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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YOX1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00459

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245610**

2.STATE VENDOR OR MEDICAID NO.
(L2) **440886100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST GERTRUDE'S HEALTH & REHABILITATION CENTER**
(L4) **1850 SARAZIN STREET**
(L5) **SHAKOPEE, MN** (L6) **55379**

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 **05/11/2017** (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)
06/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(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 :
Jane Teipel, HFE-NE II — 06/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 08/07/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/08/1996
(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
05/16/2017
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245610 June 28, 2017

Mr. Richard Meyer, Administrator
St. Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

Dear Mr. Meyer:

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 18, 2017 the above facility is recommended for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 28, 2017

Mr. Richard Meyer, Administrator
St. Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

RE: Project Number S5610025

Dear Mr. Meyer:

On March 28, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 9, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 18, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 9, 2017, effective April 18, 2017 and therefore remedies outlined in our letter to you dated March 28, 2017, 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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 25, 2017

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

Subject: St Gertrudes Health & Rehabilitation Center - Independent Dispute Resolution (IDR)
CMS Certification Number (CCN): 24 5610
Project Number: S5610025

Dear Mr. Meyer:

This is in response to your letter of April 6, 2017, about your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F225 and F226 issued pursuant to the survey event YOX111, completed on March 9, 2017.

The information presented with your letter, the CMS 2567 dated March 9, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F225 S/S - D 42 CFR § 483.12 (a) The facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately and not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury.

F226 S/S - D 42 CFR § 483.12(b) Abuse: The facility must develop and implement written policy and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.

The facility alleges the Oxycodone narcotic medication identified as missing and not reported to the State agency was in fact not missing rather, it was administered and documented appropriately in the facility narcotic reconciliation log book. The facility contends there were no missing or misappropriated narcotic medications.

The facility submitted copies of their narcotic reconciliation logbook page for the Oxycodone medication, which clearly identified the correct utilization of the narcotic medication.
Based on the information provided by the facility, this is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies (CMS 2567) is being electronically delivered.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-308-2104 Fax: 218-308-2122

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Susie Haben, Metro Team D Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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. .REVISED as a result of an Informal Dispute Resolution (IDR).	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 follow care plan approaches to minimize the risk of pressure ulcer development for 1 of 2 residents (R87) reviewed for pressure ulcers. Findings include: R87 had a recently healed stage II PU on his coccyx according to his care plan dated 12/23/16.	F 282	F282-Services by Qualified Person/Per Care Plan SPECIFIC RESIDENTS: Resident R87 affected by alleged deficient practice will be repositioned according to plan of care. OTHER RESIDENTS: Residents who are at risk for skin breakdown will be assessed upon admission, quarterly, and	4/18/17

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

Electronically Signed | 04/06/2017

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F 282	Continued From page 1 The care plan edited 1/25/17, indicated the resident had an unstageable pressure ulcer on his left heal with history of a pressure ulcer on his right coccyx with risk factors including immobility and bowel incontinence. Staff was directed to reposition every two hours and upon request, use a Roho (specialized) cushion, air mattress, pressure relieving booties, nutritional supplement daily, wound nurse referral as needed, check and change every two hours or offer the bedpan, and provide thorough peri-care after incontinent episodes. The care plan dated 1/25/17, care plan indicated the resident had impaired mobility due to Parkinson's disease, weakness, balance issues, and required staffs' assistance with transferring with the use of a Hoyer (mechanical) lift, bed mobility and locomotion in wheelchair. He also required extensive assistance with turning and repositioning every two hours and upon request by R87. Additionally, R87 had an alteration in activities of daily living and required assistance with cares, and was totally dependent on staff for toileting. R87 had an indwelling Foley catheter, and staff was to check and change his incontinence brief and offer the bedpan every two hours. Refusals of care for R87 was not identified as a problem on the resident's care plan, MDS, nor were refusals reflected in Progress Notes from the time of R87's admission through the date of the observation on 3/8/17. A Tissue Tolerance Test completed 3/4/17, indicated R87 had a history of PUs on his coccyx, right and left heels, and at the time of the assessment had a PU on his left heel. The assessment for sitting tolerance revealed no redness to the skin was noted to the buttocks after two hours, however, redness was noted after three hours.	F 282	as needed. Interventions will be put into place according to their skin risk and followed according to plan of care. MONITOR: The Director of Nursing and/or designee will observe repositioning according to plan of care via audits for those residents at risk for skin breakdown: Weekly for 4 weeks, then twice monthly for 1 month, then monthly for 1 month with review by Quality Council for further needs.	

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F 282	Continued From page 2 R87 was continuously observed on 3/8/17, from 9:25 a.m. through 12:00 noon without repositioning. R87 was observed seated in the wheelchair in his room from 9:25 to 10:09 a.m. A mechanical lift sling was beneath the resident. Although nursing assistant (NA)-A went into R87's room at 9:36 a.m. no care was provided for the resident. At 9:50 a.m. volunteer (V)-A invited the resident to an activity. The resident said he wanted to go "in a little bit," so at 10:09 a.m. V-A came back to resident's room and transported R87 to chapel for a remained in the same position in the chapel until 10:58 a.m. Following the activity V-A returned the resident to his room. R87 remained in his wheelchair watching television from 11:00 a.m. to 12:00 p.m. during this time no staff repositioned the resident. At 11:14 a.m. NA-A entered R87's room, but did not reposition the resident. NA-A reported after the observation that she had just offered the resident orange juice. At 12:00 p.m. R87 was asked about his repositioning and whether he was experiencing any pain. R87 confirmed, "I have not moved in my wheelchair since this morning...Yes, sometimes it hurts." At 12:05 p.m. the surveyor then asked NA-B R87's repositioning plan. NA-B replied, "I am not sure--let me look it up." NA-B then checked the computer and reported R87 was to be repositioned every two hours. NA-B then looked up R87's care plan on the computer, and confirmed R87 was supposed to be repositioned every two hours. RN-A was informed on 3/8/17, at 12:10 p.m. about R87's lack of repositioning that morning.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 3 On 3/8/17, at 12:16 p.m. trained medication aide (TMA)-A stated R87's care plan directed staff to reposition R87 every hour. "I do not know why the resident was not repositioned. I do not have an answer for you, but sometimes the resident refuses." R87 was transferred from his chair into bed with the use of a mechanical lift on 3/8/17, at 12:30 p.m. (at least 3 hours, 5 minutes since the observations began) by NA-A and NA-B. RN-A was present to assess the resident's skin. RN-A cleaned R87 of a small amount of incontinent stool and initially stated R87's buttocks was slightly reddened, which was confirmed by the surveyor's observation. RN-B then changed her assessment finding and stated R87's skin was pink versus red. Regarding R87's heal RN-A stated, "I see dry necrotic tissue and slough present on left heel." On 3/8/17, at 12:48 p.m. NA-B confirmed, "I did not offer him [R87] repositioning" the morning of 3/8/17.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		4/18/17

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F 314	Continued From page 4 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and to minimize the risk for further development of pressure ulcers for 1 of 2 residents (R87) reviewed for pressure ulcers. Findings include: R87 was identified as having an unstageable (not visible due to dead tissue) pressure ulcer (PU) on the left heal by registered nurse (RN)-A during an interview on 3/6/17, at 5:28 p.m. During an observation and interview on 3/7/17, at 2:07 p.m. R87 was seated in his wheelchair. He reported, "I have a little pain on my foot," but described the pain as "tolerable." R87 was continuously observed on 3/8/17, from 9:25 a.m. through 12:00 noon without repositioning. R87 was observed seated in the wheelchair in his room from 9:25 to 10:09 a.m. A mechanical lift sling was beneath the resident. Although nursing assistant (NA)-A went into R87's room at 9:36 a.m. no care was provided for the resident. At 9:50 a.m. volunteer (V)-A invited the resident to an activity. The resident said he wanted to go "in a little bit," so at 10:09 a.m. V-A came back to resident's room and transported R87 to chapel for a remained in the same position in the chapel until 10:58 a.m. Following	F 314	F314-Treatment/SVCs to Prevent/Heal Pressure Sores SPECIFIC RESIDENTS: Resident R87 affected by alleged deficient practice will be repositioned according to plan of care. OTHER RESIDENTS: Residents who are at risk for skin breakdown will be assessed upon admission, quarterly, and as needed. Interventions will be put into place according to their skin risk and followed according to plan of care. MONITOR: The Director of Nursing and/or designee will observe repositioning according to plan of care via audits for those residents at risk for skin breakdown: Weekly for 4 weeks, then twice monthly for 1 month, then monthly for 1 month with review by Quality Council for further needs.	

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F 314	Continued From page 5 the activity V-A returned the resident to his room. R87 remained in his wheelchair watching television from 11:00 a.m. to 12:00 p.m. during this time no staff repositioned the resident. At 11:14 a.m. NA-A entered R87's room, but did not reposition the resident. NA-A reported after the observation that she had just offered the resident orange juice. At 12:00 p.m. R87 was asked about his repositioning and whether he was experiencing any pain. R87 confirmed, "I have not moved in my wheelchair since this morning...Yes, sometimes it hurts." At 12:05 p.m. the surveyor then asked NA-B R87's repositioning plan. NA-B replied, "I am not sure--let me look it up." NA-B then checked the computer and reported R87 was to be repositioned every two hours. NA-B then looked up R87's care plan on the computer, and confirmed R87 was supposed to be repositioned every two hours. RN-A was informed on 3/8/17, at 12:10 p.m. about R87's lack of repositioning that morning. On 3/8/17, at 12:16 p.m. trained medication aide (TMA)-A stated R87's care plan directed staff to reposition R87 every hour. "I do not know why the resident was not repositioned. I do not have an answer for you, but sometimes the resident refuses." R87 was transferred from his chair into bed with the use of a mechanical lift on 3/8/17, at 12:30 p.m. (at least 3 hours, 5 minutes since the observations began) by NA-A and NA-B. RN-A was present to assess the resident's skin. RN-A cleaned R87 of a small amount of incontinent stool and initially stated R87's buttocks was	F 314		

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F 314	Continued From page 6	F 314		

slightly reddened, which was confirmed by the surveyor's observation. RN-B then changed her assessment finding and stated R87's skin was pink versus red. Regarding R87's heal RN-A stated, "I see dry necrotic tissue and slough present on left heel."

On 3/8/17, at 12:48 p.m. NA-B confirmed, "I did not offer him [R87] repositioning" the morning of 3/8/17.

R87's 12/12/16, admission Minimum Data Set (MDS) indicated R87 was moderately cognitively impaired, and displayed no behavioral problems or resisting care. He required extensive assistance from two staff with bed mobility and transferring, and staffs' assistance with moving his wheelchair from place to place. The MDS indicated R87 was admitted with diagnoses including Parkinson's disease and dementia. R87 had an indwelling Foley catheter and was frequently incontinent of bowel. At the time of the admission assessment he had no skin breakdown, but was identified as being at risk. Interventions to minimize breakdown included pressure relieving devices in his chair and bed, repositioning program and nutritional plan, as well as the use of ointments. R87 was identified as risk for skin breakdown at the time of his admission, but had no pressure ulcers at that time.

R87 had a recently healed stage II PU on his coccyx according to his care plan dated 12/23/16. The care plan edited 1/25/17, indicated the resident had an unstageable pressure ulcer on his left heal with history of a pressure ulcer on his right coccyx with risk factors including immobility and bowel incontinence. Staff was directed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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F 314	Continued From page 7 reposition every two hours and upon request, use a Roho (specialized) cushion, air mattress, pressure relieving booties, nutritional supplement daily, wound nurse referral as needed, check and change every two hours or offer the bedpan, and provide thorough peri-care after incontinent episodes. The care plan dated 1/25/17, care plan indicated the resident had impaired mobility due to Parkinson's disease, weakness, balance issues, and required staffs' assistance with transferring with the use of a Hoyer (mechanical) lift, bed mobility and locomotion in wheelchair. He also required extensive assistance with turning and repositioning every two hours and upon request by R87. Additionally, R87 had an alteration in activities of daily living and required assistance with cares, and was totally dependent on staff for toileting. R87 had an indwelling Foley catheter, and staff was to check and change his incontinence brief and offer the bedpan every two hours. Refusals of care for R87 was not identified as a problem on the resident's care plan, MDS, nor were refusals reflected in Progress Notes from the time of R87's admission through the date of the observation on 3/8/17. A Tissue Tolerance Test completed 3/4/17, indicated R87 had a history of PUs on his coccyx, right and left heels, and at the time of the assessment had a PU on his left heel. The assessment for sitting tolerance revealed no redness to the skin was noted to the buttocks after two hours, however, redness was noted after three hours. The assessment also indicated the residents Braden Scale test for PU risk revealed the resident was at moderate risk for PU development. A conclusion was not checked on the assessment.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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F 314	Continued From page 8 RN-A was interviewed on 3/8/16, at approximately at 2:00 p.m. regarding the resident's current PU to his heel and stated "Well, when the resident came in he was septic [systemic infection]. I think his circulation was compromised. It was hard to palpate the pedal pulse [indicating poor circulation], he had poor hydration and nutrition and a low albumin and hemoglobin [abnormal laboratory results]. It was hard to believe--it happened so quick. And then the lymphedema therapist was doing lymphedema [excessive fluid in tissue] treatment with him, like a compression wrapping [used to minimize swelling], but I do not know if that contributed to the pressure ulcer." The facility's 3/17, Skin Integrity--Pressure Sores policy revealed, "A program of prevention, care and treatment or pressure sores is provided for all residents to prevent skin breakdown and promote healing...A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."	F 314		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431		4/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 9 biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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.	F 431		

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F 431	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly store and account for medication to minimize the risk for drug diversion for 2 of 2 residents (R101, R378) and for 1 of 1 resident (R75) whose topical medication had expired and was stored for use. Finding include: R378's as needed was noted in un-graduated bottle during a review of the facility's medication storage and accounting system on 3/7/17, at 2:45 p.m. The pharmacy label indicated the bottle contained 120 milliliters (mls), however, the individual narcotic record book (page 10) revealed 118 mls had been received. The narcotic record indicated R378 had received 5 mls of the medication on 3/5/17, at 9:15 a.m. and the remaining amount was documented as 113 mls. That same day at 8:35 p.m. another 5 mls was administered and the remaining amount was recorded as 108 mls. Registered nurse (RN)-B was present during the observation and was asked how staff knew how much of the medication remained in the bottle since the bottle was unmarked. RN-B stated "I never gave this medication so I don't know. I was told just to eye ball it." RN-B then called RN-C to ask for clarification. RN-B stated, "[RN-C] told me to measure it using the weight scale," although RN-B said a scale had never been used in the past. RN-D then arrived and confirmed the nurses would have had no way to account for the amount of medication remaining in the bottle. The facility's consulting pharmacist provided the	F 431	F431-Drug Record, Label/Store Drugs & Biologicals SPECIFIC RESIDENTS: Resident R75 affected by alleged deficient practice will not have items in room. Resident R378 discharged from facility on 3/6/17. OTHER RESIDENTS: Residents will not have expired items in room. MONITOR: The Director of Nursing and/or designee will audit resident rooms for expired items: Weekly for 4 weeks, then twice monthly for 1 month, then monthly for 1 month with review by Quality Council for further needs.	

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F 431	Continued From page 11	F 431		

facility with a response letter dated 3/7/17, which verified R378's Cheratussin AC cough syrup was a controlled substance, and should have been provided in a graduated container. The amount sent was 120 mls versus 118 mls, which the pharmacist reported was "insignificant" but was a result of conversion from ounces to mls. The pharmacist noted however, "the quantity on the pharmacy label should have matched the quantity on the manufacturers label exactly."

RN-D stated on 3/8/17, at 1:58 p.m. regarding narcotic medications, usually medication was counted from shift to shift. RN-D said it was unusual for liquid medications to arrive from the pharmacy in a bottle without scored measurements. RN-D stated, "There is no way to know" how much medication remained in the bottle. RN-D said they could track when the medication had been received.

RN-C explained on 3/9/17, at 11:10 a.m that a scale had never previously been utilized to measure mls. RN-C stated "It is not the best solution, but it is better than nothing." RN-C and the surveyor then reviewed the narcotic record together.

During observation of the medication room/cart on 3/9/17, at 11:10 a.m. with registered nurse (RN)-C, the narcotic record book was reviewed. At that time R101's narcotic record revealed Oxycodone 5 milligrams (mg) had been "DC'd" (discontinued) and a line was drawn from the bottom left to the top right of the page. The last dose signed out was recorded as having been administered at 3:00 a.m. on 2/8/17. The narcotic record indicated eight doses remained. During this observation, RN-C stated the facility had

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F 431	Continued From page 12 identified inconsistencies in their system of tracking narcotics. RN-C explained that when a line was drawn across the narcotic record page, it indicated the medication had been discontinued, and removed from the cupboard for destruction. RN-C said the page should have been signed off by two nurses however, R101's record lacked the required signatures. In addition, RN-C verified she did not know what had happened to the narcotic medication. On 3/9/17, at 3:08 p.m. RN-A stated during interview that they had been unable to locate the remaining eight tablets of R101's Oxycodone. RN-A stated the missing medication was currently "under investigation." RN-A did not provide any further description of what "under investigation" entailed. In addition, there was no record R101's remaining Oxycodone had been destroyed. R75's nightstand contained expired Vanicream (prescription skin cream) on 3/8/17, at 7:00 a.m. The cream had an expiration date of 2/17/17. At 9:05 a.m. the Vanicream was in R75's bathroom, and RN-E confirmed the medication had expired. RN-E stated, "Oh that is not good. The expiration date is 2/17/17. Whoever is putting on the cream should check the expiration date." RN-E stated it was the nurses' responsibility to apply the Vanicream. On 3/9/17, at 9:12 a.m. RN-A explained medication carts were audited regularly, however, she was unsure whether those audits included creams stored in resident rooms. RN-A stated, "The nurse should look at the expiration date before using it on resident." The facility's 3/09, Narcotics Count policy	F 431		

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F 431	Continued From page 13 directed, "One RN or LPN [licensed practical nurse] going off duty and one RN or LPN coming on duty must count and justify unit's narcotics at change of shift...Narcotics newly received from the pharmacy will be counted and signed in by two licensed nurses." The facility's undated Controlled Substance(s) Being Held For Destruction form directed, "Form to be filled out by the nurse and Director of Nursing (or two nurses) and taken with the discontinued controlled drug to the Director of Nursing's office or medication room for storage under double lock until destruction by consultant pharmacist." The facility's 2/15, Discrepancies, Loss and/or Diversion of Medication policy indicated, "Immediately upon the discover or suspicion of a discrepancy, suspected loss of diversion, the Administrator, Director of Nursing (DON) and Consultant Pharmacist are notified and and investigation conducted...The DON investigated the discrepancy and researches all the records related to medication administration and the supply of medication, including medication reconciliation...A thorough search in all drug storage areas...are made to locate any missing container or medication supply...Any corrective action that the DON feels appropriate should be taken."	F 431		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YOX1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00459

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245610**

2.STATE VENDOR OR MEDICAID NO.
(L2) **440886100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST GERTRUDES HEALTH & REHABILITATION CENTER**
(L4) **1850 SARAZIN STREET**
(L5) **SHAKOPEE, MN** (L6) **55379**

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 **03/09/2017** (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)
06/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(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 :
Dawn Chiabotti, HFE NE II — 04/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/11/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/08/1996
(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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 28, 2017

Mr. Richard Meyer, Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, Minnesota 55379

RE: Project Number S5610025

Dear Mr. Meyer:

On March 10, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 18, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 June 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee,	F 225		4/18/17

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

Electronically Signed | 04/06/2017

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 225	Continued From page 1 which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 2	F 225		

Based on interview and document review, the facility failed to immediately report to the State agency (SA) missing narcotic medication as potential diversion/misappropriated property for 1 of 1 resident (R101) whose narcotic medication could not be located.

Finding include:

During observation of the medication room on 3/9/17 at 11:10 a.m. with registered nurse (RN)-C, the narcotic record book was reviewed. At that time R101's narcotic record revealed Oxycodone 5 milligrams (mg) had been "DC'd" (discontinued) and a line was drawn from the bottom left to the top right of the page. The last dose signed out was recorded as having been administered at 3:00 a.m. on 2/8/17. The narcotic record indicated eight doses remained. During this observation, RN-C stated the facility had identified inconsistencies in their system of tracking narcotics. RN-C explained that when a line was drawn across the narcotic record page, it indicated the medication had been discontinued, and removed from the cupboard for destruction. RN-C said the page should have been signed off by two nurses however, R101's record lacked the required signatures. In addition, RN-C verified she did not know what had happened to the narcotic medication.

On 3/9/17, at 3:08 p.m. RN-A stated during interview that they had been unable to locate the remaining eight tablets of R101's Oxycodone. RN-A stated the missing medication was currently "under investigation." RN-A did not provide any further description of what "under investigation" entailed. In addition, there was no record R101's remaining Oxycodone had been destroyed.

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F 225	Continued From page 3 Survey staff verified with the Office of Health Facility Complaints post survey, that no report had been made regarding R101's missing narcotic medication. The facility's undated form, Controlled Substance(s) Being Held For Destruction, included directions: "Form to be filled out by the nurse and Director of Nursing (or two nurses) and taken with the discontinued controlled drug to the Director of Nursing's office or medication room for storage under double lock until destruction by consultant pharmacist." The facility's policy Discrepancies, Loss and/or Diversion of Medication, from 2/2015 included: "Immediately upon the discovery or suspicion of a discrepancy, suspected loss or diversion, the Administrator, Director of Nursing (DON) and Consultant Pharmacist are notified and and investigation conducted...The DON investigates the discrepancy and researches all the records related to medication administration and the supply of medication, including medication reconciliation...A thorough search in all drug storage areas...are made to locate any missing container or medication supply...Any corrective action that the DON feels appropriate should be taken." The facility's policy Abuse Prevention Plan, revised 11/2016, indicated a component of abuse as: "'Misappropriation of resident property': The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent." Direction for staff included: "Contact MDH (Minnesota Department of Health)	F 225		

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F 225	Continued From page 4 via online report immediately upon receiving a report of possible abuse, neglect, and/or financial exploitation. MDH will contact the Minnesota Adult Abuse Reporting Center (MAARC) regarding the report."	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 226		4/18/17

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F 226	Continued From page 5 (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policies for immediate reporting to the State agency (SA) regarding misappropriation of resident property for 1 of 1 resident (R101) whose remaining narcotic medication could not be located. Finding include: The facility's policy Abuse Prevention Plan, revised 11/2016, indicated a component of abuse as: "'Misappropriation of resident property': The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent." Direction for staff included: "Contact MDH (Minnesota Department of Health) via online report immediately upon receiving a report of possible abuse, neglect, and/or financial exploitation. MDH will contact the Minnesota Adult Abuse Reporting Center (MAARC) regarding the report." The facility's policy Discrepancies, Loss and/or Diversion of Medication, from 2/2015 included: "Immediately upon the discovery or suspicion of a discrepancy, suspected loss or diversion, the Administrator, Director of Nursing (DON) and Consultant Pharmacist are notified and and investigation conducted...The DON investigates the discrepancy and researches all the records related to medication administration and the supply of medication, including medication reconciliation...A thorough search in all drug storage areas...are made to locate any missing	F 226		

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F 226	Continued From page 6	F 226		

container or medication supply...Any corrective action that the DON feels appropriate should be taken."

During observation of the medication room on 3/9/17 at 11:10 a.m. with registered nurse (RN)-C, the narcotic record book was reviewed. At that time R101's narcotic record revealed Oxycodone 5 milligrams (mg) had been "DC'd" (discontinued) and a line was drawn from the bottom left to the top right of the page. The last dose signed out was recorded as having been administered at 3:00 a.m. on 2/8/17. The narcotic record indicated eight doses remained. During this observation, RN-C stated the facility had identified inconsistencies in their system of tracking narcotics. RN-C explained that when a line was drawn across the narcotic record page, it indicated the medication had been discontinued, and removed from the cupboard for destruction. RN-C said the page should have been signed off by two nurses however, R101's record lacked the required signatures. In addition, RN-C verified she did not know what had happened to the narcotic medication.

The facility's undated form, Controlled Substance(s) Being Held For Destruction, included directions: "Form to be filled out by the nurse and Director of Nursing (or two nurses) and taken with the discontinued controlled drug to the Director of Nursing's office or medication room for storage under double lock until destruction by consultant pharmacist."

On 3/9/17, at 3:08 p.m. RN-A stated during interview that they had been unable to locate the remaining eight tablets of R101's Oxycodone. RN-A stated the missing medication was currently

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F 226	Continued From page 7 "under investigation." RN-A did not provide any further description of what "under investigation" entailed. In addition, there was no record R101's remaining Oxycodone had been destroyed. No report had been made to the State agency. Survey staff verified this information with the Office of Health Facility Complaints post survey.	F 226		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 follow care plan approaches to minimize the risk of pressure ulcer development for 1 of 2 residents (R87) reviewed for pressure ulcers. Findings include: R87 had a recently healed stage II PU on his coccyx according to his care plan dated 12/23/16. The care plan edited 1/25/17, indicated the resident had an unstageable pressure ulcer on his left heal with history of a pressure ulcer on his right coccyx with risk factors including immobility and bowel incontinence. Staff was directed to reposition every two hours and upon request, use a Roho (specialized) cushion, air mattress,	F 282		4/18/17

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pressure relieving booties, nutritional supplement daily, wound nurse referral as needed, check and change every two hours or offer the bedpan, and provide thorough peri-care after incontinent episodes. The care plan dated 1/25/17, care plan indicated the resident had impaired mobility due to Parkinson's disease, weakness, balance issues, and required staffs' assistance with transferring with the use of a Hoyer (mechanical) lift, bed mobility and locomotion in wheelchair. He also required extensive assistance with turning and repositioning every two hours and upon request by R87. Additionally, R87 had an alteration in activities of daily living and required assistance with cares, and was totally dependent on staff for toileting. R87 had an indwelling Foley catheter, and staff was to check and change his incontinence brief and offer the bedpan every two hours. Refusals of care for R87 was not identified as a problem on the resident's care plan, MDS, nor were refusals reflected in Progress Notes from the time of R87's admission through the date of the observation on 3/8/17.

A Tissue Tolerance Test completed 3/4/17, indicated R87 had a history of PUs on his coccyx, right and left heels, and at the time of the assessment had a PU on his left heel. The assessment for sitting tolerance revealed no redness to the skin was noted to the buttocks after two hours, however, redness was noted after three hours.

R87 was continuously observed on 3/8/17, from 9:25 a.m. through 12:00 noon without repositioning. R87 was observed seated in the wheelchair in his room from 9:25 to 10:09 a.m. A mechanical lift sling was beneath the resident. Although nursing assistant (NA)-A went into R87's

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F 282	Continued From page 9	F 282		

room at 9:36 a.m. no care was provided for the resident. At 9:50 a.m. volunteer (V)-A invited the resident to an activity. The resident said he wanted to go "in a little bit," so at 10:09 a.m. V-A came back to resident's room and transported R87 to chapel for a remained in the same position in the chapel until 10:58 a.m. Following the activity V-A returned the resident to his room. R87 remained in his wheelchair watching television from 11:00 a.m. to 12:00 p.m. during this time no staff repositioned the resident. At 11:14 a.m. NA-A entered R87's room, but did not reposition the resident. NA-A reported after the observation that she had just offered the resident orange juice. At 12:00 p.m. R87 was asked about his repositioning and whether he was experiencing any pain. R87 confirmed, "I have not moved in my wheelchair since this morning...Yes, sometimes it hurts."

At 12:05 p.m. the surveyor then asked NA-B R87's repositioning plan. NA-B replied, "I am not sure--let me look it up." NA-B then checked the computer and reported R87 was to be repositioned every two hours. NA-B then looked up R87's care plan on the computer, and confirmed R87 was supposed to be repositioned every two hours.

RN-A was informed on 3/8/17, at 12:10 p.m. about R87's lack of repositioning that morning.

On 3/8/17, at 12:16 p.m. trained medication aide (TMA)-A stated R87's care plan directed staff to reposition R87 every hour. "I do not know why the resident was not repositioned. I do not have an answer for you, but sometimes the resident refuses."

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F 282	Continued From page 10 R87 was transferred from his chair into bed with the use of a mechanical lift on 3/8/17, at 12:30 p.m. (at least 3 hours, 5 minutes since the observations began) by NA-A and NA-B. RN-A was present to assess the resident's skin. RN-A cleaned R87 of a small amount of incontinent stool and initially stated R87's buttocks was slightly reddened, which was confirmed by the surveyor's observation. RN-B then changed her assessment finding and stated R87's skin was pink versus red. Regarding R87's heal RN-A stated, "I see dry necrotic tissue and slough present on left heel." On 3/8/17, at 12:48 p.m. NA-B confirmed, "I did not offer him [R87] repositioning" the morning of 3/8/17.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 314		4/18/17

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by:
Based on observation, interview and document review, the facility failed to provide care and to minimize the risk for further development of pressure ulcers for 1 of 2 residents (R87) reviewed for pressure ulcers.

Findings include:

R87 was identified as having an unstageable (not visible due to dead tissue) pressure ulcer (PU) on the left heal by registered nurse (RN)-A during an interview on 3/6/17, at 5:28 p.m.

During an observation and interview on 3/7/17, at 2:07 p.m. R87 was seated in his wheelchair. He reported, "I have a little pain on my foot," but described the pain as "tolerable."

R87 was continuously observed on 3/8/17, from 9:25 a.m. through 12:00 noon without repositioning. R87 was observed seated in the wheelchair in his room from 9:25 to 10:09 a.m. A mechanical lift sling was beneath the resident. Although nursing assistant (NA)-A went into R87's room at 9:36 a.m. no care was provided for the resident. At 9:50 a.m. volunteer (V)-A invited the resident to an activity. The resident said he wanted to go "in a little bit," so at 10:09 a.m. V-A came back to resident's room and transported R87 to chapel for a remained in the same position in the chapel until 10:58 a.m. Following the activity V-A returned the resident to his room. R87 remained in his wheelchair watching television from 11:00 a.m. to 12:00 p.m. during this time no staff repositioned the resident. At 11:14 a.m. NA-A entered R87's room, but did not reposition the resident. NA-A reported after the observation that she had just offered the resident

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orange juice. At 12:00 p.m. R87 was asked about his repositioning and whether he was experiencing any pain. R87 confirmed, "I have not moved in my wheelchair since this morning...Yes, sometimes it hurts."

At 12:05 p.m. the surveyor then asked NA-B R87's repositioning plan. NA-B replied, "I am not sure--let me look it up." NA-B then checked the computer and reported R87 was to be repositioned every two hours. NA-B then looked up R87's care plan on the computer, and confirmed R87 was supposed to be repositioned every two hours.

RN-A was informed on 3/8/17, at 12:10 p.m. about R87's lack of repositioning that morning.

On 3/8/17, at 12:16 p.m. trained medication aide (TMA)-A stated R87's care plan directed staff to reposition R87 every hour. "I do not know why the resident was not repositioned. I do not have an answer for you, but sometimes the resident refuses."

R87 was transferred from his chair into bed with the use of a mechanical lift on 3/8/17, at 12:30 p.m. (at least 3 hours, 5 minutes since the observations began) by NA-A and NA-B. RN-A was present to assess the resident's skin. RN-A cleaned R87 of a small amount of incontinent stool and initially stated R87's buttocks was slightly reddened, which was confirmed by the surveyor's observation. RN-B then changed her assessment finding and stated R87's skin was pink versus red. Regarding R87's heal RN-A stated, "I see dry necrotic tissue and slough present on left heel."

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	245610	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

(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
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On 3/8/17, at 12:48 p.m. NA-B confirmed, "I did not offer him [R87] repositioning" the morning of 3/8/17.

R87's 12/12/16, admission Minimum Data Set (MDS) indicated R87 was moderately cognitively impaired, and displayed no behavioral problems or resisting care. He required extensive assistance from two staff with bed mobility and transferring, and staffs' assistance with moving his wheelchair from place to place. The MDS indicated R87 was admitted with diagnoses including Parkinson's disease and dementia. R87 had an indwelling Foley catheter and was frequently incontinent of bowel. At the time of the admission assessment he had no skin breakdown, but was identified as being at risk. Interventions to minimize breakdown included pressure relieving devices in his chair and bed, repositioning program and nutritional plan, as well as the use of ointments. R87 was identified as risk for skin breakdown at the time of his admission, but had no pressure ulcers at that time.

R87 had a recently healed stage II PU on his coccyx according to his care plan dated 12/23/16. The care plan edited 1/25/17, indicated the resident had an unstageable pressure ulcer on his left heal with history of a pressure ulcer on his right coccyx with risk factors including immobility and bowel incontinence. Staff was directed to reposition every two hours and upon request, use a Roho (specialized) cushion, air mattress, pressure relieving booties, nutritional supplement daily, wound nurse referral as needed, check and change every two hours or offer the bedpan, and provide thorough peri-care after incontinent episodes. The care plan dated 1/25/17, care plan

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indicated the resident had impaired mobility due to Parkinson's disease, weakness, balance issues, and required staffs' assistance with transferring with the use of a Hoyer (mechanical) lift, bed mobility and locomotion in wheelchair. He also required extensive assistance with turning and repositioning every two hours and upon request by R87. Additionally, R87 had an alteration in activities of daily living and required assistance with cares, and was totally dependent on staff for toileting. R87 had an indwelling Foley catheter, and staff was to check and change his incontinence brief and offer the bedpan every two hours. Refusals of care for R87 was not identified as a problem on the resident's care plan, MDS, nor were refusals reflected in Progress Notes from the time of R87's admission through the date of the observation on 3/8/17.

A Tissue Tolerance Test completed 3/4/17, indicated R87 had a history of PUs on his coccyx, right and left heels, and at the time of the assessment had a PU on his left heel. The assessment for sitting tolerance revealed no redness to the skin was noted to the buttocks after two hours, however, redness was noted after three hours. The assessment also indicated the residents Braden Scale test for PU risk revealed the resident was at moderate risk for PU development. A conclusion was not checked on the assessment.

RN-A was interviewed on 3/8/16, at approximately at 2:00 p.m. regarding the resident's current PU to his heel and stated "Well, when the resident came in he was septic [systemic infection]. I think his circulation was compromised. It was hard to palpate the pedal pulse [indicating poor circulation], he had poor hydration and nutrition

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F 314	Continued From page 15 and a low albumin and hemoglobin [abnormal laboratory results]. It was hard to believe--it happened so quick. And then the lymphedema therapist was doing lymphedema [excessive fluid in tissue] treatment with him, like a compression wrapping [used to minimize swelling], but I do not know if that contributed to the pressure ulcer." The facility's 3/17, Skin Integrity--Pressure Sores policy revealed, "A program of prevention, care and treatment or pressure sores is provided for all residents to prevent skin breakdown and promote healing...A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."	F 314		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and	F 431		4/18/17

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F 431	Continued From page 16 disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 properly store and account for medication to minimize the risk for drug diversion for 2 of 2 residents (R101, R378) and for 1 of 1 resident (R75) whose topical medication had expired and was stored for use.	F 431		

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F 431	Continued From page 17 Finding include: R378's as needed was noted in un-graduated bottle during a review of the facility's medication storage and accounting system on 3/7/17, at 2:45 p.m. The pharmacy label indicated the bottle contained 120 milliliters (mls), however, the individual narcotic record book (page 10) revealed 118 mls had been received. The narcotic record indicated R378 had received 5 mls of the medication on 3/5/17, at 9:15 a.m. and the remaining amount was documented as 113 mls. That same day at 8:35 p.m. another 5 mls was administered and the remaining amount was recorded as 108 mls. Registered nurse (RN)-B was present during the observation and was asked how staff knew how much of the medication remained in the bottle since the bottle was unmarked. RN-B stated "I never gave this medication so I don't know. I was told just to eye ball it." RN-B then called RN-C to ask for clarification. RN-B stated, "[RN-C] told me to measure it using the weight scale," although RN-B said a scale had never been used in the past. RN-D then arrived and confirmed the nurses would have had no way to account for the amount of medication remaining in the bottle. The facility's consulting pharmacist provided the facility with a response letter dated 3/7/17, which verified R378's Cheratussin AC cough syrup was a controlled substance, and should have been provided in a graduated container. The amount sent was 120 mls versus 118 mls, which the pharmacist reported was "insignificant" but was a result of conversion from ounces to mls. The pharmacist noted however, "the quantity on the	F 431		

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pharmacy label should have matched the quantity on the manufacturers label exactly."

RN-D stated on 3/8/17, at 1:58 p.m. regarding narcotic medications, usually medication was counted from shift to shift. RN-D said it was unusual for liquid medications to arrive from the pharmacy in a bottle without scored measurements. RN-D stated, "There is no way to know" how much medication remained in the bottle. RN-D said they could track when the medication had been received.

RN-C explained on 3/9/17, at 11:10 a.m that a scale had never previously been utilized to measure mls. RN-C stated "It is not the best solution, but it is better than nothing." RN-C and the surveyor then reviewed the narcotic record together.

During observation of the medication room/cart on 3/9/17, at 11:10 a.m. with registered nurse (RN)-C, the narcotic record book was reviewed. At that time R101's narcotic record revealed Oxycodone 5 milligrams (mg) had been "DC'd" (discontinued) and a line was drawn from the bottom left to the top right of the page. The last dose signed out was recorded as having been administered at 3:00 a.m. on 2/8/17. The narcotic record indicated eight doses remained. During this observation, RN-C stated the facility had identified inconsistencies in their system of tracking narcotics. RN-C explained that when a line was drawn across the narcotic record page, it indicated the medication had been discontinued, and removed from the cupboard for destruction. RN-C said the page should have been signed off by two nurses however, R101's record lacked the required signatures. In addition, RN-C verified

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she did not know what had happened to the narcotic medication.

On 3/9/17, at 3:08 p.m. RN-A stated during interview that they had been unable to locate the remaining eight tablets of R101's Oxycodone. RN-A stated the missing medication was currently "under investigation." RN-A did not provide any further description of what "under investigation" entailed. In addition, there was no record R101's remaining Oxycodone had been destroyed.

R75's nightstand contained expired Vanicream (prescription skin cream) on 3/8/17, at 7:00 a.m. The cream had an expiration date of 2/17/17. At 9:05 a.m. the Vanicream was in R75's bathroom, and RN-E confirmed the medication had expired. RN-E stated, "Oh that is not good. The expiration date is 2/17/17. Whoever is putting on the cream should check the expiration date." RN-E stated it was the nurses' responsibility to apply the Vanicream.

On 3/9/17, at 9:12 a.m. RN-A explained medication carts were audited regularly, however, she was unsure whether those audits included creams stored in resident rooms. RN-A stated, "The nurse should look at the expiration date before using it on resident."

The facility's 3/09, Narcotics Count policy directed, "One RN or LPN [licensed practical nurse] going off duty and one RN or LPN coming on duty must count and justify unit's narcotics at change of shift...Narcotics newly received from the pharmacy will be counted and signed in by two licensed nurses."

The facility's undated Controlled Substance(s)

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F 431	Continued From page 20 Being Held For Destruction form directed, "Form to be filled out by the nurse and Director of Nursing (or two nurses) and taken with the discontinued controlled drug to the Director of Nursing's office or medication room for storage under double lock until destruction by consultant pharmacist." The facility's 2/15, Discrepancies, Loss and/or Diversion of Medication policy indicated, "Immediately upon the discover or suspicion of a discrepancy, suspected loss of diversion, the Administrator, Director of Nursing (DON) and Consultant Pharmacist are notified and and investigation conducted...The DON investigated the discrepancy and researches all the records related to medication administration and the supply of medication, including medication reconciliation...A thorough search in all drug storage areas...are made to locate any missing container or medication supply...Any corrective action that the DON feels appropriate should be taken."	F 431		

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

F561023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/10/2017**

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ST GERTRUDES HEALTH & REHABILITATION	**1850 SARAZIN STREET SHAKOPEE, MN 55379**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Facility name) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 Existing Health Care. This facility will be surveyed as two separate buildings. The original building was constructed at 3 different times, St. Gertrude's Health Center is a 1-story building with no basement constructed in 1996 and was determined to be of Type V (111) construction. In 1999, an addition was constructed to the East Wing that was determined to be of Type V(111) construction. In 2007 an addition is an 1-story building with no basement and was constructed to be determined to be of Type V(111) construction. This facility will be surveyed as two separate buildings the original building was type V (111) construction and Building 2 was type II (111) construction and is a two story building. The buildings are protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 105 certified beds.	K 000		

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING **03 - BLDG THREE NEW ADDITION** B. WING _____	**03/10/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Facility name) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 Existing Health Care. St. Gertrudes Health Center, in 2011 this addition is a 2-story building with a full basement. The addition was constructed and was determined to be of Type II(222) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 105 certified beds.	K 000		

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

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