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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YFCJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00672

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245345**
2.STATE VENDOR OR MEDICAID NO.
(L2) **100182500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE**
(L4) **800 SECOND AVENUE NORTHWEST**
(L5) **PLAINVIEW, MN** (L6) **55964**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/29/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(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 :
Kyla Einertson, HFE NE II 04/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/12/2015 (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
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/07/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245345

May 12, 2015

Ms. Paula Lewis, Administrator
St Isidore Health Center Of Greenwood Prairie
800 Second Avenue Northwest
Plainview, Minnesota 55964

Dear Ms. Lewis:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 8, 2015 the above facility is certified for:

53 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 53 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 30, 2015

Ms. Paula Lewis, Administrator
St Isidore Health Center Of Greenwood Prairie
800 Second Avenue Northwest
Plainview, Minnesota 55964

RE: Project Number S5345024

Dear Ms. Lewis:

On March 12, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 27, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 29, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 14, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 8, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 27, 2015, effective April 8, 2015 and therefore remedies outlined in our letter to you dated March 12, 2015, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245345	A. Building B. Wing	4/29/2015

Name of Facility	Street Address, City, State, Zip Code
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **04/08/2015**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/08/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/08/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/08/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/08/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/08/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	04/30/2015	31221	04/29/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/27/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245345	A. Building 01 - MAIN BUILDING 01 B. Wing	4/14/2015

Name of Facility	Street Address, City, State, Zip Code
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/08/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/kfd	Date: 04/30/2015	Signature of Surveyor: 25822	Date: 04/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/25/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245345	A. Building B. Wing 02 - CHAPEL	4/14/2015

Name of Facility	Street Address, City, State, Zip Code
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 04/08/2015	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/08/2015	ID Prefix Reg. # NFPA 101 LSC K0073	Correction Completed 04/08/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	4/30/2015	25822	04/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/25/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YFCJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00672

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245345**
2.STATE VENDOR OR MEDICAID NO.
(L2) **100182500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE**
(L4) **800 SECOND AVENUE NORTHWEST**
(L5) **PLAINVIEW, MN** (L6) **55964**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(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 :
Gail Sorensen, HFE NE II 03/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/02/2015 (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
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 12, 2015

Ms. Paula Lewis, Administrator
St Isidore Health Center Of Greenwood Prairie
800 Second Avenue Northwest
Plainview, Minnesota 55964

RE: Project Number S5345024

Dear Ms. Lewis:

On February 27, 2015, 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 8, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 8, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 May 27, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 27, 2015 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure staff spoke to residents in a dignified manner for 2 of 2 residents (R67, R42) reviewed for dignity. Findings Include: R67 was interviewed on 2/23/15, at 1:56 p.m. and asked, " Do staff treat you with respect and dignity?" R67 responded, " No, they [staff] talk down to you. I have been called honey and sweetie pie. I don't like that. I feel like they [staff] are talking down to me."	F 241	St. Isidore Health Center of Greenwood Prairie promotes care for residents in a manner and an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. The staff routinely interacts with residents and encourages/provides activities which assist the resident in experiencing the highest possible quality of life and which maintains and enhances his/her self-esteem and self-worth.	4/8/15

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

Electronically Signed | 03/20/2015

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 241	Continued From page 1 R67's resident admission record indicated she was admitted to the facility on 2/11/15 and had diagnoses that included but were not limited to aftercare following left joint replacement, diabetes mellitus type II and osteoarthrosis and did not indicate a preferred name. R67's initial care plan was reviewed and did indicate a preferred name. R67's brief interview for mental status completed on 2/17/15 indicated intact cognition with a score of 15. On 2/25/15 at 3:22 p.m. the director of nurses (DON) stated her expectation is staff calls the residents by their preferred name. If a resident prefers to be called something other than their given name it is documented on the face sheet and in their care plan. The DON verified it was a dignity issue to call a resident honey or sweetie pie if it was not the preference of the resident. The resident bill of rights dated 7/1/07, read, "Facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality." R42 was interviewed on 2/23/15, at 4:11 p.m. and asked, "Do staff treat you with respect and dignity?" R42 responded,"No, they [staff] call me honey or sweetheart, I would prefer they don't do that because it is belittling to me. They [staff] also talk to each other while they are taking care of me instead of talking to me." R42's admission record indicated she was admitted to the facility on 3/15/13 and had diagnoses that included but were not limited to Parkinson's, depressive disorder, and chronic pain and did not indicate preferred name. R42 ' s care plan last updated on 1/2/15 did not indicate a	F 241	The resident is asked how they preferred to be addressed as part of the admission process. The residents will also be asked if they are opposed to being addressed by a term of endearment. Their preferences will be addressed in the individualized plan of care and included on the care giver□s care reference cards. During the mandatory meetings March 25 and 26, 2015, the nursing staff will be reinstructed on the residents□ right to dignified and respectful treatment and interactions. Instruction will also include the need to 1) be sensitive to the residents□ psychosocial well-being 2) assure resident-focused conversation/interactions while providing resident cares/services 3) engage the resident in conversation as appropriate 4) recognize and respect the residents□ name preferences and 5) avoid addressing the resident by a term of endearment unless that preference has been expressed by the resident and is documented in the individualized plan of care. As part of the orientation process, new employees are instructed on the residents□ right to dignity and respect. Resident number 67 -- The staff was informed regarding the resident□s preferred form of address. The resident□s condition improved and she returned home March 5, 2015. Resident number 42 □ The staff was informed regarding the resident□s preferred form of address. The care plan	

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F 241	Continued From page 2 preferred name. R42's significant change Minimum Data Set (MDS) dated 12/21/14 indicated brief interview for mental status (BIMS) revealed intact cognition with a score of 15. During an interview on 2/26/15, at 9:10 a.m., social services (SS)-A director stated staff is not supposed to call residents nick names unless it was approved by the resident and the preferred name is care planned, the facility does not encourage terms of endearment.	F 241	was reviewed and updated accordingly. The Quality Assurance Coordinator will monitor compliance by random audits of staff/resident interaction weekly for one month. The Social Worker will ask the residents during their next quarterly care conference if they are being addressed by their preferred name/term. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the April Quality Assurance Committee meeting. Date of completion: April 8, 2015	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide bathing frequency choice for 1 of 3 (R42) reviewed for choices. Findings included: R42 was interviewed on 2/23/15, at 4:11 p.m. and when asked, "Do you choose how many times a week you take a shower or bath?" R42 responded, "No, I only take one shower a week	F 242	St. Isidore Health Center of Greenwood Prairie respects the resident's rights to 1) choose activities, schedules, and heath care consistent with his or her interests, assessments, and plans of care and 2) make choices about aspects of his or her life in the facility that are significant to the resident. The facility recognizes the right of the resident or resident representative	4/8/15

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F 242	Continued From page 3 now, I would prefer to take a shower twice a week, I have told them [staff] but they won't do that." R42 also explained she had chronic back and leg pain and showers helped relax her. R42's admission record indicated she was admitted to the facility on 3/15/13 and had diagnoses that included but were not limited to Parkinson's, depressive disorder, and chronic pain. R42's significant change Minimum Data Set (MDS) dated 12/21/14 indicated brief interview for mental status (BIMS) revealed intact cognition with a score of 15. The MDS indicated R42 was frequently incontinent of urine and occasionally incontinent of bowel. According to the preference for customary routine and activities interview; R42 indicated it was very important to choose what clothes to wear, choose between bathing types, and choose own bedtime. R42's care plan last updated on 1/2/15 was reviewed and read, "Set up weekly bath/shower per her preference." The care plan did not indicate what R42's preference of taking a bath or a shower was or preference of shower frequency, or mention past home routine. During an interview on 2/25/15, at 9:40 a.m., assistant director of nursing (ADON) stated on admission to the facility residents are assigned showers/bath times and days based on the room and bed they resided in. The staffing coordinator (SC)-E assisted in the coordination of scheduling bath/shower days and times. If the resident objects to what is offered then we made accommodations or if the resident had impaired skin integrity then we would have assigned more shower/bath days. The ADON was then asked, "On admission, is the resident asked how many showers they would like a week or what time they would like them?" ADON replied,"As far as I know they don ' t ask them [resident]."	F 242	to make informed choices about accepting or declining care and treatment including the right to determine his/her bathing schedule, frequency, and type of bath. The residents are encouraged to participate to the greatest extent possible in the care planning process and the staff assists them in exercising their rights by discussing with the resident (or the resident□s representative) the resident□s condition, treatment options, personal preferences, and any potential consequences of accepting or refusing the recommended treatment. As part of the admission process, residents are asked about preferences and the importance of choosing what to wear, type of bath, snack availability, locking up personal belongings, choosing arise/bedtime, having reading material available, listening to favorite music, keeping up with the news, participating in religious services/practices, etc. Attempts are made to follow preferences for cares and services to the greatest extent possible. The resident□s preferred bathing schedule, frequency of bathing, and type of bath (tub/shower/ bed bath) will be addressed and his/her preferences included in the individualized plan of care. The resident/legal representative will be asked about satisfaction with cares/services during the quarterly care conferences, with significant change and more often if indicated. During the mandatory meetings, the nursing staff will be informed of the	

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F 242	Continued From page 4 During an interview on 2/25/15, at 3:23 p.m. SC-E stated, when a resident was admitted they are assigned a shower/bath based on the room and bed number. SC-E further explained, "If the resident wants more than what is offered or doesn't like it, then we accommodate that." SC-E was not aware if the admitting nurse specifically asked the resident what their preference was for R42. During an interview on 2/25/15, at 3:26 p.m. licensed practical nurse (LPN)-A stated she participated in the resident admission process. LPN-A stated, showers and bath days are determined by room. LPN-A stated, "You tell them [residents] their assigned day and if there is a problem then we change it, but we ask if there is a preference between a bath and a shower." When LPN-A was asked, "Is the resident asked a preference of shower/bath day or is the shower/bath day assigned to them?" LPN-A stated, "Well, we ask them [resident] if it [bathing frequency] is ok." During an interview on 2/26/15, at 9:00 a.m., social service director (SSD)-A explained, baths and showers are set up as part of the admission process with completing the nursing paperwork. Showers/baths are assigned times and days unless the resident requested more often. The SSD-D stated, "They [residents] are offered a preference of time of day and if they want a shower or bath, if that doesn't work for the resident we are able to make some shifts." The social worker was asked, "On admission the resident is told which day (frequency) they will take a shower/bath versus being asked how many they would like or what their preference is? The SSD-A confirmed the residents are presented with bathing schedule versus being specifically asked how many showers/baths the	F 242	residents□ right to make choices regarding heath care services consistent with their interests, assessments, and plans of care including the right to have their bathing preferences respected. The nursing assistants have been advised that resident number 42 prefers two baths per week. The resident□s plan of care and the nursing assistants□ care reference cards have been updated to reflect the resident□s bathing preference. The social worker will ask the resident about her satisfaction with cares during their one-to-one visits. Respect for the resident□s right to self-determine and participate in health care decisions will be monitored by the Social Worker during one-on-one interviews, during the care conferences, and through feedback from Resident Council meetings. Any concerns will be communicated to the appropriate department manager/supervisor.	

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F 242	Continued From page 5 resident would have liked a week. The resident bill of rights dated 7/1/07, read, "Facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality."	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		4/8/15

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F 278	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code the quarterly Minimum Data Set (MDS) assessment for 1 of 1 resident (R24) reviewed who had a lesion and received an application of a dressing to the right foot at the time of the quarterly MDS assessment. Findings Include: R24's record was reviewed and the quarterly MDS dated 2/7/15, identified that R24 was cognitively intact with a brief interview mental status score of 15, and indicated that R24 had not had an application of a dressing to feet (with or without topical medications). R24's treatment administration record revealed R24 had a dressing change to the bottom of her right foot on 2/2/15 and 2/6/15 both occurring within the assessment reference dates (ARD) period of the MDS. R24's nurse progress note dated 2/4/15 read, "Area on the bottom of right foot is scabbed over with a dark colored scab. Area is not tender to touch and has no drainage and measures 0.5 in diameter. A Tegaderm foam dressing was applied for protection." On 2/26/15 at 9:53 a.m. the MDS coordinator who is licensed practical nurse (LPN)-D stated she missed coding the application of the dressing change at time of the quarterly MDS dated 2/7/15. LPN-D stated it was an oversight on her part and the MDS was inaccurate as the resident did receive applications of a dressing to her right	F 278	St. Isidore Health Center of Greenwood Prairie staff routinely completes assessments that accurately reflect each resident□s status. Assessments are completed according to CMS guidelines as outlined in the User□s Manual for the Resident Assessment Instrument. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals and signs to certify that the assessment is completed. Each individual who completes a portion of the assessment signs to certify the accuracy of that portion of the assessment. A registered nurse signs to certify that the assessment is complete. The nurse completing MDS section M1200 has been instructed to review the treatment sheets when completing the MDS assessments. The Minimum Data Set (MDS) assessment for resident number 24 has been modified to reflect a dressing application to the right foot. A corrected MDS was submitted to the State data base. The Assistant Director of Nursing has reviewed all residents with foot dressings for accurate MDS coding of Section M1200 I (application of dressing to feet); the assessments were found to be accurate. The accuracy of MDS coding of foot problems will be reviewed during the resident□s next quarterly care conference. If inaccuracies are found,	

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F 278	Continued From page 7 foot during the ARD period.	F 278	additional audits and staff training will be done. Compliance will be reviewed during the April Quality Assurance and Assessment Committee meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to provide directions to staff related to management and safety of dialysis services for 1 of 1 resident (R25) reviewed for dialysis services. Findings include:	F 280	St. Isidore Health Center of Greenwood Prairie routinely develops comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered	4/8/15

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F 280	Continued From page 8 R25 was interviewed on 2/26/15 at 10:40 a.m. R25 stated she had been receiving dialysis for over a year. She stated she was on a fluid restriction and would get fluids with meals and a small amount with her pills. She stated that at times she was thirsty. R25 stated that she received medications and food prior to going to dialysis and that she was rarely told if her laboratory values were incorrect. R25 did indicate that she experienced pain, but that the facility provided medications and position changes and that helped. R25's care plan dated 12/18/14 noted R25 had dialysis Tuesday, Thursday, and Saturday (this conflicts what the physician notes dated 1/12/15 reads), was on a therapeutic diet with fluid restriction of 1200 cubic centimeter (cc) and that daily intake monitoring was to be completed. The care plan did not identify the amount of fluid to be given by dietary and the amount to be given by nursing so the total amount was no more than 1200 cc per day. The care plan noted that dialysis was responsible for dressing changes to dialysis site and that it was not necessary to check the dialysis site for bruits or thrills, but the written plan of care did not address monitoring the dialysis site for infection or bleeding. The care plan did not address provision medications in case they could not get to the dialysis run or food prior to dialysis, emergency measures which includes directions if the shunt starts to bleed or emergency contact information in case the dialysis services needs to be contacted. The hospital discharge summary dated 12/11/14 identified diagnoses of chronic kidney disease stage 5, dialysis dependent, congestive heart	F 280	nurse with responsibility for the resident, the social worker, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the resident□s functional abilities and quality of life. The resident and his/her family/legal representative are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each assessment. The policies and procedures addressing management and safety of residents receiving dialysis services were reviewed and found appropriate. The nurse responsible for care plan development has been instructed to review the regulatory guidelines addressing dialysis services. During the March 25, 2015 mandatory meeting, the licensed nurses will be reinstructed on 1) the facility□s policies for care plan reviews and updates 2) the requirement that resident care plans be current at all times and 3) the responsibility shared by all nurses to update the care plans and 4) developing a plan of care that reflects the management and safety of residents receiving dialysis services. The policies and procedures for residents receiving dialysis services will be reviewed. During the March 26, 2015 mandatory meeting, the nursing assistants will be instructed to observe dialysis access sites for bleeding and to	

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F 280	Continued From page 9 failure, hypertension and peripheral vascular disease. The admission Minimum Data Set (MDS) dated 12/18/14 noted R25 was not cognitively impaired, required extensive assistance to complete activities of daily living experienced pain. The physician notes dated 1/12/15 indicated R25 received dialysis Monday, Wednesday and Friday for chronic kidney disease stage 5. The treatment administration record noted to check dressing site on central line every shift for bleeding, but did direct staff to monitor for signs of infection, or provide direction on what to do if bleeding or infection was a problem. At 2:00 p.m. on 2/26/15 registered nurse (RN)-B stated the facility did not have clear dialysis interventions to fully care for residents receiving dialysis.	F 280	report any symptoms of infection (pain, swelling, redness) to the licensed nurse. The care plan for resident number 25 has been reviewed and revised to reflect 1) dialysis services every Monday, Wednesday, and Friday 2) monitoring of the dialysis access site for infection and bleeding 3) fluid restricted diet with the amount of fluids offered by dietary and nursing identified and 4) dialysis provider emergency contact information. The resident does not receive any routine medications administered by the dialysis center staff; the resident is not routinely at the dialysis center at meal times. The service agreement with the dialysis provider addresses many of the above issues and has been incorporated into the care plan by reference. The dialysis related care plan of resident number 25 was audited for completeness and accuracy by the Director of Nursing/Assistant Director of Nursing. The interdisciplinary team will continue to review care plans for completeness, accuracy, and relevancy during the resident□s quarterly care conferences, with a significant changes in condition, and more often if necessary. Compliance will be reviewed during the April quarterly Quality Assessment and Assurance Committee meeting.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		4/8/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 281	Continued From page 10 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a temporary care plan to assist a newly admitted resident to manage current pain for 1 of 1 resident (R66) reviewed for pain control. Findings include: R66 was interviewed on 2/23/15 at 2:20 p.m. R66 stated that she did not have pain in legs and shoulders at this moment and that she took Tylenol (mild pain reliever) which seemed to work. However, R66 stated that she had trouble lifting her right arm to comb her hair or get dressed without having pain. R66 was sitting in a recliner chair. She displayed guarded movement of her right arm and shoulder. On 2/24/15 at 8:15 a.m. R66 was in the dining room and stated that her shoulder hurt this morning. R66 ' s temporary care plan dated 2/20/15 was provided. The care plan indicated R66 needed assist of one staff with bathing, and setting up supplies; indicated R66 needed assist of one with transfers, ambulation, and wheelchair locomotion, indicated R66 was alert and oriented and able to make needs known. The temporary care plan did not identify the chronic shoulder pain and any assistance the resident would require managing the pain and her activities of daily living while in the facility. The pain assessment dated 2/20/25 indicated R66 had diagnoses that included chronic pain,	F 281	St. Isidore Health Center of Greenwood Prairie provides or arranges for resident cares and services by appropriate qualified persons that meet accepted practice standards for quality. The procedures for identifying and managing pain that is present at or soon after admission and before the development of the comprehensive interdisciplinary care plan were reviewed. A designated space to address pain symptoms, goals, and interventions has been added to the initial care plan form. During the mandatory March 25, 2015 meeting, the nursing staff will be instructed on the revisions to the Initial Care Plan form, the importance of early identification, and management of pain symptoms. The condition of resident number 66 improved and she moved home March 6, 2015. The need for the initial plan of care to address pain management has been reviewed by the management staff and is being addressed as part of the facility□s ongoing quality improvement program and staff education activities. The Initial Care Plan forms for new admissions will be audited by the Director of Nursing/designee for one month to	

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F 281	Continued From page 11 ischemic heart disease, muscle weakness, and osteoarthrosis (a condition of chronic arthritis, usually mechanical, without inflammation). The assessment indicated the resident received Tylenol and Gabapentin (seizure medication used for its ability to reduce pain). The assessment noted the resident complained of occasional pain that was rated at 6 on a 0-10 scale (0 no pain and 10 worst pain). The summary indicated R66 had chronic right shoulder pain, indicated analgesics are effective and no referrals were necessary. The progress notes dated 2/24/15 completed by social services noted R66 had moderate cognitive impairment and minimal depression, and had diagnoses of chronic pain. The director or nursing was interviewed on 2/23/15 at 10:00 a.m. and indicated she was unaware the resident had ongoing pain and that she felt a referral to therapy was needed. The occupational screening dated 2/24/15 noted R66 had chronic right shoulder pain with range of motion limitation. The screening noted that the nursing assistant stated R66 did occasionally require increased assistance with clothing management. A facsimile dated 3/2/15 received from the director of nursing indicated R66 was in the facility for respite care for two weeks, that the facility was aware of her chronic shoulder pain, and that pain control regimen had not been established maintain as much pain control as possible including both medication and other interventions to promote pain control.	F 281	ensure pain management is addressed. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the April quarterly Quality Assessment and Assurance Committee meeting.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		4/8/15

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F 282	Continued From page 12 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance to the care plan for 1 of 3 residents (R7) reviewed for activities of daily living and failed to follow the plan of care for 1 of 3 residents (R41) reviewed for pain. Findings included: R7 was observed on 2/23/15 at 2:42 p.m. and on 2/23/15 at 5:26 p.m. and on 2/24/15 at 8:39 a.m., to have long finger nails with brown debris underneath nails. R7's admission record indicated R7 was admitted to the facility on 1/7/2013 and had diagnoses that included but not limited to hand joint contracture, muscle weakness, hemiplegia affecting the dominant side. R7's quarterly Minimum Data Set (MDS) dated 1/11/15 indicated R7 required extensive assistance from staff to perform personal hygiene and had severe cognitive impairment with a brief interview for mental status (BIMS) score of 5. R7's care plan last updated 1/20/15 read, "Resident is limited in ability to maintain grooming/personal hygiene ...related to history of cerebral vascular accident with right side weakness ... Extensive assist with hygiene ..." The care plan lacked direction to staff on who should provide nail care and when to provide nail care.	F 282	St. Isidore Health Center of Greenwood Prairie provides services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, registered) in accordance with each resident□s written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being; 2) implements procedures and practices as outlined in the plan; 3) reviews the plan at least quarterly and with significant changes in condition; and 4) makes modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicating the plan to the direct care givers by use of the care reference cards. The care cards are revised to reflect changes in the plan of care. The facility goal is to maximize the resident□s comfort. The resident□s pain level/potential is routinely assessed and a pain management program implemented with ongoing reviews of effectiveness.	

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F 282	Continued From page 13 During an interview on 2/25/15, at 9:42 a.m. assistant director of nursing (ADON) stated, nail care is supposed to be done on bath days by the nursing assistant (NA) unless the resident was diabetic. ADON stated, "I would expect the NAs to ask questions on how to perform nail care if they were not aware of how to provide nail care." The ADON explained, nail care is included as part of grooming and hygiene cares.	F 282	During the March 25 and 26, 2015 mandatory meetings, the nursing staff will be reminded/instructed 1) that the plans of care must be followed; 2) that nail care is part of routine grooming procedures; 3) that job performance expectations include being aware of and following the resident□s plan of care including grooming/hygiene; and 4) that pain management/interventions should be addressed in the plan of care and the physician notified of under/untreated pain. The orientation for new employees will continue to address the importance of following the resident□s plan of care for grooming/hygiene and maximizing the resident□s comfort. Resident number 7 □ The resident□s grooming plan of care was reviewed and found appropriate. The direct care staff is aware of the need to provide nail care as part of the resident□s routine grooming/bathing. Resident number 41 □ The resident□s pain was reassessed by a registered nurse on March 17, 2015. The resident reported no pain in the past five days and that she rarely has pain, pain does not make it difficult for her to sleep at night, and her day-to-day activities have not been limited due to pain. The March 13, 2015 sleep assessment notes that the resident is sleeping eight to ten hours per night. The January 1, 2015 sleep assessment indicates that the resident sleeps six to ten hours per night with a one-hour nap in the afternoon.	

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F 282	Continued From page 14	F 282	The resident has an order for Tylenol three times per day plus an as-needed dose. The resident was counseled that when in pain she can ask for pain medication as well as non-pharmacological interventions such as heat/cold packs, repositioning, massage, etc. The resident will be asked every shift about pain for ten days; the effectiveness of her pain management program will be reviewed during her March 26, 2015 interdisciplinary care conference. The resident□s pain management plan of care was reviewed and updated. Compliance with the facility□s grooming/hygiene procedures will be monitored by the Quality Assurance Coordinator/designee through random observations of residents□ appearance for the next 60 days. A hygiene audit tool as been drafted to document audit findings. If noncompliance is noted, additional auditing and staff training will be done. Compliance with pain management/interventions will be monitored by the registered nurse conducting the routine pain assessments. For the next 90 days, the plan for managing pain for residents who report pain with an intensity of 5 or greater on a 10-point scale or who complain of moderate or severe pain will be audited for appropriateness. If noncompliance is	

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F 282	Continued From page 15	F 282	noted additional auditing and staff training will be done.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide preventative skin breakdown skin services for 1 of 3 residents (R7) reviewed for skin integrity issues and the facility failed to assess ongoing pain management of chronic pain for 1 of 3 residents (R41) reviewed for chronic and current pain; and the facility failed to provide services to maintain safe dialysis management for 1 of 1 resident (R25) who received dialysis services. Findings included: Lack of identification and monitoring of wound: R7 was observed on 2/23/15, at 6:04 p.m. and had a healing wound measuring approximately 0.4 centimeters (cm) on his right hand. The wound was covered with a dark red/brown " L " shaped scab. The wound periphery was bright red. R7 was not aware of how or when the wound was obtained. R7's admission record indicated R7 was admitted	F 309	St. Isidore Health Center of Greenwood Prairie provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident□s condition indicates. A plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments. The following policies and procedures were reviewed and found appropriate: 1) skin observations and assessments 2) pain assessments/monitoring and 3) facilitating dialysis services and documenting dialysis related safety and	4/8/15

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F 309	Continued From page 16 to the facility on 1/7/2013 and had diagnoses that included but not limited to hand joint contracture, muscle weakness, hemiplegia affecting the dominant side (right side), congestive heart failure, stage 3 kidney disease, and atrial fibrillation. R7's quarterly MDS dated 1/11/15 indicated R7 required extensive assistance from staff for activities of daily living with the exception of eating where R7 is independent. The MDS identified R7 had severe cognitive impairment with a BIMS score of 5. R7's care plan dated 1/20/15 read, "Resident is at risk for skin breakdown related to history of cerebral vascular accident ...decreased sensation in right arm and leg" and "At risk for bruising easily related to daily Coumadin use." The care plan directed staff to complete a skin evaluation annually, quarterly, with significant changes and as needed. The care plan further directed staff to observe skin around right hand orthotic and during cares for redness or pressure areas. The care plan did not identify the right hand wound. R7's signed physician order report dated 1/20/15 revealed R7 was prescribed Allopurinol (gout medication) 100 milligrams (mg) daily, aspirin 81 mg daily, furosemide 40 mg daily, Coumadin (blood thinning medication) 2 mg on Monday, Wednesday, and Friday and 4 mg on all other days. Physician ' s orders had no mentions of wound care or treatment for hand tear. R7's skin risk assessment with Braden scale (tool to calculate risk for pressure ulcers) dated 1/13/15 did not identify R7 had any type of impaired skin integrity at the time of assessment. R7's nursing progress notes were reviewed for the last thirty days and did not reveal identification, monitoring, or treatment of right hand wound.	F 309	emergency interventions. The facility will continue with the practice of completing a pain evaluation and skin assessment for each resident at the time of admission, readmission, every three months, and with significant changes in condition. During the March 25, 2015 mandatory meetings, the licensed nurses will be instructed on 1) the procedures for investigating, reporting, documenting, and tracking open skin areas; 2) the need for ongoing monitoring of the effectiveness of pain management programs, with timely notification of the physician when there are chronic complaints of pain or a resident has functional decline due to pain; and 3) developing a plan of care that reflects the management and safety of residents receiving dialysis services. During the March 26, 2015 mandatory meeting, the nursing assistants will be instructed to 1) observe dialysis access sites for bleeding and to report any symptoms of infection (pain, swelling, redness) to the registered/licensed nurse; 2) be observant for open skin lesions and to report findings to a registered/licensed nurse in a timely manner; and 3) report resident□s complaints of pain, or behaviors that could be indicative of pain, to the nurse. Resident number 7 - The resident □s skin .4 centimeter right hand skin tear was routinely monitored and treated by the staff. The physician and family were notified of the injury. On March 9, 2015	

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F 309	Continued From page 17 R7 ' s treatment administration record (TAR) was reviewed for the last thirty days; the record did not reflect R7 had received treatment or monitoring of right hand wound. During an interview on 2/24/15, at 3:30 p.m. assistant director of nursing (ADON) confirmed wound on R7's right hand and the wound had not previously been identified or treated. A facility policy entitled skin integrity assessment/documentation directed staff to do daily inspections of skin. The policy also read, "Resident's determined to be "at risk" or have loss of skin integrity receive aggressive/appropriate preventative measures and care specific to addressing the resident's unique risk factors." The policy included the following possible intervention/prevention measures to implement: physician consultation, nutrition monitoring, supplements, special mattresses, pads, and resident repositioned minimally every 2 hours. Pain Management: R41 was interviewed on 2/23/15 at 5:00 p.m. R41 complained of left hip pain and repeatedly complained of the hip hurting during the interview. R 41 was also observed to be rubbing the left leg. R41 stated the pain was from a previous hip fracture. R41 was observed to stand and walk independently using a walker. On 2/24/15 at 9:40 a.m. R41 was observed in an exercise group, but did not participate. On 2/25/15 at 9:30 a.m. R41 was not observed the exercise group, but watching TV in her room. On 2/26/15 at 7:40 a.m. R41 was observed sitting on the edge of her bed. R41 stated she had pain in her left hip. When asked to rate it on a scale of 0-10 with 0 as no pain and 10 as the worst pain, R41 said it was pretty bad, but would not rate it numerically. R41 stated she was unable to dress her lower body	F 309	the nurse documented that the right hand skin lesions were much improved. The resident□s right hand injury was reassessed by a registered nurse on March 17, 2015 and was noted to be healed. The care plan has been updated accordingly. Resident number 41 □ The March 17, 2015 pain reassessment by a registered nurse indicated that during the past five days the resident reported no pain or hurting, that she rarely has pain, that pain does not make it difficult for her to sleep at night, and that her day-to-day activities have not been limited due to pain. The March 13, 2015 sleep assessment notes that the resident is sleeping eight to ten hours per night. The January 1, 2015 sleep assessment indicates that the resident sleeps six to ten hours per night with a one-hour nap in the afternoon. The physician□s assistant (PA-C) was asked to reassess the resident□s pain management program March 17, 2015. A diagnostic x-ray was ordered. Based on the results of the x-ray, additional pain relief interventions and/or an orthopedic consult will be considered. The resident has an order for Tylenol three times per day plus an as-needed dose. The resident was counseled that when in pain she can ask for pain medication as well as non-pharmacological interventions such as heat/cold packs, repositioning,	

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F 309	Continued From page 18 because of the pain. R41 was admitted to the facility on 4/3/13 according to the face sheet. The physician orders of 2/18/15 listed diagnoses that included: aftercare of fractured bone, debility, and neuropathy, difficulty in walking, weakness of muscle, mild cognitive impairment and joint stiffness of lower leg. The physician orders dated 2/18/15 identified Tylenol Extra Strength (analgesic for mild pain) three times a day. The order was originally written 4/9/13. Also on 10/24/13 the physician ordered as needed Tylenol. The quarterly MDS dated 12/13/14 noted R41 had a BIMS (brief interview of mental status) score of 8 or moderate cognitive impairment, that R41 required extensive assistance for activities of daily living (increased assistance required when compared to 10/5/14 MDS where supervision to limited assistance was noted), and that R41 denied pain, but received scheduled pain medications. The care area assessments dated 10/14 completed at the time of a significant change MDS did not trigger for pain. The facility Observation Report (pain management evaluation) completed 12/18/14 was reviewed. The observation indicated R41 stated she had not had pain in the last 5 days and received Tylenol 1000 mg three times a day. No referrals were indicated. The care plan dated 10/16/14 did not have a problem related to pain but did note the resident had occasional pain, directed administration of pain medications as ordered, and listed	F 309	massage, etc. The resident will be asked every shift about pain for ten days; the effectiveness of her pain management program will be reviewed during her March 26, 2015 interdisciplinary care conference. The resident□s pain management plan of care was reviewed and updated. Resident number 25 □ The resident□s care plan has been reviewed and revised to reflect 1) dialysis services every Monday, Wednesday, and Friday; 2) monitoring of the dialysis access site for infection and bleeding; 3) fluid-restricted diet with the amount of fluids offered by dietary and nursing identified; and 4) dialysis provider emergency contact information. The resident does not receive any routine medications administered by the dialysis center staff; the resident is not routinely at the dialysis center at meal times. The service agreement with the dialysis provider addresses many of the above issues and has been incorporated into the care plan by reference. Compliance with facility/regulatory policies for identification and reporting of skin lesions will be monitored by the Director of Nursing/designee by conducting random skin audits of residents at high risk for skin breakdown for two weeks. If previously unreported skin problems are observed, additional auditing and staff training/counseling will be done. Compliance with pain management interventions/management will be	

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F 309	Continued From page 19 non-pharmacological interventions to use to ease discomfort. The care plan directed to monitor for pain. The physician documentation for 8/6/14 was reviewed. The documentation noted that R41 was experiencing discomfort in the hip and noted a follow-up in orthopedics would be appropriate to determine if the pain was from the nail or from adhesion formation. The physician noted that if orthopedics was negative, then the resident would be a candidate for therapy. On 10/20/14 the physician documented chronic left hip pain nearly 2 years status post intramedullary nailing for treatment of fracture. The 12/17/14 physician documentation noted that R41 had osteoarthritis and received Tylenol Extra Strength. Physician notes of 2/18/15 noted osteoarthritis of her weight bearing joints and chronic left hip pain. The physician noted her left hip was stable and that she did have pain in her hip. The resident progress notes were reviewed for 1/15/15 through 2/24/15. On 1/28/15 R41 complained of left hip pain and requested cold packs throughout the day and evening. The note indicated R41 would at times ask for assistance to walk in the halls. On 1/29/15 the progress notes indicated R41 complained of left hip pain and requested assistance to walk to and from meals. Another note on 1/29/15 documented R41 continued to complain of left hip pain, requested ice packs, requested assistance with cares and transfers, and requested assistance to walk with a gait belt and walker. On 1/30/15 R41 stated her hip was better, but was still requesting assistance with walking. The 1/30/15 note stated the resident continued to complain of left help pain and requested ice packs. On 2/1/15 the	F 309	monitored by the registered nurse conducting the routine pain assessments. For the next 90 days, the pain management interventions for residents who report pain with an intensity of 5 or greater on a 10-point scale or who complain of moderate or severe pain will be further evaluated to assure that the physician is aware of the resident□s pain and that interventions have been implemented to control pain to the greatest extent possible. If noncompliance is noted, additional monitoring and staff education will be done. Compliance with documenting the management and safety of dialysis services will be monitored by the MDS Coordinator. When a resident is admitted needing dialysis or who subsequently starts dialysis treatment, the MDS Coordinator will review the care plan and related documentation to assure the required dialysis components are addressed. Compliance will be addressed during the April quarterly Quality Assessment and Assurance Committee meeting.	

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resident complained of unsteadiness and requested staff to walk with her. The progress notes did not indicate the physician or physician assistant had been informed of the residents increase in pain and the progress notes did not indicate as needed Tylenol had been given to help the resident manage her pain. Review of the medication administration record showed no as needed Tylenol had been administered during the past two weeks even though R41 complained of leg pain and was rubbing leg on 2/23/15 at 5:00 p.m.

Therapy notes were reviewed. On 10/30/14 the therapist noted an annual screen had been completed. On 12/26/14 the therapist quarterly screen was completed and documented the resident had returned to her baseline after an illness.

The physical therapy aide (PTA)-F was interviewed on 2/24/15 at 2:04 p.m. and stated R41 had experienced pain on and off since hip surgery. PTA-F stated R41 had first started in therapy in 2013 but had not been on the case load since July 2014. The registered physical therapist (RPT)-G was interviewed on 2/24/15 at 2:08 p.m. RPT-G stated a quarterly screen was done to evaluate function in mobility. During a quarterly screen physical therapy does not actually see the resident or do any hands-on evaluation, but would review the notes and talk to staff. RPT-G stated R41 was last seen in July 2014 for pain related problems with mobility and transfers. RPT stated that she felt R41 should be evaluated by orthopedics prior to any further therapy evaluation.

Registered nurse (RN)-B was interviewed on

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F 309	Continued From page 21 2/24/15 at 3:10 p.m. RN-B stated pain had been an issue ever since surgery. RN-B stated R41 did not have an orthopedic recheck like the physician had recommended. RN-B stated R41 displayed pain by rubbing her hip and saying it hurt and would not describe pain by using a number. RN-B stated she did not realize that a therapy screen did not involve a hands-on evaluation of the resident. Interventions used for R41 would usually include heat or ice packs. The activities director (AD)-A was interviewed on 2/25/15 at 10:45 a.m. AD-A stated that R41 would come to exercise programs but had not come for a couple days and had not come today. When R41 attended the activity exercise program she would usually do upper body exercises and play kick ball. AD-A knew that R41 had refused to come to exercises, but was unaware of a pain issue. At 10:50 a.m. activity aide (AA)-B stated R41 did come to exercises today, but would just do a few upper extremity stretches because she had been bothered by hip pain lately. R41 was refusing to do more because of her hip pain. AA-B stated she had mentioned to the nurses that R41 was complaining of pain. Dialysis management: R25 was interviewed on 2/26/15 at 10:40 a.m. R25 stated she had been receiving dialysis for over a year. She stated she was on a fluid restriction and would get fluids with meals and a small amount with her pills. She stated that at times she was thirsty. R25 stated that she received medications and food prior to going to dialysis and that she was rarely told if her laboratory values were incorrect. The hospital discharge summary dated 12/11/14 identified diagnoses of chronic kidney disease	F 309		

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stage 5, dialysis dependent, congestive heart failure, hypertension and peripheral vascular disease.

The admission Minimum Data Set dated 12/18/14 noted R25 was not cognitively impaired, required extensive assistance to complete activities of daily living and experienced pain.

The physician orders dated 2/16/15 were reviewed. The physician ordered renal, low potassium diet with 1200 cubic centimeters (cc) fluid restriction, but did not identify what amount of the 1200 cc of fluid was to be provided by dietary or nursing so it did not go over the 1200 cc per day.

The fluid intake record was reviewed for 2/18/15 to 2/25/15. The record did not note the amount of fluid to be provided by dietary or the amount of fluid to be provided by nursing, or the total amount of fluid (1200 cc) available for a 24 hour period. The fluid intake record for 2/18 to 2/25 indicated in a 24 hour period R25 received 440 cc to 1220 cc fluid. The physician documented on 1/12/15 that R25 had low blood pressure and wondered if the 1200 cc per 24 hour fluid restrictions was a bit harsh.

The medication administration record (MAR) was reviewed. The MAR listed a time frame of a.m. medications at 4 a.m. to 7:30 a.m. but did not note when to give medications on days she goes for dialysis services. At 2:09 p.m. on 2/26/15 registered nurse (RN)-A stated she gave medications prior to dialysis, but did not know if that was a written order or not.

A contract with the Mayo Dialysis Unit was

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F 309	Continued From page 23 provided 2/26/15. The contract was dated 2/26/15. The contract dated 2/26/15 noted the monitoring of the dialysis access (including intravenous catheters) for signs of infection, what to do in case of bleeding from the dialysis access site, and emergency contract information. Medical records director (MR)-A was interviewed on 2/26/15 at 2:00 p.m. MR-A stated she had called the dialysis unit and received the contract today. MR-A stated the facility did not have a dialysis contract for R25 prior to today. R25's care plan dated noted R25 had dialysis Tuesday, Thursday, and Saturday, was on a therapeutic diet, was on a fluid restriction of 1200 cc and that daily intake monitoring was to be completed. The care plan did not identify the amount of fluid to be given by dietary and the amount to be given by nursing. The care plan addressed pain and non-pharmacological interventions to use. The care plan noted that dialysis was responsible for dressing changes to site and that it was not necessary to check the dialysis site for bruits or thrills. The written plan of care did not address dialysis interventions that included, medications or food prior to dialysis, emergency measures, infection monitoring of dialysis site. The treatment administration record noted to check dressing site on central line every shift for bleeding, but did direct staff to monitor for signs of infection, or provide direction on what to do if bleeding or infection was a problem. At 2:00 p.m. on 2/26/15 RN-B stated the facility did not have care and services interventions for a dialysis resident on the care plan for R25 but should have one.	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		4/8/15

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F 312 SS=D	Continued From page 24 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal grooming cares for 1 of 2 residents (R7) dependent on staff to meet their activities of daily living. Findings included: R7 was observed on 2/23/15 at 2:42 p.m., 2/23/15 at 5:26 p.m., and on 2/24/15 at 8:39 a.m. to have long finger nails with brown debris underneath nails. R7's admission record indicated R7 was admitted to the facility on 1/7/2013 and had diagnoses that included but not limited to hand joint contracture, muscle weakness, hemiplegia affecting the dominant side. R7's quarterly Minimum Data Set (MDS) dated 1/11/15 indicated R7 required extensive assistance from staff to perform personal hygiene and had severe cognitive impairment with a brief interview for mental status (BIMS) score of 5. R7's care plan last updated 1/20/15 read, " Resident is limited in ability to maintain grooming/personal hygiene ...related to history of cerebral vascular accident with right side weakness ... Extensive assist with hygiene ..." The care plan lacked direction to staff on who should provide nail care and when to provide nail	F 312	St. Isidore Health Center of Greenwood Prairie provides the necessary services to maintain good nutrition, grooming, personal care, and oral hygiene for residents who are unable to carry out activities of daily living independently. Based on the comprehensive resident assessment, the staff provides cares which assist the resident in maintaining and enhancing his/her self-esteem and self-worth, including assistance with nail care according to resident preferences and as outlined in the plan of care. The residents need for assistance with personal hygiene is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary. During the mandatory meetings March 25 and 26, the nursing staff will be 1) reinstructed on the facility s policies for providing personal hygiene to the residents; 2) reminded that their job description requires knowledge of, and responsibility for, following the resident s plan of care; and 3) instructed on the importance of providing nail care. The need to provide cares as necessary to	

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F 312	Continued From page 25 care. During an interview on 2/25/15, at 9:42 a.m. assistant director of nursing (ADON) stated, nail care is supposed to be done on bath days by the nursing assistant (NA) unless the resident was diabetic. ADON stated, "I would expect the NAs to ask questions on how to perform nail care if they were not aware of how to provide nail care." The ADON explained, nail care is included as part of grooming and hygiene cares.	F 312	improve/enhance the residents appearance, comfort, and dignity will be emphasized. The grooming plan of care for resident number 7 was reviewed and found appropriate in addressing the resident s personal care needs. The direct care staff is aware of the need to provide nail care as part of the routine grooming/bathing procedures. The Quality Assurance Coordinator/designee will be responsible for monitoring compliance by randomly checking resident hygiene for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the next quarterly Quality Assurance and Assessment Committee meeting.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		4/8/15

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F 329	Continued From page 26 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop parameters for use of as needed psychotropic medications (Lorazepam & Haldol) and as needed pain medication (Dilaudid & Tylenol), also the facility failed to revise a plan of care to include the use of as needed medications, and failed to consistently document the as needed medications for effectiveness, non-pharmacological interventions attempted before medication for 1 of 5 residents (R38) reviewed for unnecessary medications. Findings include: R38 was observed on 2/23/15 sitting in a Broda chair being pushed by family (F)-A. R38 had no response to conversation directed at her. F-A stated R38 was not conversing much anymore. R38 was observed on 2/24/15 at 8:15 a.m. sitting in a Broda chair in register nurse (RN)-B ' s office. RN-B was holding R38 ' s hand. RN-B stated she had assisted R38 to eat 100% of her breakfast. R38 was observed to be screaming at this time. RN-B stated the behaviors had improved and that she was given Dilaudid and Ativan this morning.	F 329	St. Isidore Health Center of Greenwood Prairie staff ensures that each resident□s drug regime is free from unnecessary drugs. The resident□s drug regime is reviewed by the staff, physician, and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. St. Isidore Health Center of Greenwood Prairie staff ensures that 1) residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and 2) residents who use psychotropic drugs receive gradual dose reductions with attempts to manage behaviors using non-pharmacological interventions. An	

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F 329	Continued From page 27 R38 was admitted in 2012 according to the face sheet and according to the physician orders dated 12/24/14 through 2/24/15 had diagnoses that included: mild cognitive impairment, anxiety disorder, depressive disorder, and hemiplegia and, lumbago. The quarterly Minimum Data Set (MDS) dated 1/18/15 noted short term memory impairment with moderately impaired decision making skills, moods that included little energy and poor appetite, and behaviors of disorganized thinking, physical and verbal aggressions during 1 to 3 days of the 7 day assessment period. The MDS noted the behaviors had little impact on the resident or others. The MDS also noted R38 ' s pain management included scheduled pain medications. Physician orders dated 12/24/14 through 2/24/15 listed pain medications of Tylenol (analgesic used to treat mild pain) three times a day and as needed dated 10/14/14, Dilaudid (narcotic used to treat moderate to severe pain) every 4 hours as needed dated 2/24/15. The physician orders listed psychoactive medications as Lorazepam (antianxiety medication) twice a day and as needed every 4 hours for restlessness and anxiety dated 2/17/15, and Haldol (antipsychotic) twice a day and as needed every four hours dated 2/24/15. The physician orders did not provide directions to staff as to the symptoms for which the medications were to be given or in what order the medications were to be given. R38's plan of care dated 1/28/15 identified problems of impaired temporal orientation, problems with memory/recall, depression and	F 329	effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of these medications whenever possible. The policies and procedures related to the administration of psychotropic medications were reviewed and revised. Use of the daily Behavior Flowsheet will continue. This tool is completed by the direct care staff and identifies target behaviors and tracks the frequency and the effectiveness of related medications for residents who receive antipsychotic and/or antianxiety medications. Guidelines/parameters are developed when psychotropic medications are prescribed on an as needed (PRN) basis. At the time of the quarterly care conference and more often if needed, the resident□s medications are reassessed by licensed nurses and the social worker. The medication type/dose and other related information are reviewed to assure that the record continues to reflect adequate indications for use, the consideration of dose reductions, and non-pharmacological interventions when appropriate. Psychotropic medication use will continue to be reviewed monthly by the consultant pharmacist and during the routine 30/60 day visits by the attending physician, nurse practitioner, or physician assistant. During the March 25, 2015 mandatory meetings, the licensed nurses will be instructed on behavior related policies and	

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F 329	Continued From page 28 identified target behaviors as "physically abusive, verbally abusive, statements of distress, resists care, wandering, etc." The approaches listed non-pharmacological interventions to be provided prior to administering Ativan that included approach in a calm manner, reassurance, redirect her not to do this, remind her of past work as a nurse and mother of 11 children, offer snacks, and keep her company. The plan of care dated 1/22/15 listed complaints of chronic low back pain and listed non-medicated pain relief measures of music, activities, rest massage, heat/cold. The care plan did not address the parameters for use of the as needed pain medications of Tylenol and Dilaudid and as needed psychoactive medications of lorazepam and Haldol nor resident specific symptom such as pain level and what pain medication to use. The medication administration record was also reviewed and did not provide directions to staff as to what symptoms should be displayed, what non-pharmacological interventions should be attempted prior to the use of the as needed medications. The medication administration record for 2/17/15 through 2/24/15 was reviewed. The MAR indicated R66 received Dilaudid 0.5 mg every 4 hours from 8 p.m. on 2/17/15 to 4 p.m. on 2/23/17. The MAR notes did not indicate the location, intensity or duration of the pain or if any non-verbal signs of pain were being displayed. On 2/22/15 in addition to the Dilaudid received at 8 p.m. and 12:00 a.m., R66 received 0.5 mg Dilaudid at 10:16 p.m. and 11:33 p.m. The notes documented in the MAR indicated the resident was yelling and the first dose was not effective. On 2/23/15 the order was changed to Dilaudid 0.5 mg every hour as needed and that R66 received	F 329	procedures including 1) the need to document the resident□s target behaviors, non-pharmacological interventions, and the response to pharmacological and non-pharmacological interventions; and 2) the need to follow the care plan and update the care plan as needed. The hospice agency staff will be informed that guidelines/parameters are necessary when multiple analgesics and psychotropic medications are ordered for end-of-life care. During the March 26, 2015 mandatory meetings, the certified nursing assistants will instructed 1) to be observant for behaviors; 2) to consistently use the Behavior Flowsheet to record the frequency of target behaviors, the interventions attempted to modify the behavior, and the effectiveness of the intervention; and 3) on the necessity to report behavior symptoms to the nurse. Hospice services were initiated for Resident Number 38 on February 5, 2015 due to decline in condition and the need for pain control. The resident had a history of generalized depression and anxiety disorder with behaviors including physical and verbal abuse to others and statements of distress. The hospice agency was aware of the resident□s frequent, prolonged screaming with distressed demeanor. The agency staff was contacted routinely regarding the resident□s symptoms of distress and	

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F 329	Continued From page 29 the medication 4 times between 7:00 a.m. and 12:22 p.m. The notes documented in the MAR did not indicate behaviors to warrant use of the medication nor effectiveness of the medication give. Haldol was ordered on 2/24/15 but the MAR provided did not indicate that Haldol had been administered. The MAR for 2/17/16 through 2/24/15 indicated R66 had received Lorazepam 0.5 mg as scheduled twice a day. In addition as needed Lorazepam was given twice on 2/19, once on 2/20, once on 2/21, 4 times on 2/22. The as needed Lorazepam was documented in the MAR as given for agitation, yelling, screaming, increased anxiety (not specific symptom), but the results were documented only twice and no non-pharmacological interventions were documented. The progress notes were reviewed for 2/18/15 through 2/23/15. None to twice a day the progress notes identified behaviors of yelling and interventions attempted. No rationale for giving the Lorazepam or the Dilaudid was documented. Review of the MAR records for 2/24/15, showed R66 received as needed Lorazepam at 5:45 a.m., scheduled Lorazepam at morning med pass (between 6 a.m. and 8 a.m.), received as needed Dilaudid at 7:00 a.m., as needed Dilaudid at 8:59 a.m., received as needed Lorazepam at 9:51 a.m., received as needed Dilaudid at 10:03 a.m. and as needed Dilaudid at 12:00 p.m. received as needed Lorazepam at 12:08 p.m. and as needed Dilaudid at 12:22 p.m. The MAR notes stated the Dilaudid was given for wrist pain and twice for yelling out. The MAR notes stated the Lorazepam was given for yelling out. The documentation did not indicate if any	F 329	pain; guidance was provided to the nurses regarding which medications to administer to calm the resident and maximize her comfort at end of life. The resident died at the facility March 16, 2015. The need for documenting of parameters/guidelines for the administration of as-needed medication, the effectiveness of the interventions, and the non-pharmacological interventions that are attempted prior to medication administration will be reviewed as part of the facility□s ongoing quality improvement process. The records of residents receiving PRN analgesics and psychotropic medications have been audited to ensure administration parameter/guidelines are established and documented. For the next 30 days, the Director of Nursing/designee will monitor the records of new residents to ensure that appropriate parameters/guidelines are in place. New orders for PRN analgesic and/or psychotropic medications will also be checked for administration guidelines/ parameters. The Consultant Pharmacist will continue with monthly medication audits which include checking for appropriate indications for psychotropic and analgesic medication use. Compliance will be reviewed during the April quarterly Quality Assessment and Assurance Committee meeting and on-going	

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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 329	Continued From page 30 non-pharmacological interventions had been used or the effectiveness of the medications or how the licensed practical nurse determined which medication Dilaudid or Lorazepam to use. Review of the behavior flow sheets revealed no behaviors documented for 2/24/15. Progress notes for 2/24/15 were reviewed. Seven notes indicated behaviors or yelling. Some of the notes identified non-pharmacological interventions used, but did not indicate why Lorazepam or Dilaudid was given over the other medication. RN-B was interviewed on 2/24/15 at 2:59 p.m. RN-B stated the resident was on hospice and was receiving more of the medication. RN-B indicated no parameters had been written for the use of the Dilaudid, Haldol or Ativan. The facility had no protocol as to what medication was to be given first or what non-pharmacological medications were to be used. RN-B stated that primarily R38 will display a screaming behavior. RN-B stated interventions used would include aroma therapy, hand holding, family visits. RN-B added staff was to document why the medication was given and the effectiveness of the medication.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		4/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 431	Continued From page 31 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accurate labeling of open medication in accordance with current standards of practice for 1 of 1 resident (R5) reviewed for medication storage. Findings include: During the medication storage review on 2/26/15 at 9:40 a.m. with registered nurse (RN)-A, it was noted that an opened bottle of sublingual nitrostat (nitroglycerin- It works by relaxing the blood vessels and increasing the supply of blood and oxygen to the heart while reducing its work load)	F 431	St. Isidore Health Center of Greenwood Prairie provides pharmaceutical services to meet the needs of each resident. The facility has a contract with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and to guide the development and implementation of related procedures to ensure the accurate acquiring, receiving, dispensing, storing, and administering of drugs and biologicals.	

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	245345	A. BUILDING _____ B. WING _____	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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F 431	Continued From page 32 0.4 mg labeled for R5 was located in the 300 Wing medication cart. The bottle was inside a larger plastic medicine bottle with a label that stated it had been dispensed on 1/16/14 and expired on 01/2015. The inside bottle had a label on it, with the manufacturer expiration date of 6/2016. The vial had no seal (which indicated the bottle had been opened) on it and it had not been dated when it was opened. This was verified by RN-A. R5, according to his face sheet, was admitted on 1/16/14 with diagnoses including but not limited to: ischemic heart disease, history of a myocardial infarction (heart attack), congestive heart failure, aortic valve disorder, kidney disease, chronic, stage III, hyperlipidemia and hypertension. R5's signed physician orders indicated that he was to receive nitrostat sublingual 0.4 mg as needed. Special instructions included to give one tab; if symptoms continue then give another after 10 minutes for 3 doses, and then stop. Although record review of the medication administration record from 11/26/15 - 2/26/15 showed that R5 had not used the nitrostat during that period of time, because of his multiple cardiac diagnoses he had the potential for requiring the use of the nitrostat. During an interview with the consultant pharmacist on 2/26/15 at 11:39 a.m., the pharmacist indicated that the pharmacy should not have dispensed it without a new plastic medication bottle to place it in indicating when it had been dispensed. The consultant also indicated that not knowing when it had been dispensed nor when it had been opened, a person would not know if it was expired or not affective to relieve chest pain. An undated facility policy titled Policy 5.3 directs	F 431	In accordance with State and Federal laws, the facility stores all drugs and biologicals in locked compartments under proper temperature controls and permits only authorized personnel to have access. The facility utilizes only persons authorized under state requirements to administer medications. Outdated and expired drugs and biologicals are routinely discarded/destroyed according to accepted practice standards. All medication storage areas were checked for proper content and for outdated and discontinued medications and biologicals. No additional outdated medications were found. The registered/licensed nurses are responsible for removing and discarding/destroying expired medications. During the mandatory meeting March 25, 2015, the nurses and trained medication assistants will be reinstructed on the procedures for processing discontinued and outdated medications and biologicals. To monitor compliance, a trained medication aide will audit the medication storage areas weekly for one month and then monthly thereafter to check for expired/outdated medications and biologicals. Compliance will be reviewed during the April Quality Assurance and Assessment Committee meeting.	

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	245345	A. BUILDING _____ B. WING _____	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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F 431	Continued From page 33 staff to do the following: #5 Facility staff should record the date when opened on the medication container as the medication has a shortened expiration date once opened.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		4/8/15

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F 441	Continued From page 34 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure regular and isolation laundry were washed according current recommendations when soiled with potential Clostridium difficile (C. diff) to prevent the spread of the infection. This had the potential to affect all residents who had laundry done in the facility. Findings include: R45 had been diagnosed with Clostridium difficile (c-diff) in November 2014. This was confirmed by laboratory reports on two different occasions by Mayo Clinic during hospitalizations. R45 was treated with antibiotics. The care area assessments part of the Minimum data Set dated 12/2/14 indicated at the time of this observation the resident had been having loose stools and that the stool specimen were cultured and found to having been positive for C-diff. R45 was then placed on strict isolation. The progress notes of 2/21/15 noted R45 had large incontinent stool. The bowel movement (BM) reports for 2/14/15 through 2/22/15 noted multiple BMs daily and most frequently of loose consistency (loose stools is indicative of active C. diff). During the facility tour of the laundry room on 2/25/15 at 1:00 p.m. the maintenance director (MD)-A stated the washing machine used for all laundry water temperature was at 150 degrees.	F 441	St. Isidore Health Center of Greenwood Prairie has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has policies and procedures reflecting an infection control program that 1) investigates, controls, and prevents infections in the facility; 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease; and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The policies and procedures for processing linens and clothes for residents in isolation, and especially with with C.Diff., were reviewed and revised. The isolated resident□'s room will have a three-bin container for 1)soiled personal laundry; 2)soiled facility linens used specifically for the resident, including any resident with C.Diff (sheets, towels, blankets, etc.); and 3)trash. Before leaving the resident'□s room, personal laundry and linens are separately double bagged in yellow bags for transport to the	

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F 441	Continued From page 35 At that time MD-A stated he was unsure if a sanitizing agent was used, but thought that a chlorinated additive was used for white linens but not colored linens. He stated that all clothing was dried in the commercial dryer on high heat. At 1:30 p.m. MD-A had a telephone call with the administrator. MD-A stated he had been told that the laundry soap and dryer would kill everything, but that he did not know what sanitizing agent was in the laundry soap. The administrator stated that the facility had colored table clothes and bed spreads and that bleach would not be used with these linens. There was no other resident who had symptoms or confirmed C. diff. Laundry Aide (LA)-A was interviewed on 2/25/15 at 1:15 p.m. LA-A stated that the bleach was dispensed into the washer at two different concentrations dependent on the punch cards (cards that tell the washer what to add and when) used. LA-A did not know if the laundry soap had a sanitizing agent added. At 1:45 p.m. LA-A described the procedure used for isolation laundry. LA-A stated the isolation laundry (both facility linens and personal clothing) would be placed in the washing machine and detergent is added and no bleach would be added. After the clothing/linens are washed, dried, and folded they would go back to the floor for resident/s use. The laundry director (LD)-B was interviewed on 2/26/15 at 11:30 a.m. LD-B stated the wash cycle was 25 minutes long and that no bleach would be used with colored clothing or linens. LD-B verified that the linen and personal laundry would be washed together for isolation residents and no bleach would be used in that wash cycle. The Center of Disease Control and Preventions	F 441	laundry room. The water temperature in the water heater has been increased to 180 degrees Fahrenheit to assure at least 160 degree Fahrenheit water in the washing machines. A chlorinated detergent is now used during the two-stage wash cycles for non-colored laundry. The linens are dried for thirty minutes. To sanitize the personal laundry of isolated residents, the clothes are washed separately in 160 degree Fahrenheit water and dried for thirty minutes. Clean linens used by residents with C.Diff will not be comingled with other facility linens. The laundry and nursing staff have been informed of the laundry policy and procedure changes. The procedural changes will be reinforced during the mandatory nursing staff meetings on March 25 and 26, 2015. When there is a resident(s) on isolation, a daily log of the water temperature and presence of chlorine in the laundry detergent for facility linens will be completed for each load by the Environmental Services Director/designee. ESD/Director of Nursing or her designee will review log daily for compliance. Compliance will also be monitored by the infection control nurse through random direct observation of the laundry handling twice weekly for residents on isolation for two weeks or the duration of isolation, whichever is less. Findings will be	

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	245345	A. BUILDING _____ B. WING _____	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

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F 441	Continued From page 36 recommends commercial laundry facilities use water temperature of at least 160 degrees and chlorine bleach to remove significant quantities of microorganisms. CDC also noted that temperatures less than 160 digress were suitable when chemicals suitable for low-temperature washing were used at the proper concentrations. The C-Diff Foundation recommended use of hot water temperature cycles and using chlorine bleach along with laundry soap. The laundry products supplier (LPS)-A was interviewed on 2/26/14 at 11:00 a.m. via telephone. LPS-A stated the chlorinated rinse would kill c-diff if the water was at 135 to 145 degrees, but that detergent alone would not kill the c-diff spores. LPS-A said the laundry soap does not contain any chlorine or sanitizing agent. LPS-A added that the chlorinated rinse was not used for the colors and that Compass laundry soap used for personal laundry did not kill anything in reference to infectious agents. At 11:45 a.m. LSP-A stated he would check to see what dryer temperatures needed to be to destroy C. diff spores and if it was okay to place the multi-use linen back into use by other residents if bleach had not been used. LSP-A also agreed to provide environmental protection agency (EPA) studies for the chlorinated rinse. A return call was not received and the United States Environmental Protection Agency (EPA) guidelines were not provided as requested. The facility's policy entitled Clostridium Difficile dated 12/3/14 directed disinfection of items with fecal soiling using a disinfecting agent recommended for Clostridium difficile.	F 441	recorded. If non-compliance is noted, further observation and education will be conducted.	

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	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2015**

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ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Isidore Health Center of Greenwood Prairie was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

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

Electronically Signed | 03/20/2015

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

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K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. St. Isidore Health Center of Greenwood Prairie is a 2-story building that was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1993, addition was constructed to the South that was determined to be of Type II(222) construction. Because these two buildings are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2015**

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K 000	Continued From page 2 The facility has a capacity of 53 beds and had a census of 49 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, documentation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7 and 1998 NFPA 25, sections 2-2.1.1, 2-4.1.4 and 9-4.2.1. This deficient practice could affect all 49 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 02/25/2015, documentation review and observation revealed that the following was found: 1. The spare sprinkler head box - does not contain (2) spare sprinkler heads of each type in the facility; 2. In the main kitchen area, there are fire sprinkler heads that have paint on them;	K 062	1. The 5 year internal check valve inspection for the sprinkler system will be completed per regulation. 2. The sprinkler heads in the kitchen area will be replaced. 3. Lint will be removed from facility sprinkler heads. 4. The spare sprinkler head box will contain two types of each sprinkler head used in the building. Environmental Services Director is responsible for the repairs. Administrator to monitor for completion.	4/8/15

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K 062	Continued From page 3 3. The fire sprinkler heads through out the facility has lint build up on them; 4. The annual sprinkler report from Olympic Sprinkler dated 10/22/2014, indicated that no internal check valve inspection has been done in the last 5 year These deficient practices were confirmed by the Facility Maintenance Director (JL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062		

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	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**02/25/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Isidore Health Center of Greenwood Prairie - Chapel Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	**800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964**

(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 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. St. Isidore Health Center of Greenwood Prairie, 2005 addition is a 2-story building. The 2005 addition was determined to be of Type II (222) construction. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 49 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		4/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**02/25/2015**

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K 011	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide 2-hour rated construction at building separation walls between the hospital building and the non-conforming building construction as required by NFPA 101" Life Safety Code " 2000 edition, sections 18.1.1.4.1. The deficient practice could negatively impact the residents of the facility by allowing a fire to spread from one building to another. Findings include: On facility tour between 8:00 AM and 11:00 AM on 02/25/2015, observation revealed that on the 2 hour building separation walls from nursing home to assisted living the following was found: 1. 2nd floor - chapel north wall a open conduit end above the lay in ceiling; 2. 2nd floor - chapel north 90 minute fire rated door frame is separating from wall creating a gap at least a 1/8 inch around the entire frame; 3. 1st floor - 90 minute fire rated door from nursing home to assisted living does not shut and positively latch NOTE: Check all 2 hour fire separation walls	K 011	1. The chapel north wall open conduit will be sealed to meet code. 2. The chapel north door frame will be repaired to meet code. 3. The first floor door from the nursing home to the apartment building will shut and positively latch. Environmental Services Director is responsible for the repairs. Administrator to monitor for completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**02/25/2015**

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ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

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K 011	Continued From page 3 throughout facility. These deficient practices were confirmed by the Facility Maintenance Director (JL) at the time of discovery.	K 011		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, documentation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.5 and 9.7 and 1998 NFPA 25, sections 2-2.1.1, 2-4.1.4 and 9-4.2.1. This deficient practice could affect all 49 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 02/25/2015, documentation review and observation revealed that the following was found: 1. The spare sprinkler head box - does not contain (2) spare sprinkler heads of each type in the facility; 2. The fire sprinkler heads through out the facility has lint build up on them;	K 062	1. The 5 year internal check valve inspection for the sprinkler system will be completed per regulation. 2. The sprinkler heads in the kitchen area will be replaced. 3. Lint will be removed from facility sprinkler heads. 4. The spare sprinkler head box will contain two types of each sprinkler head used in the building. Environmental Services Director is responsible for the repairs. Administrator to monitor for completion.	4/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **02 - CHAPEL** B. WING _____	**02/25/2015**

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K 062	Continued From page 4 3. The annual sprinkler report from Olympic Sprinkler dated 10/22/2014, indicated that no internal check valve inspection has been done in the last 5 year These deficient practices were confirmed by the Facility Maintenance Director (JL) at the time of discovery.	K 062		
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 18.7.5.2, 18.7.5.3, 18.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was free of combustible decorations in accordance with NFPA 101 - 2000 edition, Section 18.7.5.4. This could affect approximately 25 out of 49 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 02/25/2015, observation revealed that a candle was lit in the 2nd floor chapel adoration room unattended. This deficient practice was confirmed by the Facility Maintenance Director (JL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 073	An electric or battery operated perpetual candle will replace the current lit candle. Environmental Services Director is responsible for the repairs. Administrator to monitor for completion.	4/8/15