after admission will include facility completing a smoking safety assessment and care plan development to optimize safety if resident chooses to leave facility grounds to smoke.	

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F 689	Continued From page 3	F 689		

DON stated assessments should be done annually and stored in the resident's hard chart. Findings from assessments should then go into the resident's care plan to provide communication appropriate interventions to staff. DON stated they were a non-smoking facility so R31 was not to smoke on the facility property and staff did not assist him with smoking.

When interviewed on 1/11/23, at 9:29 a.m. DON was not able to locate a smoking safety assessment. The facility administrator stated R31 had been observed smoking by staff, but no formal assessment had been done since he was not allowed to smoke on the facility grounds.

When interviewed on 1/11/23, at 12:34 p.m. the director of physical therapy (PT)-A stated R31 had been receiving services from both physical and occupational therapy. PT-A stated assessments were done to ensure R31 was safely independent ambulating outdoors on his own, but smoking safety was not addressed. PT-A stated occupational therapy worked on general safety awareness but nothing specific to smoking. PT-A stated she had addressed smoking cessation with R31, but he was not interested.

A facility policy titled Resident Smoking, dated 12/29/22, indicated the facility was a smoke-free facility and staff "may not offer to assist residents off campus to smoke or to go with staff on smoke breaks," and "resident care plan will reflect interventions to help with smoking cessation and adjustment to not smoking."

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	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**01/11/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/11/2023. At the time of this survey, GUNDERSON ST ELIZABETH'S CARE CENTER BLDG 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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Electronically Signed		02/09/2023

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

GUNDERSON ST ELIZABETH'S CARE CENTER - BLDG. 01 is a 1 story building with full basement.

The original building was constructed at 3 different times. The original building was constructed in 1970 and was determined to be of Type II (111) construction. The Chapel addition is 1-story with full basement, constructed in December 2003 and was determined to be of

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K 000	Continued From page 2 Type II (111) construction. The Four Season Sun Room addition is 1-story with no basement, constructed 2012 and was determined to be of Type V (111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition),	K 711	Fire safety plan document updated to identify that staff will call 911 by 2/17/2023. Centralized security will	2/17/23

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K 711	Continued From page 3 Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/11/2023 between 09:15 AM to 12:15 PM, it was revealed by a review of available documentation that the documentation presented for review, the Fire Safety Plan, instructed staff, "DO NOT CALL 9-1-1". An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 711	continue to call 911 at time of activation of smoke detector or pull station. Facilities maintenance team will be responsible for reviewing this and monitoring the practice during monthly fire drills throughout organization. Emergency preparedness lead and facilities maintenance director are responsible for corrective steps and monitoring of compliance. Audit findings will be reviewed at quarterly organizational safety meetings and additional corrective actions addressed as indicated.	
K 761 SS=C	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 761	Procedure that lists the 13-point	2/9/23

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K 761	Continued From page 4 and staff interview the facility failed to document fire-rated door inspection and testing per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, and 8.3.3.1, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/11/2023 between 09:15 AM to 12:15 PM, it was revealed by a review of available documentation that documentation was presented for review, that Door Inspections documentation contained a single signature sign-off with no cross-reference or correlation to the multi-point inspection required per door assembly. No additional documentation was provide to confirm that all points were inspected and if any door assemblies did not pass the inspection, or were repaired as a result of inspection findings. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	inspection process added to the fire management book 2/3/2023. Current work order PM software lists the 13-point inspection that is required and inspections have been completed on time. Facilities maintenance director will conduct routine audits to verify completion of door inspections and report deficient practices/corrective actions at quarterly organization safety meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		2/9/23

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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
K 918	Continued From page 5 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and test notification devices associated to the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3 and 6.5.4.1.1.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2 and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 918	2-hour load test completed 1/26/2023. Facilities maintenance director, in collaboration with vendor to ensure completion of required monthly testing and follow up as indicated. Facilities maintenance director (or designee) to report any abnormal findings or corrective actions required at quarterly organization safety meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN ST ELIZABETH'S CARE CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 6 On 01/11/2023 between 09:15 AM to 12:15 PM, it was revealed by a review of available documentation that the documentation presented for review identified that the diesel generator was not achieving 30% load during monthly testing. There was no follow-on documentation to confirm that an annual load-bank test of the generator was completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING ______	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN ST ELIZABETH'S CARE CENTER	**1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/11/2023. At the time of this survey, GUNDERSON ST ELIZABETH'S CARE CENTER BLDG 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/09/2023

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
	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING ______	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN ST ELIZABETH'S CARE CENTER	**1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

K 000 — K 000

Continued From page 1

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

GUNDERSON ST ELIZABETH'S CARE CENTER - Bldg. 02 is a 2 story building with full basement.

The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type II (222) construction. In 1939, an addition was constructed to the West Wing that was determined to be of Type II (222) construction. In

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING ______	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN ST ELIZABETH'S CARE CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 1961, an addition was constructed to the North Wing that was determined to be of Type II (222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building. Skilled Nursing Care is contained to a portion of the 2nd Floor of the Building The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 20 beds and had a census of 13 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2,	K 711		2/17/23

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	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING ______	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN ST ELIZABETH'S CARE CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

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K 711	Continued From page 3 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/11/2023 between 09:15 AM to 12:15 PM, it was revealed by a review of available documentation that the documentation presented for review, the Fire Safety Plan, instructed staff, "DO NOT CALL 9-1-1". An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 711	Fire safety plan document updated to identify that staff will call 911 by 2/17/2023. Centralized security will continue to call 911 at time of activation of smoke detector or pull station. Facilities maintenance team will be responsible for reviewing this and monitoring the practice during monthly fire drills throughout organization. Emergency preparedness lead and facilities maintenance director are responsible for corrective steps and monitoring of compliance. Audit findings will be reviewed at quarterly organizational safety meetings and additional corrective actions addressed as indicated.	
K 761 SS=C	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		2/9/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN ST ELIZABETH'S CARE CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

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K 761	Continued From page 4 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview the facility failed to document fire-rated door inspection and testing per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, and 8.3.3.1, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/11/2023 between 09:15 AM to 12:15 PM, it was revealed by a review of available documentation that documentation was presented for review, that Door Inspections documentation contained a single signature sign-off with no cross-reference or correlation to the multi-point inspection required per door assembly. No additional documentation was provide to confirm that all points were inspected and if any door assemblies did not pass the inspection, or were repaired as a result of inspection findings. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	Procedure that lists the 13-point inspection process added to the fire management book 2/3/2023. Current work order PM software lists the 13-point inspection that is required and inspections have been completed on time. Facilities maintenance director will conduct routine audits to verify completion of door inspections and report deficient practices/corrective actions at quarterly organization safety meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		2/9/23

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	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING ______	**01/11/2023**

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GUNDERSEN ST ELIZABETH'S CARE CENTER	**1200 FIFTH GRANT BOULEVARD WEST** **WABASHA, MN 55981**

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K 918	Continued From page 5 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and test notification devices associated to the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3 and 6.5.4.1.1.2 and NFPA 110 (2010	K 918	2-hour load test completed 1/26/2023. Facilities maintenance director, in collaboration with vendor to ensure completion of required monthly testing and follow up as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 6 edition), Standard for Emergency and Standby Power Systems, sections 8.4.2 and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/11/2023 between 09:15 AM to 12:15 PM, it was revealed by a review of available documentation that the documentation presented for review identified that the diesel generator was not achieving 30% load during monthly testing. There was no follow-on documentation to confirm that an annual load-bank test of the generator was completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	Facilities maintenance director (or designee) to report any abnormal findings or corrective actions required at quarterly organization safety meeting.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		2/17/23

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	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING _______________	**01/11/2023**

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K 920	Continued From page 7 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, section 400-8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/11/2023 between 09:15 AM to 12:15 PM, during a tour of the facility, it was revealed by observation that in the staff coffee break area, a 1-to-3 electrical tri-tap adapter was in use with appliances connected. The Maintenance Director removed the device at the time of discovery. 2. On 01/11/2023 between 09:15 AM to 12:15 PM, during a tour of the facility, it was revealed by observation in South corridor of the 1939 addition, that an extension cord was in use to power a holiday decoration. The Maintenance Director removed the extension cord at the time of discovery. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Facilities maintenance director corrected identified issues at time of survey 1/11/23. Environment of care rounds to be completed monthly to include observation for appropriate use of electrical outlets and power strips throughout facility. Facilities maintenance director (and designees) to correct any observed practices and share findings with department managers involved and just in time education to be completed as indicated. Survey findings and plan of correction shared with all staff through communication mode of email and internal messaging by 2/17/2023. All staff members continue to be required to complete annual safety education including fire safety.	

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 28, 2023

Administrator
Gundersen St Elizabeth's Care Center
1200 Fifth Grant Boulevard West
Wabasha, MN 55981

RE: CCN: 245487
Cycle Start Date: January 12, 2023

Dear Administrator:

On March 2, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us