DEPARTMENT OF HEAL	<b>FH AND HUMAN</b>	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
	MEDIC	CARE/MEDICA	ID CERTIFI	CATION A	AND TRANSMITTAL	ID: YOX1
	PART I	- TO BE COMP	LETED BY	THE STAT	TE SURVEY AGENCY	Facility ID: 00459
1.         MEDICARE/MEDICAID PROVID           (L1)         245610           2.STATE VENDOR OR MEDICAID N           (L2)         440886100		<ol> <li>NAME AND AI</li> <li>(L3) ST GERTRI</li> <li>(L4) 1850 SARAZ</li> <li>(L5) SHAKOPER</li> </ol>	UDE'S HEALT ZIN STREET		BILITATION CENTER (L6) 55379	4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	/11/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
<ul> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited</li> <li>1 TJC</li> <li>2 AOA</li> <li>3 Othe</li> </ul>	(L10) r	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	06/30
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY	IS CERTIFIED A	S:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of TI	he Following Requirements:
To (b) :			Requirements ce Based On:		2. Technical Personnel	6. Scope of Services Limit
		1	Acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNI	<ul><li>F) 8. Patient Room Size</li></ul>
12.Total Facility Beds	105 (L18)		Acceptable FOC			9. Beds/Room
13.Total Certified Beds	<b>105</b> (L17)		mpliance with Pro and/or Applied W	-	5. Life Safety Code * Code: A	9. Beds/koom (L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SN 105	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Jane Teipel, HFE-NE II			06/28/2017	(L19)	Anne Peterson, Enforce	ement Specialist 08/07/2017
	PART II - TO BI	E COMPLETED	BY HCFA R	EGIONAI	C OFFICE OR SINGLE ST	CATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBI</li> <li>X 1. Facility is Eligible t</li> <li>2. Facility is not Eligible</li> </ol>	o Participate		MPLIANCE WITH GHTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>11/08/1996</b>	BEGINNING	DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursem	ent 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Sus	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL I	DATE		
	(L32)	05/16/2017		(L33)	DETERMINATION APPR	ROVAL



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 Retenson\_

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



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 Retenson\_

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



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,

Ja Burkman

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

TAG       REGULATORY ON LISC IDENTIFYING INFORMATION)       TAG       CROSS REFERENCES TO THE APPROPRIATE       DMTE         F 000       INITIAL COMMENTS       F 000	DEPART	MENT OF HEALTH	AND HUMAN SERVICES				M APPROVED
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BULDING       COMPLETED         245610       B. WING       03/09/2017         INME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2P CODE       1980 SARAZIN STREET         STREET ADDRESS, CITY, STATE, 2P CODE       1980 SARAZIN STREET       SHAMAPY STATE, 2P CODE         YAU, D.       SUMMARY STATEMENT OF DEPOSITION CENTER       STREET ADDRESS, CITY, STATE, 2P CODE       1980 SARAZIN STREET         YAU       RESULATORY OR US IN EP RECEDENCES FILL       00       PROVIDERS PLAN OF CORRECTION       000         PRETX       RESULATORY OR US IDENTIFYING INFORMATION)       PRESS       PROVIDERS PLAN OF CORRECTION       000         F 000       INITIAL COMMENTS       F 000       F 000       F 000       F 000       INITIAL COMMENTS       F 000         The facility is enrolled in ePOC will be used as verification of compliance.       F 000       F 282       4/18/17         Kb(3) Comprehensive Care Plans       The services provided or an informal Dispute Resolution (IDR).       F 282       4/18/17         Kb(3) Comprehensive Care Plans       The services provided or arranged by the facility, as outlined by flee of plans the sk of pressure ulcer development for 1 of 2 residents (R87) reviewed for pressure ulcer development for 1 of 1 2 residents (R87) reviewed for pressure ulcer development for 1 of 1 2 residents (R87) reviewed for pressure ulcer development for 1 of	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0. 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. GITV. STATE, ZIP CODE       ST GERTRUDES HEALTH & REHABILITATION CENTER     STREET ADDRESS. GITV. STATE, ZIP CODE       Image: Comparison of the POC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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.     F 000       INITIAL COMMENTS     F 000       REVISED as a result of an alcoptable 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 each resident's written plan of care.     F 282       SS-D     PERSONS/PER CARE PLAN     F 282       (i) Be provided by qualified persons in accordance with each resident's written plan of care.     F 282-Services by Qualified Person/Per Care Plans       (ii) Be provided by qualified persons in accordance with each resident's written plan of care.     F 282-Services by Qualified Person/Per Care Plan       (iii) Be provided by qualified persons in accordance with each resident's written plan of care.     SPECIFIC RESIDENTS: Resident R87 affected by alleged deficient practice will be repositioned accordance with each resident's written plan of care.       Findings include:     Findings include:	-						
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STREET STREET         STREET ADDRESS, CITY, STREET ADDRESS, CITY, STREET SHAROPE CORRECTION       ISIO SARZIN STREET         (M) ID       SUMMARY STATEMENT OF DEFICIENCIES       IP         (PA) ID       SUMMARY STATEMENT OF DEFICIENCIES       IP         (EACH DEFICIENCY MUST BE FRICEDED BY FULL       PREEX       PREEX         (EACH DEFICIENCY MUST BE FRICEDED BY FULL       PREEX       F000         F 000       INITIAL COMMENTS       F 000         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.       F 000         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 282         KEVISED as a result of an Informal Dispute Resolution (IDR).       F 282       F 282         Submission of the POC will be used as verification.       F 282       Streef Paraone Pa			245610	B. WING		03	3/09/2017
ST GERTRUDES HEALTH & REHABILITATION CENTER       SHAKOPEE, MN 55379         (M4) ID PREEX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCIES) (EACH DEPICIES) (EACH DEPICIES)	NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S		
PIERT       reach deficiency must be preceded by Full       PREVATORY OR LSC DENTIFYING INFORMATION)       PREVATORY OR LSC DENTIFYING INFORMATION)       COMMENT       COMMENT<	ST GERT	RUDES HEALTH & R	EHABILITATION CENTER				
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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). .REVISED as a result of a result of a result of the resolution of care.         	F 000	INITIAL COMMENT	ſS	FO	000		
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). .REVISED as a result of an Informal Dispute Resolution (IDR). 		signature is not req page of the CMS-29 submission of the F	uired at the bottom of the first 567 form. Electronic POC will be used as				
Resolution (IDR).       483.21(b)(3)(ii) SERVICES BY QUALIFIED       F 282       4/18/17         SS=D       PERSONS/PER CARE PLAN       F 282       4/18/17         (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.       F 282       F 282       F 282         (iii) Be provided by qualified persons in accordance with each resident's written plan of care.       F 282-Services by Qualified Person/Per Care Plan       F 282-Services by Qualified Person/Per Care Plan         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.       SPECIFIC RESIDENTS: Resident R87 affected by alleged deficient practice will be repositioned according to plan of care.         Findings include:       OTHER RESIDENTS: Residents who are at risk for skin breakdown will be		revisit of your facilit validate that substa regulations has bee	y may be conducted to ntial compliance with the				
<ul> <li>(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</li> <li>(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.</li> <li>Findings include:</li> <li>R87 had a recently healed stage II PU on his</li> </ul>		Resolution (IDR). 483.21(b)(3)(ii) SEF	RVICES BY QUALIFIED	F 2	282		4/18/17
<ul> <li>accordance with each resident's written plan of care.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>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.</li> <li>Findings include:</li> <li>R87 had a recently healed stage II PU on his</li> <li>Findings include:</li> <li>R87 had a recently healed stage II PU on his</li> <li>Findings include:</li> <l< td=""><td>33=D</td><td>(b)(3) Comprehens The services provid as outlined by the c</td><td>ive Care Plans led or arranged by the facility,</td><td></td><td></td><td></td><td></td></l<></ul>	33=D	(b)(3) Comprehens The services provid as outlined by the c	ive Care Plans led or arranged by the facility,				
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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.Care PlanFindings include:SPECIFIC RESIDENTS: Resident R87 affected by alleged deficient practice will be repositioned according to plan of care.R87 had a recently healed stage II PU on hisOTHER RESIDENTS: Residents who are at risk for skin breakdown will be		by:				F000 Convises by Ouslified Deveous/Dev	
development for 1 of 2 residents (R87) reviewed for pressure ulcers.SPECIFIC RESIDENTS: Resident R87 affected by alleged deficient practice will be repositioned according to plan of care.Findings include:OTHER RESIDENTS: Residents who are at risk for skin breakdown will be		review, the facility fa	ailed to follow care plan				
Findings include:       OTHER RESIDENTS: Residents who are         R87 had a recently healed stage II PU on his       at risk for skin breakdown will be		development for 1 d	of 2 residents (R87) reviewed			affected by alleged deficient practice will	
R87 had a recently healed stage II PU on his at risk for skin breakdown will be		Findings include:					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Electronically Signed 04/06/20			ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE 04/06/2017

**Electronically Signed** 

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.

PRINTED: 07/25/2017

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	TIPLE CONSTRUCTION	OMB NO.	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245610	B. WING		03/0	9/2017
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
T GERI	RUDES HEALTH & R	EHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 282	Continued From pa	age 1	F 23	82		
	The care plan edite	ed 1/25/17, indicated the		as needed. Interventions will be	e put into	
		stageable pressure ulcer on		place according to their skin ris		
		story of a pressure ulcer on his sk factors including immobility		followed according to plan of ca	ire.	
		ence. Staff was directed to		MONITOR: The Director of Nur	sina	
		o hours and upon request, use		and/or designee will observe re	positioning	
		d) cushion, air mattress,		according to plan of care via au		
		pooties, nutritional supplement		those residents at risk for skin b		
		referral as needed, check and nours or offer the bedpan, and		Weekly for 4 weeks, then twice for 1 month, then monthly for 1		
		eri-care after incontinent		review by Quality Council for fu		
		plan dated 1/25/17, care plan		needs.		
		ent had impaired mobility due				
		ase, weakness, balance				
		d staffs' assistance with e use of a Hoyer (mechanical)				
		d locomotion in wheelchair. He				
		sive assistance with turning				
		very two hours and upon				
		Iditionally, R87 had an				
		es of daily living and required res, and was totally dependent				
		. R87 had an indwelling Foley				
		was to check and change his				
	incontinence brief a	and offer the bedpan every two				
		care for R87 was not identified				
		e resident's care plan, MDS,				
		ofloated in Drearces Nates				
		eflected in Progress Notes 37's admission through the				
	date of the observa	37's admission through the				
	A Tissue Tolerance	37's admission through the tion on 3/8/17. Test completed 3/4/17,				
	A Tissue Tolerance indicated R87 had	37's admission through the ation on 3/8/17. Test completed 3/4/17, a history of PUs on his coccyx,				
	A Tissue Tolerance indicated R87 had right and left heels,	37's admission through the attion on 3/8/17. Test completed 3/4/17, a history of PUs on his coccyx, and at the time of the				
	A Tissue Tolerance indicated R87 had right and left heels, assessment had a	37's admission through the ation on 3/8/17. Test completed 3/4/17, a history of PUs on his coccyx, and at the time of the PU on his left heel. The				
	A Tissue Tolerance indicated R87 had right and left heels, assessment had a assessment for sitt	37's admission through the attion on 3/8/17. Test completed 3/4/17, a history of PUs on his coccyx, and at the time of the				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245610	B. WING		03/(	09/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST GERT	RUDES HEALTH & R	EHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR LE Continued From pa R87 was continuou 9:25 a.m. through 1 repositioning. R87 w wheelchair in his ro mechanical lift sling Although nursing as room at 9:36 a.m. n resident. At 9:50 a.r resident to an activi wanted to go "in a li came back to reside R87 to chapel for a position in the chap the activity V-A retu R87 remained in his television from 11:0 this time no staff re 11:14 a.m. NA-A en reposition the reside observation that sho orange juice. At 12: his repositioning an experiencing any pa moved in my wheel sometimes it hurts. <sup>1</sup> At 12:05 p.m. the su R87's repositioning surelet me look it computer and repor	ge 2 sly observed on 3/8/17, from 2:00 noon without was observed seated in the om from 9:25 to 10:09 a.m. A g was beneath the resident. ssistant (NA)-A went into R87's to care was provided for the m. volunteer (V)-A invited the ty. The resident said he ittle bit," so at 10:09 a.m. V-A ent's room and transported remained in the same el until 10:58 a.m. Following rned the resident to his room. s wheelchair watching 0 a.m. to 12:00 p.m. during positioned the resident. At ttered R87's room, but did not ent. NA-A reported after the e had just offered the resident 00 p.m. R87 was asked about d whether he was ain. R87 confirmed, "I have not chair since this morningYes,"	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE
	confirmed R87 was every two hours. RN-A was informed	on the computer, and supposed to be repositioned on 3/8/17, at 12:10 p.m. repositioning that morning.				

PRINTED: 07/25/2017

		E & MEDICAID SERVICES				). 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245610	B. WING _		03	8/09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ST GERI	RUDES HEALTH & F	REHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 3	F 28	32		
	(TMA)-A stated R8 reposition R87 ever resident was not re answer for you, bu refuses." R87 was transferre the use of a mecha p.m. (at least 3 hou observations bega was present to ass cleaned R87 of a s stool and initially st slightly reddened, w surveyor's observa assessment finding pink versus red. Re stated, "I see dry n present on left hee					
F 314 SS=D	not offer him [R87] 3/8/17. 483.25(b)(1) TREA	3 p.m. NA-B confirmed, "I did repositioning" the morning of ATMENT/SVCS TO PRESSURE SORES	F 31	4		4/18/17
	(b) Skin Integrity -					
	(1) Pressure ulcers comprehensive as facility must ensure	sessment of a resident, the				
	professional stand pressure ulcers an ulcers unless the ir	ves care, consistent with ards of practice, to prevent d does not develop pressure ndividual's clinical condition they were unavoidable; and				

If continuation sheet Page 4 of 14

		AND HUMAN SERVICES				FORM	07/25/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245610	B. WING			03/0	09/2017
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		18	REET ADDRESS, CITY, STATE, ZIP CODE 350 SARAZIN STREET HAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 4	F 3	14			
	necessary treatmen professional standa healing, prevent inf from developing. This REQUIREMEN by: Based on observat review, the facility f minimize the risk for pressure ulcers for reviewed for pressur Findings include: R87 was identified visible due to dead the left heal by regi interview on 3/6/17 During an observat 2:07 p.m. R87 was reported, "I have a described the pain R87 was continuou 9:25 a.m. through 1 repositioning. R87 wheelchair in his ro mechanical lift sling Although nursing as room at 9:36 a.m. r resident to an activ wanted to go "in a I came back to resid R87 to chapel for a	as having an unstageable (not tissue) pressure ulcer (PU) on stered nurse (RN)-A during an , at 5:28 p.m. ion and interview on 3/7/17, at seated in his wheelchair. He little pain on my foot," but as "tolerable." sly observed on 3/8/17, from			F314-Treatment/SVCs to Prevent/ Pressure Sores SPECIFIC RESIDENTS: Resident affected by alleged deficient practic be repositioned according to plan of OTHER RESIDENTS: Residents w at risk for skin breakdown will be assessed upon admission, quarter as needed. Interventions will be pu place according to their skin risk ar followed according to plan of care. MONITOR: The Director of Nursing and/or designee will observe repos according to plan of care via audits those residents at risk for skin brea Weekly for 4 weeks, then twice mo for 1 month, then monthly for 1 mo review by Quality Council for further needs.	R87 ce will of care. tho are y, and it into nd itioning for ikdown: nthly nth with	

If continuation sheet Page 5 of 14

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETED	
		245610	B. WING			03/	09/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST GERI	RUDES HEALTH & R	EHABILITATION CENTER			50 SARAZIN STREET IAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 314	Continued From pa	age 5	F 3	814			
	the activity V-A retu R87 remained in hi television from 11:0 this time no staff re 11:14 a.m. NA-A er reposition the resid observation that sh orange juice. At 12 his repositioning an experiencing any p moved in my whee sometimes it hurts. At 12:05 p.m. the s R87's repositioning surelet me look it computer and repo repositioned every up R87's care plan confirmed R87 was every two hours. RN-A was informed about R87's lack of	urveyor then asked NA-B plan. NA-B replied, "I am not up." NA-B then checked the reted R87 was to be two hours. NA-B then looked on the computer, and supposed to be repositioned		S			
	(TMA)-A stated R8 reposition R87 ever resident was not re answer for you, but refuses." R87 was transferre the use of a mecha	p.m. trained medication aide 7's care plan directed staff to ry hour. "I do not know why the positioned. I do not have an sometimes the resident and from his chair into bed with unical lift on 3/8/17, at 12:30					
	observations begar was present to ass cleaned R87 of a s	Irs, 5 minutes since the n) by NA-A and NA-B. RN-A ess the resident's skin. RN-A mall amount of incontinent ated R87's buttocks was					

If continuation sheet Page 6 of 14

-		& MEDICAID SERVICES	T			). 0938-039 <sup>-</sup>
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245610	B. WING		03	/09/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ST GER	TRUDES HEALTH & F	REHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 314	slightly reddened, w surveyor's observa assessment finding pink versus red. Re stated, "I see dry n present on left hee On 3/8/17, at 12:48 not offer him [R87] 3/8/17. R87's 12/12/16, ad (MDS) indicated R87 impaired, and displ or resisting care. H assistance from tw transferring, and st his wheelchair from indicated R87 was including Parkinson had an indwelling F frequently incontine	which was confirmed by the tion. RN-B then changed her g and stated R87's skin was egarding R87's heal RN-A ecrotic tissue and slough		14		

If continuation sheet Page 7 of 14

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		VG	COMPLETED	
		245610	B. WING _		03	/09/2017
AME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD	E	
T GERT	RUDES HEALTH & F	REHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 314	Continued From pa	age 7	F 3 <sup>-</sup>	14		
		o hours and upon request, use				
		d) cushion, air mattress,				
		pooties, nutritional supplement referral as needed, check and				
	change every two h	nours or offer the bedpan, and				
e i t		eri-care after incontinent				
		e plan dated 1/25/17, care plan ent had impaired mobility due				
		ase, weakness, balance				
		d staffs' assistance with				
		e use of a Hoyer (mechanical) d locomotion in wheelchair. He				
		sive assistance with turning				
	and repositioning e	very two hours and upon				
		Iditionally, R87 had an				
		es of daily living and required res, and was totally dependent				
	on staff for toileting	. R87 had an indwelling Foley				
		was to check and change his and offer the bedpan every two				
		care for R87 was not identified				
		e resident's care plan, MDS,				
		eflected in Progress Notes				
	date of the observa	37's admission through the ation on 3/8/17				
		Test completed 3/4/17,				
		a history of PUs on his coccyx,				
	assessment had a assessment for sitt	a history of PUs on his coccyx, and at the time of the PU on his left heel. The ing tolerance revealed no				
	assessment had a assessment for sitt redness to the skin	a history of PUs on his coccyx, and at the time of the PU on his left heel. The ing tolerance revealed no was noted to the buttocks				
	assessment had a assessment for sitt redness to the skin after two hours, ho	a history of PUs on his coccyx, and at the time of the PU on his left heel. The ing tolerance revealed no				
	assessment had a assessment for sitt redness to the skin after two hours, ho after three hours. T	a history of PUs on his coccyx, and at the time of the PU on his left heel. The ing tolerance revealed no was noted to the buttocks wever, redness was noted				
	assessment had a assessment for sitt redness to the skin after two hours, ho after three hours. T the residents Brade revealed the reside	a history of PUs on his coccyx, and at the time of the PU on his left heel. The ing tolerance revealed no was noted to the buttocks wever, redness was noted he assessment also indicated				

If continuation sheet Page 8 of 14

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		TE SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COI	MPLETED
		245610	B. WING _		03	/09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERI	RUDES HEALTH & R	EHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 314 F 431 SS=D	at 2:00 p.m. regardi to his heel and state came in he was sep his circulation was of palpate the pedal p circulation], he had and a low albumin a laboratory results]. happened so quick, therapist was doing in tissue] treatment wrapping [used to n know if that contribut The facility's 3/17, S policy revealed, "A p and treatment or pr all residents to prev promote healingA sores receives need to promote healing, new sores from dev 483.45(b)(2)(3)(g)(h LABEL/STORE DR The facility must pro drugs and biologica them under an agre §483.70(g) of this p unlicensed personn	red on 3/8/16, at approximately ing the resident's current PU ed "Well, when the resident otic [systemic infection]. I think compromised. It was hard to ulse [indicating poor poor hydration and nutrition and hemoglobin [abnormal It was hard to believeit . And then the lymphedema lymphedema [excessive fluid with him, like a compression ninimize swelling], but I do not uted to the pressure ulcer." Skin IntegrityPressure Sores program of prevention, care essure sores is provided for rent skin breakdown and a resident having pressure essary treatment and services prevent infection and prevent veloping." n) DRUG RECORDS, UGS & BIOLOGICALS ovide routine and emergency its to its residents, or obtain eement described in eart. The facility may permit uel to administer drugs if State by under the general	F 31	4		4/18/17
	pharmaceutical ser that assure the acc	acility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245610	B. WING			
	PROVIDER OR SUPPLIER	243610	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		/09/2017
		REHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	<ul> <li>(b) Service Consult employ or obtain the pharmacist who</li> <li>(2) Establishes a sy disposition of all co- detail to enable an</li> <li>(3) Determines that that an account of a maintained and per</li> <li>(g) Labeling of Drug (g) Labeling of Drug Drugs and biologic labeled in accordan professional princip appropriate access instructions, and the applicable.</li> <li>(h) Storage of Drug (1) In accordance with the facility must stor locked compartment controls, and perminave access to the</li> <li>(2) The facility must permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe</li> </ul>	t the needs of each resident. tation. The facility must be services of a licensed system of records of receipt and ontrolled drugs in sufficient accurate reconciliation; and t drug records are in order and all controlled drugs is riodically reconciled. gs and Biologicals. als used in the facility must be nee with currently accepted oles, and include the sory and cautionary e expiration date when gs and Biologicals. with State and Federal laws, ore all drugs and biologicals in nts under proper temperature it only authorized personnel to	F 43			

If continuation sheet Page 10 of 14

NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ST GERTRUDES HEALTH & REHABILITATION CENTER     1850 SARAZIN STREET       SHAKOPEE, MN 55379     SHAKOPEE, MN 55379       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE     (x5) COMPLE	TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED
1860 SARAZIN STREET SHAKOPEE, MN 55373       SUMMARY STATEMENT OF DEFICIENCIES PRETRY REQUITED Y MUST BE PRECIENCIES PRETRY REQUITED Y OR LSC IDENTIFYING INFORMATION)     IND PRETRY TAG     IND CONSERVENT ACTION SHOULD BE CROSS-REFERENCE OT ON HEAPPOPRIATE DEFICIENCY)     COMPARIANCE OF THE PROPERIATE DEFICIENCY)       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 (R153) whose topical medication had expired and was stored for use.     F 431       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 37/17, at 2455 p.m. The pharmacy label indicated the bottle contained 120 millillers (mls), however, the individual narcotic record bolk (R29g 10) revealed 118 mls had been received. The narcotic record inclated R378 had received 5 mls of the medication nemaining 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 so 1 don't know. I was told just oeye balls: "RN-B stated T never gave this medication so 1 don't know. I was told just oeye balls: "RN-B stated T never gave this medication so 1 don't know. I was told just oeye balls: "RN-B stated T never gave this medication so 1 don't know. I was told just oeye ball: "RN-B stated, TRN-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			245610	B. WING	NG		03/09/2017	
PREFIX TAG       (EACH DEPRICENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       (EACH CORREPTENCED TO THE APPROPRIATE DEFICIENCY)       COMMENT DEFICIENCY)         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.       F 431         Finding include:       F378's as needed was noted in un-graduated bottle during a review of the facility's medication storage and accounting system on 37/17, at 2/45 p.m. The pharmacy label indicated the bottle contained 120 millillers (mis), however, the individual narcotic record book (page 10) revealed 118 mIs had been received. The narcotic record book (page 10) revealed 118 mIs had been received 5 mIs of the medication on 3/5/17, at 9:15 a.m. and the remaining amount was documented as 113 mis. That same day at 8:35 p.m. another 5 mIs was administered and the remaining amount was recorded as 108 mIs.       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 monthy for 1 month, then monthy for 1 month, uthen review by Quality Council for further needs.         Registered nurse (RN)-B was present during the observation and was asked how staff knew how much of the medication realines in the caller, TN-C1 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       Ima			EHABILITATION CENTER		1	1850 SARAZIN STREET		
<ul> <li>This REQUIREMENT is not met as evidenced by:</li> <li>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.</li> <li>Finding include:</li> <li>R378's as needed was noted in un-graduated bottle during a review of the facility's medication storage and accounting system on 37/17, rd 12:45 p.m. The pharmacy label indicated the bottle contained 120 milliliters (mIs), however, the individual narcotic record box(page 10) revealed 118 mis had been received 5 mils of the medication on 3/5/17, at 9:15 a.m. and the remaining amount was documented as 113 mils. That same day at 8:35 p.m. another 5 mils was administered and the remaining amount was recorded as 108 mils.</li> <li>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 medications on 1 don't Know. I was told just to eye ball it." RN-B then called RN-C to ask for clarification. RN-B stated, "IRN-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</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETIC DATE
The facility's consulting pharmacist provided the	F 431	This REQUIREMENT by: Based on observative review, the facility f account for medical drug diversion for 2 and for 1 of 1 reside medication had exp Finding include: R378's as needed we bottle during a review storage and accourt p.m. The pharmacy contained 120 millili individual narcotic revealed 118 mls h narcotic record indi mls of the medicative the remaining amount was administered at recorded as 108 ml Registered nurse (If observation and was much of the medicative since the bottle was never gave this me told just to eye ball ask for clarification to measure it using RN-B said a scale If past. RN-D then arri- nurses would have amount of medication	NT is not met as evidenced tion, interview and document ailed to properly store and tion to minimize the risk for e of 2 residents (R101, R378) ent (R75) whose topical bired and was stored for use. was noted in un-graduated ew of the facility's medication nting system on 3/7/17, at 2:45 ( label indicated the bottle iters (mls), however, the record book (page 10) ad been received. The cated R378 had received 5 on on 3/5/17, at 9:15 a.m. and unt was documented as 113 ( at 8:35 p.m. another 5 mls and the remaining amount was ls. RN)-B was present during the as asked how staff knew how ation remained in the bottle s unmarked. RN-B stated "I dication so I don't know. I was it." RN-B then called RN-C to . RN-B stated, "[RN-C] told me the weight scale," although nad never been used in the rived and confirmed the had no way to account for the on remaining in the bottle.	F	431	F431-Drug Record, Label/Store Dru Biologicals SPECIFIC RESIDENTS: Resident F affected by alleged deficient practice not have items in room. Resident Ri discharged from facility on 3/6/17. OTHER RESIDENTS: Residents wi have expired items in room. MONITOR: The Director of Nursing and/or designee will audit resident ri for expired items: Weekly for 4 weet then twice monthly for 1 month, ther monthly for 1 month with review by	R75 e will 378 Il not ooms ks, n	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/25/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY PLETED
		245610	B. WING	ì		03/	09/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GER	FRUDES HEALTH & R	EHABILITATION CENTER			1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	facility with a response verified R378's Che a controlled substant provided in a gradu sent was 120 mls v pharmacist reported result of conversion pharmacy label sho on the manufacture RN-D stated on 3/8 narcotic medication counted from shift t unusual for liquid m pharmacy in a bottle measurements. RN know" how much m bottle. RN-D said th medication had bee RN-C explained on scale had never pre- measure mls. RN-C solution, but it is be the surveyor then re- together. During observation on 3/9/17, at 11:10 (RN)-C, the narcotic At that time R101's Oxycodone 5 millig (discontinued) and bottom left to the to dose signed out wa administered at 3:0 record indicated eig	nse letter dated 3/7/17, which eratussin AC cough syrup was nce, and should have been ated container. The amount ersus 118 mls, which the d was "insignificant" but was a from ounces to mls. The owever, "the quantity on the ould have matched the quantity ers label exactly." /17, at 1:58 p.m. regarding is, usually medication was o shift. RN-D said it was nedications to arrive from the e without scored I-D stated, "There is no way to nedication remained in the ney could track when the	F	431			

If continuation sheet Page 12 of 14

		AND HUMAN SERVICES					RINTED: 07 FORM AP MB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SU COMPLE	JRVEY
		245610	B. WING	à			03/09/2	2017
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZI	P CODE		
ST GERT	<b>FRUDES HEALTH &amp; R</b>	EHABILITATION CENTER			SARAZIN STREET			
			1	SH/	AKOPEE, MN 55379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPF	BE CC	(X5) DMPLETION DATE
F 431	tracking narcotics. line was drawn acro indicated the medic and removed from RN-C said the page by two nurses howe required signatures she did not know w narcotic medication On 3/9/17, at 3:08 p interview that they h remaining eight tab RN-A stated the mi "under investigation further description of entailed. In addition remaining Oxycodo R75's nightstand co (prescription skin co The cream had an 9:05 a.m. the Vanic and RN-E confirme RN-E stated, "Oh th date is 2/17/17. Wh should check the ex- was the nurses' res Vanicream. On 3/9/17, at 9:12 a medication carts we she was unsure wh creams stored in re- "The nurse should before using it on re-	encies in their system of RN-C explained that when a poss the narcotic record page, it eation had been discontinued, the cupboard for destruction. e should have been signed off ever, R101's record lacked the a. In addition, RN-C verified hat had happened to the hat had happened to the hat had happened to the hat had happened to locate the lets of R101's Oxycodone. ssing medication was currently n." RN-A did not provide any of what "under investigation" n, there was no record R101's one had been destroyed. Dentained expired Vanicream ream) on 3/8/17, at 7:00 a.m. expiration date of 2/17/17. At ream was in R75's bathroom, id the medication had expired. hat is not good. The expiration hoever is putting on the cream expiration date." RN-E stated it sponsibility to apply the a.m. RN-A explained ere audited regularly, however, lether those audits included esident rooms. RN-A stated, look at the expiration date		431				
FORM CMS-25	567(02-99) Previous Versions		1	Facility	v ID: 00459	If continuation	on sheet Pag	e 13 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES			FORI	D: 07/25/2017 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245610	B. WING		0;	8/09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ST GERT	RUDES HEALTH & R	EHABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 431	nurse] going off dut on duty must count change of shiftNa the pharmacy will b two licensed nurses The facility's undate Being Held For Des to be filled out by th Nursing (or two nur discontinued contro Nursing's office or r under double lock u pharmacist." The facility's 2/15, I Diversion of Medica "Immediately upon discrepancy, suspe Administrator, Direc Consultant Pharma investigation condu the discrepancy and related to medicatio supply of medicatio reconciliationA the storage areasare container or medica	or LPN [licensed practical y and one RN or LPN coming and justify unit's narcotics at protics newly received from e counted and signed in by	F 43			

Facility ID: 00459

If continuation sheet Page 14 of 14

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

								ID: YOX1
		I - TO BE COM	PLETED BY TI	HE STATI	E SURVEY	YAGENCY		Facility ID: 00459
	Э.				JTATION (	CENTER	4. TYPE OF ACTION	N: <u>2 (</u> L8)
							1. Initial	2. Recertification
(L2) <b>440886100</b>						(L6) <b>55379</b>	3. Termination 5. Validation	<ol> <li>CHOW</li> <li>Complaint</li> </ol>
	IERSHIP				<u>02</u> 13 PTIP	(L7) 22 CLIA	<ol> <li>7. On-Site Visit</li> <li>8. Full Survey After</li> </ol>	9. Other Complaint
6. DATE OF SURVEY <b>03/09</b> /	2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR ENDIN	IG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPI	CE	06/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				1	
From (a):		A. In Complian	nce With		And/Or A	Approved Waivers Of The	Following Requirements:	
To (b) :		-	-		2.	Technical Personnel	6. Scope of Se	rvices Limit
12. Total Facility Beds	105 (L18)	1. A	Acceptable POC		4.	. 7-Day RN (Rural SNF)	8. Patient Roor	n Size
13. Total Certified Beds	105 (L17)	X B. Not in Com	pliance with Program		5.	Life Safety Code	9. Beds/Room	
		Requirements	and/or Applied Waive	ers:	* Code:	B*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACIL	ITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e)	(1) or 1861 (j) (1):	(L15)	
105	(1.20)	(1.42)	(1.42)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY AGENCY AP	PROVAL	Date:
Dawn Chiabot	tti, HFE NE	II	04/12/2017	(L19)	Kate	JohnsTon, Pr	ogram Special	ist 05/11/2017 (L20)
PART 1- TO BE COMPLETED BY THE STATE SURVEY AGENCY       Pacility         1. MEDICARE/MEDICAID PROVIDER NO. (1.1)       245610       3. NAME AND ADDRESS OF FACILITY (1.3) ST GERTRIDES HEALTH & REHABILITATION CENTER (1.4) ISSO SARAZIN STREET       4. TYPE OF ACTION: (1.6) 55379       1. Initial       2. 3. Reministrim       4. (1.6) 55379         2. STATE VENDOR OR OR MEDICAID NO. (1.2)       (1.5) STAKOPEE, NN       (1.6) 55379       5. EFFECTIVE DATE CHANGE OF OWNERSHIP (1.9)       7. PROVIDER/SUPPLIER CATEGORY       0.       0.       6. Partice of SURVEY       0.3/09/2017       (1.34)       0.5 SKP NFD/build       0.6 PRTF       10 NF       H cORF       1. SPTIP       2.2 CLAA       6. Fell Sincey After Complaine 0.0 SNF NFD/build       0.5 SKP NFD/build       0.6 SNF       1.0 SNF       H cORF       1. SACC       0.6/30       0.0/30         10. Undercende 2.AOA       3. Other       10. THE FACILITY IS CERTIFIED AS:       A. In Compliance With       A. Add/Or Approved Waivers OT For Singer After Compliance 0. SNF NFD/build       1. SACC       9. Sologe of Services Linger 0. SNF NFD/build       -       6. Sologe of Services Linger 0. SNF NFD/build       -       -       6. Sologe of Services Linger 0. SNF NFD/build       -       -       -       6. Sologe of Services Linger 0. SNF NFD/build       -       -       -       6. Sologe of Services Linger 0. SNF NFD/build       -       -       -       .       1.       0.					(*)			
19. DETERMINATION OF ELIGIBILITY		20. COM	IPLIANCE WITH CI	IVIL	21.	1. Statement of Financi	al Solvency (HCFA-2572)	
1 Eacility is Eligible to Part	icipate	RIGI	HTS ACT:				nterest Disclosure Stmt (HC	FA-1513)
	loiputo					5. Both of the Above .		
2. Taking is not 2.6,500	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	NT	26. TERM	INATION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE	ı I	VOLUNTA	<u>.RY</u> 00	INVOLU	NTARY
11/08/1996					01-Merger,	Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatist	faction W/ Reimbursemen	nt 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of I	involuntary Termination	OTHER	
	A. Suspension	of Admissions:			04-Other Re	eason for Withdrawal	07-Provid	er Status Change
(1.27)			(L44)				00-Active	
	B. Rescind Sus	pension Date:						
28. TERMINATION DATE:	29		CARRIER NO.		30. REMAI	RKS		
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DAT	Έ				
	(L32)			(L33)	DETERN	/INATION APPRO	VAL	



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:

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

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

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

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

# <u>Informal Dispute Resolution</u> - 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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, 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

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRU G			ATE SURVEY DMPLETED
		245610	B. WING				03/09/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET AD	DRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER			IZIN STREET EE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	cility is enrolled in ePOC and therefore a re is not required at the bottom of the first the CMS-2567 form. Electronic sion of the POC will be used as tion of compliance. ecceipt of an acceptable POC an on-site of your facility may be conducted to that substantial compliance with the ons has been attained in accordance with		00			
	signature is not requi page of the CMS-256	red at the bottom of the first 7 form. Electronic 0C will be used as					
F 225	revisit of your facility validate that substant regulations has been your verification.	may be conducted to ial compliance with the attained in accordance with	F 2	25			4/18/17
SS=D	ALLEGATIONS/INDI						
		erwise engage individuals					
		guilty of abuse, neglect, opriation of property, or urt of law;					
	or her professional lic						
	licensing authorities a	e nurse aide registry or any knowledge it has of law against an employee,					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	1	TITLE		(X6) DATE
Electroni	cally 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.

PRINTED: 05/11/2017

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	L 1	E SURVEY IPLETED
		245610	B. WING		0	3/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	
F 225	Continued From page	e 1	F 22	25		
_ · · · · · · ·		unfitness for service as a cility staff.				
		egations of abuse, neglect, atment, 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.	itation or mistreatment, nknown source and esident property, are , but not later than 2 hours made, if the events that nvolve abuse or result in or not later than 24 hours if e the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established				
	(2) Have evidence the thoroughly investigate	at all alleged violations are ed.				
	(3) Prevent further po exploitation, or mistre investigation is in pro					
	administrator or his o representative and to with State law, includ Agency, within 5 worl if the alleged violation corrective action mus	other officials in accordance ing to the State Survey king days of the incident, and n is verified appropriate				

Facility ID: 00459

If continuation sheet Page 2 of 21

			0.00			D. 0938-039
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			L` /	E SURVEY PLETED
		245610	B. WING		03	/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 225			F 22	5		
	facility failed to imme agency (SA) missing potential diversion/mi	and document review, the diately report to the State narcotic medication as sappropriated property for 1 whose narcotic medication				
	Finding include:					
	3/9/17 at 11:10 a.m. v (RN)-C, the narcotic if At that time R101's n Oxycodone 5 milligra (discontinued) and a bottom left to the top dose signed out was administered at 3:00 record indicated eigh this observation, RN- identified inconsisten tracking narcotics. R line was drawn acros indicated the medicat and removed from the RN-C said the page s by two nurses howev required signatures.	f the medication room on with registered nurse record book was reviewed. arcotic record revealed ms (mg) had been "DC'd" line was drawn from the right of the page. The last recorded as having been a.m. on 2/8/17. The narcotic t doses remained. During C stated the facility had cies in their system of N-C explained that when a s the narcotic record page, it tion had been discontinued, e cupboard for destruction. should have been signed off er, R101's record lacked the n addition, RN-C verified at had happened to the				
	interview that they ha remaining eight table RN-A stated the miss "under investigation." further description of	m. RN-A stated during d been unable to locate the ts of R101's Oxycodone. ing medication was currently RN-A did not provide any what "under investigation" there was no record R101's				

Facility ID: 00459

If continuation sheet Page 3 of 21

		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245610	B. WING		03	/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 225	<ul> <li><sup>2</sup> 225 Continued From page 3</li> <li>Survey staff verified with the Office of Health Facility Complaints post survey, that no report had been made regarding R101's missing narcotic medication.</li> </ul>		F 22	25		
S ii r t S S C C T T E " " C C C I I I T T S S C C T T S S C C C T T S S C C C S S C C S S C C S S C C S S C C S S C S S C S S C S S S C S	nurse and Director of taken with the discon Director of Nursing's	Held For Destruction, Form to be filled out by the Nursing (or two nurses) and tinued controlled drug to the office or medication room for a lock until destruction by				
	Diversion of Medicati "Immediately upon the discrepancy, suspect Administrator, Director Consultant Pharmaci investigation conduct the discrepancy and related to medication supply of medication, reconciliationA thor storage areasare medication	iscrepancies, Loss and/or on, from 2/2015 included: e discovery or suspicion of a ed loss or diversion, the or of Nursing (DON) and st are notified and and edThe DON investigates researches all the records administration and the including medication ough search in all drug nade to locate any missing on supplyAny corrective ieels appropriate should be				
	revised 11/2016, india as: "'Misappropriation deliberate misplacem wrongful, temporary, resident's belongings resident's consent."	buse Prevention Plan, cated a component of abuse of resident property': The lent, exploitation, or or permanent use of a or money without the Direction for staff included: esota Department of Health)				

Facility ID: 00459

If continuation sheet Page 4 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/11/2017 M APPROVED D. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245610	B. WING			03	/09/2017
NAME OF PF	OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST GERTR	UDES HEALTH & REHA	BILITATION CENTER			1850 SARAZIN STREET SHAKOPEE, MN 55379		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	.1	0(5)
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F 225	Continued From page	2.4	F	225			
_		ediately upon receiving a		220			
	report of possible abu	use, neglect, and/or financial					
		I contact the Minnesota Adult hter (MAARC) regarding the					
	report."	iter (MAARC) regarding the					
F 226	483.12(b)(1)-(3), 483.	.95(c)(1)-(3)	F	226	5		4/18/17
SS=D	DEVELOP/IMPLMEN POLICIES	IT ABUSE/NEGLECT, ETC					
	483.12						
		levelop and implement rocedures that:					
		ent abuse, neglect, and nts and misappropriation of					
	(2) Establish policies investigate any such						
	(3) Include training as §483.95,	s required at paragraph					
	the freedom from aburrequirements in § 483	nd exploitation. In addition to use, neglect, and exploitation 3.12, facilities must also eir staff that at a minimum					
		onstitute abuse, neglect, appropriation of resident at § 483.12.					
		reporting incidents of abuse, or the misappropriation of					

Facility ID: 00459

If continuation sheet Page 5 of 21

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURV	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETE	J
		245610	B. WING		03/09/20	017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE CON	(X5) MPLETIO DATE
F 226	<ul> <li>(c)(3) Dementia mana prevention.</li> <li>This REQUIREMENT by:</li> <li>Based on interview a facility failed to impler immediate reporting regarding misappropri for 1 of 1 resident (R1 narcotic medication c</li> <li>Finding include:</li> <li>The facility's policy At revised 11/2016, indic as: "Misappropriation deliberate misplacem wrongful, temporary, resident's belongings resident's consent." D</li> <li>"Contact MDH (Minnevia via online report immer report of possible abu exploitation. MDH will Abuse Reporting Cen report."</li> <li>The facility's policy Di Diversion of Medication</li> <li>"Immediately upon the discrepancy, suspector</li> </ul>	agement and resident abuse is not met as evidenced and document review, the ment their abuse policies for to the State agency (SA) riation of resident property 101) whose remaining ould not be located.	F 2:	26		

Facility ID: 00459

If continuation sheet Page 6 of 21

		MEDICAID SERVICES	(Y2) MUU סיד וו	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		B		IPLETED
		245610	B. WING		03	3/09/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 226	Continued From page	e 6	F 22	6		
	container or medication supplyAny 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. v (RN)-C, the narcotic f At that time R101's n Oxycodone 5 milligra (discontinued) and a bottom left to the top dose signed out was administered at 3:00 record indicated eigh this observation, RN- identified inconsisten tracking narcotics. R line was drawn across indicated the medicat and removed from th RN-C said the page s by two nurses howev required signatures.					
	nurse and Director of taken with the discon Director of Nursing's	Held For Destruction, Form to be filled out by the Nursing (or two nurses) and tinued controlled drug to the office or medication room for block until destruction by				
	interview that they hat remaining eight table	m. RN-A stated during Id been unable to locate the ts of R101's Oxycodone. ing medication was currently				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVE	8-039 Y
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		245610	B. WING		03/09/20	17
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	ABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	(X5) PLETIO DATE
F 226	Continued From pag	e 7	F 226			
		" RN-A did not provide any				
	· ·	what "under investigation"				
		there was no record R101's e had been destroyed.				
	No report had been r	nade to the State agency.				
	Survey staff verified	this information with the				
<b>F</b> 000		lity Complaints post survey.	<b>F</b> 000			
F 282 SS=D	PERSONS/PER CAP	VICES BY QUALIFIED RE PLAN	F 282		4/18/	17
	(b)(3) Comprehensiv					
		d or arranged by the facility,				
	as outlined by the co must-	mprehensive care plan,				
	(ii) Be provided by qu accordance with eac care.	ualified persons in h resident's written plan of				
		T is not met as evidenced				
		on, interview and document				
		led to follow care plan				
		ize the risk of pressure ulcer 2 residents (R87) reviewed				
	for pressure ulcers.					
	Findings include:					
	coccyx according to The care plan edited resident had an unst his left heal with histor right coccyx with risk and bowel incontiner	ealed stage II PU on his his care plan dated 12/23/16. 1/25/17, indicated the ageable pressure ulcer on bry of a pressure ulcer on his factors including immobility nce. Staff was directed to hours and upon request, use				

Facility ID: 00459

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	S FOR MEDICARE &					IO. 0938-03	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING		0	03/09/2017		
NAME OF PROVIDER OR SUPPLIER ST GERTRUDES HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODI	E		
			1850 SARAZIN STREET SHAKOPEE, MN 55379				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOT TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		SHOULD BE	(X5) COMPLETIO DATE	
F 282	Continued From pag	e 8	F 28	82			
	pressure relieving booties, nutritional supplement						
	-	eferral 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						
		resident's care plan, MDS,					
	-	lected in Progress Notes					
		's admission through the					
	date of the observation	on on 3/8/17.					
	A Tissue Tolerance T	est completed 3/4/17,					
		history of PUs on his coccyx,					
	right and left heels, a	and at the time of the					
		U on his left heel. The					
		g tolerance revealed no vas noted to the buttocks					
		ever, redness was noted					
	after three hours.						
		ly observed on 3/8/17, from					
	9:25 a.m. through 12	::00 noon without as observed seated in the					
		m from 9:25 to 10:09 a.m. A					
			1	1		1	
	mechanical lift sling v	was beneath the resident.					

Facility ID: 00459

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CENTERS FOR MEDICARE & MEDICAID SERVICES           TATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DAT	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		COMPLETED	
		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	EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO DATE
F 282	Continued From page	9	F 28	2		
	resident. At 9:50 a.m. resident to an activity wanted to go "in a littl came back to residen R87 to chapel for a re position in the chapel the activity V-A return R87 remained in his v television from 11:00 this time no staff repo 11:14 a.m. NA-A enter reposition the residen observation that she orange juice. At 12:00 his repositioning and experiencing any pair	until 10:58 a.m. Following ned the resident to his room. wheelchair watching a.m. to 12:00 p.m. during ositioned the resident. At ered R87's room, but did not ht. NA-A reported after the had just offered the resident 0 p.m. R87 was asked about				
	R87's repositioning p surelet me look it up computer and reporte repositioned every tw up R87's care plan or	o hours. NA-B then looked				
		n 3/8/17, at 12:10 p.m. epositioning that morning.				
	(TMA)-A stated R87's reposition R87 every resident was not repo	.m. trained medication aide care plan directed staff to hour. "I do not know why the ositioned. I do not have an ometimes the resident				

Facility ID: 00459

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						<u>D. 0938-039</u>	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED 03/09/2017			
		B. WING				03	
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	E		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		50 SARAZIN STREET IAKOPEE, MN 55379			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		SHOULD BE	IOULD BE COMPLETIO	
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		F 282				
	p.m. (at least 3 hours observations began) was present to asses cleaned R87 of a sma stool and initially state slightly reddened, wh surveyor's observatio assessment finding a pink versus red. Rega						
F 314 SS=D	not offer him [R87] re 3/8/17. 483.25(b)(1) TREATM		F 314			4/18/17	
	<ul> <li>(b) Skin Integrity -</li> <li>(1) Pressure ulcers.</li> <li>comprehensive assessing facility must ensure the</li> </ul>	ssment of a resident, the					
	professional standard pressure ulcers and o ulcers unless the indi	s care, consistent with ls of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and					
	necessary treatment professional standard	essure ulcers receives and services, consistent with ls of practice, to promote tion and prevent new ulcers					

Facility ID: 00459

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
		245610	B. WING		03/09/2017		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	E		
ST GERT	RUDES HEALTH & REHA	BILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC		
F 314	by: Based on observation review, the facility fait minimize the risk for pressure ulcers for 1 reviewed for pressure Findings include: R87 was identified as visible due to dead the the left heal by regist interview on 3/6/17, and During an observation 2:07 p.m. R87 was so reported, "I have a litt described the pain as R87 was continuousl 9:25 a.m. through 12 repositioning. R87 was wheelchair in his room mechanical lift sling way Although nursing ass room at 9:36 a.m. no resident. At 9:50 a.m. resident to an activity wanted to go "in a litt came back to resider R87 to chapel for a re position in the chape the activity V-A return R87 remained in his television from 11:00 this time no staff report	an, interview and document led to provide care and to further development of of 2 residents (R87) e ulcers. a having an unstageable (not ssue) pressure ulcer (PU) on ered nurse (RN)-A during an at 5:28 p.m. n and interview on 3/7/17, at eated in his wheelchair. He tle pain on my foot," but s "tolerable." y observed on 3/8/17, from :00 noon without as observed seated in the m from 9:25 to 10:09 a.m. A vas beneath the resident. istant (NA)-A went into R87's care was provided for the . volunteer (V)-A invited the the bit," so at 10:09 a.m. V-A at's room and transported emained in the same until 10:58 a.m. Following ned the resident to his room.	F 31	4			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/11/2017 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245610	B. WING				03/	09/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
ST GERT	RUDES HEALTH & REHA	BILITATION CENTER			850 SARAZIN STREET SHAKOPEE, MN 55379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 314	orange juice. At 12:00 his repositioning and rexperiencing any pair moved in my wheelch sometimes it hurts." At 12:05 p.m. the surv R87's repositioning pl surelet me look it up computer and reporte repositioned every tw up R87's care plan or confirmed R87 was su every two hours. RN-A was informed o about R87's lack of re On 3/8/17, at 12:16 p. (TMA)-A stated R87's reposition R87 every resident was not repo answer for you, but so refuses." R87 was transferred f the use of a mechanic p.m. (at least 3 hours, observations began) f was present to assess cleaned R87 of a sma stool and initially state slightly reddened, whi surveyor's observation assessment finding an pink versus red. Rega	D p.m. R87 was asked about whether he was n. R87 confirmed, "I have not hair since this morning Yes, weyor then asked NA-B lan. NA-B replied, "I am not b." NA-B then checked the ed R87 was to be to hours. NA-B then looked in the computer, and upposed to be repositioned an 3/8/17, at 12:10 p.m. epositioning that morning. .m. trained medication aide is care plan directed staff to hour. "I do not know why the positioned. I do not have an cometimes the resident from his chair into bed with cal lift on 3/8/17, at 12:30	F	314				

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					OMB NO. 0938- (X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		245610	B. WING		03	8/09/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
ST GERTI	RUDES HEALTH & REHA	ABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 314	On 3/8/17, at 12:48 p not offer him [R87] re 3/8/17. R87's 12/12/16, adm (MDS) indicated R87 impaired, and display or resisting care. He assistance from two s transferring, and staf his wheelchair from p indicated R87 was ac including Parkinson's had an indwelling Fo frequently incontinen admission assessme breakdown, but was Interventions to minir pressure relieving de repositioning program as the use of ointmer risk for skin breakdow	b.m. NA-B confirmed, "I did epositioning" the morning of ission Minimum Data Set was moderately cognitively yed no behavioral problems required extensive staff with bed mobility and fs' assistance with moving blace to place. The MDS dmitted with diagnoses disease and dementia. R87 ley catheter and was t of bowel. At the time of the ent he had no skin identified as being at risk. mize breakdown included evices in his chair and bed, n and nutritional plan, as well nts. R87 was identified as	F 31	4			
	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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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-03 TE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED		
		245610	B. WING		0	3/09/2017		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		)E			
ST GERTF	RUDES HEALTH & REHA	ABILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE		
F 314	Continued From page	e 14	F 31	4				
	indicated the resident had impaired mobility due							
		se, weakness, balance						
	issues, and required staffs' assistance with transferring with the use of a Hoyer (mechanical)							
		locomotion in wheelchair. He						
	-	ve assistance with turning						
		ery two hours and upon						
	request by R87. Addi							
		of daily living and required s, and was totally dependent						
		R87 had an indwelling Foley						
		as to check and change his						
		d offer the bedpan every two						
		re for R87 was not identified resident's care plan, MDS,						
	-	lected in Progress Notes						
		s admission through the						
	date of the observation	on on 3/8/17.						
	A Tissue Tolerance To	est completed 3/4/17,						
		history of PUs on his coccyx,						
	right and left heels, a	nd at the time of the U on his left heel. The						
		g tolerance revealed no						
		as noted to the buttocks						
		ever, redness was noted						
		e assessment also indicated Scale test for PU risk						
		was at moderate risk for PU						
		lusion was not checked on						
	the assessment.							
	RN-A was interviewe	d on 3/8/16, at approximately						
		g the resident's current PU						
	to his heel and stated	"Well, when the resident						
		ic [systemic infection]. I think						
	his circulation was co palpate the pedal pul	ompromised. It was hard to se lindicating poor						
	i paipate trie peual pul		1	1		1		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245610	B. WING		03/09/201
NAME OF P	ROVIDER OR SUPPLIER	-	STRE	EET ADDRESS, CITY, STATE, ZIP COD	E
ST GERTI	RUDES HEALTH & REH	ABILITATION CENTER		SARAZIN STREET KOPEE, MN 55379	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPL
F 314 F 431 SS=D	laboratory results]. It happened so quick therapist was doing l in tissue] treatment v wrapping [used to m know if that contribut The facility's 3/17, Sl policy revealed, "A p and treatment or pre- all residents to preve promote healingA sores receives neces to promote healingA sores receives neces to promote healing, p new sores from deve 483.45(b)(2)(3)(g)(h) LABEL/STORE DRU The facility must pro- drugs and biologicals them under an agree §483.70(g) of this pa	and hemoglobin [abnormal was hard to believeit And then the lymphedema ymphedema [excessive fluid with him, like a compression inimize swelling], but I do not ted to the pressure ulcer." kin IntegrityPressure Sores rogram of prevention, care ssure sores is provided for ent skin breakdown and resident having pressure sary treatment and services prevent infection and prevent eloping." DRUG RECORDS, JGS & BIOLOGICALS vide routine and emergency is to its residents, or obtain ement described in urt. The facility may permit el to administer drugs if State r under the general nsed nurse.	F 314		4/18/1
	pharmaceutical servithat assure the accu dispensing, and adm biologicals) to meet the (b) Service Consulta	tices (including procedures rate acquiring, receiving, ninistering of all drugs and the needs of each resident. tion. The facility must services of a licensed			

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			()() · · · · - · ·			. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		(X3) DATE S COMPL		
		245610	B. WING		03/0	9/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		1850 SARAZIN STREET SHAKOPEE, MN 55379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 431	Continued From page	e 16	F 43	1			
		rolled drugs in sufficient ccurate reconciliation; and					
	(3) Determines that d that an account of all maintained and perio						
	(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.						
	the facility must store locked compartments	h State and Federal laws, all drugs and biologicals in s under proper temperature only authorized personnel to					
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT	provide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can					
	review, the facility fail account for medicatio drug diversion for 2 o and for 1 of 1 residen	n, interview and document led to properly store and on to minimize the risk for f 2 residents (R101, R378) it (R75) whose topical ed and was stored for use.					

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					OMB NO. 0938-0 (X3) DATE SURVEY	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			E SURVEY IPLETED
		245610	B. WING		0;	3/09/2017
NAME OF P	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER		850 SARAZIN STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX		RECTION (X5) HOULD BE COMPLET PPROPRIATE DATE	
F 431	Continued From page	e 17	F 431			
	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 unever gave this medic told just to eye ball it. ask for clarification. Fito measure it using the RN-B said a scale has past. RN-D then arriving the source of the	unmarked. RN-B stated "I cation so I don't know. I was " RN-B then called RN-C to RN-B stated, "[RN-C] told me ne weight scale," although id never been used in the red and confirmed the ad no way to account for the in 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					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/11/2017 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245610	B. WING			03/	09/2017
NAME OF PF	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
		BU ITATION CENTER		1	850 SARAZIN STREET		
SIGERIN	UDES HEALTH & REHA	BILITATION CENTER		S	HAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	431	DEFICIENCY)		
	Oxycodone 5 milligra (discontinued) and a bottom left to the top dose signed out was administered at 3:00 record indicated eigh this observation, RN- identified inconsisten tracking narcotics. R line was drawn acros indicated the medicat and removed from the RN-C said the page s	arcotic record revealed ms (mg) had been "DC'd" line was drawn from the right of the page. The last recorded as having been a.m. on 2/8/17. The narcotic t doses remained. During C stated the facility had cies in their system of N-C explained that when a s the narcotic record page, it tion had been discontinued, e cupboard for destruction. should have been signed off					
		er, R101's record lacked the n addition, RN-C verified					

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## PRINTED: 05/11/2017 FORM APPROVED

		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMF	SURVEY PLETED
		245610	B. WING			03/	09/2017
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST GERTE	RUDES HEALTH & REHA	BILITATION CENTER		18	850 SARAZIN STREET		
				S	HAKOPEE, MN 55379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page she did not know what narcotic medication. On 3/9/17, at 3:08 p.r interview that they hat remaining eight tablet RN-A stated the miss "under investigation." further description of entailed. In addition, remaining Oxycodone R75's nightstand cont (prescription skin creat The cream had an ex 9:05 a.m. the Vanicreat and RN-E confirmed RN-E stated, "Oh that date is 2/17/17. Who should check the exp was the nurses' respon Vanicream. On 3/9/17, at 9:12 a.r medication carts were she was unsure whet creams stored in resit "The nurse should loo before using it on res The facility's 3/09, Nat directed, "One RN or nurse] going off duty on duty must count at change of shiftNarc	e 19 at had happened to the m. RN-A stated during d been unable to locate the ts of R101's Oxycodone. ing medication was currently RN-A did not provide any what "under investigation" there was no record R101's e had been destroyed. tained expired Vanicream am) on 3/8/17, at 7:00 a.m. piration date of 2/17/17. At am was in R75's bathroom, the medication had expired. t is not good. The expiration ever is putting on the cream iration date." RN-E stated it onsibility to apply the m. RN-A explained e audited regularly, however, her those audits included dent rooms. RN-A stated, ok at the expiration date ident." mrcotics Count policy LPN [licensed practical and one RN or LPN coming nd justify unit's narcotics at otics newly received from counted and signed in by		431			
	The facility's undated	Controlled Substance(s)					

Facility ID: 00459

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PRINTED: 05/11/2017 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/11/2017 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245610	B. WING			_	03/	09/2017
NAME OF P	ROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
ST GERTI	RUDES HEALTH & REHA	BILITATION CENTER			850 SARAZIN STREET HAKOPEE, MN 55379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	Being Held For Destri to be filled out by the Nursing (or two nurse discontinued controlle Nursing's office or me under double lock unt pharmacist." The facility's 2/15, Dis Diversion of Medicatio "Immediately upon the discrepancy, suspect Administrator, Directo Consultant Pharmacis investigation conduct the discrepancy and r related to medication, reconciliationA thor storage areasare m container or medication	uction form directed, "Form nurse and Director of es) and taken with the ed drug to the Director of edication room for storage til destruction by consultant screpancies, Loss and/or on policy indicated, e discover or suspicion of a ed loss of diversion, the or of Nursing (DON) and st are notified and and edThe DON investigated researches all the records administration and the	F	431				

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	MENT OF HEALTH			ŦS	6/0023	FORM	03/14/2017 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1 · · ·	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245610		B, WING		03/10	/2017
					STATE, ZIP CODE		
SIGER	TRUDES HEALTH &	REHABILITATION		ARAZIN S <sup>-</sup> Pee, Mn			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
K 000	FIRE SAFETY A Life Safety Code Minnesota Departm Fire Marshal Divisio (Facility name) was requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 18 Existing This facility will be s buildings. The origin 3 different times, St. Gertrude's Heal with no basement of determined to be of 1999, an addition w Wing that was dete construction. In 200 building with no bas to be determined to construction.	Survey was conduct bent of Public Safety on. At the time of this a found in compliance articipation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code g Health Care. Surveyed as two sepanal building was constructed in 1996 a f Type V (111) constructs as constructed in 1996 a f Type V (111) constructs as constructed to the rmined to be of Type 07 an addition is an 1 sement and was con	- State survey, e with the 2012 ciation (LSC), arate structed at / building and was uction. In e East > V(111) -story structed arate / (111) (111) sprinkler tem with	K 000			
	spaces open to the for automatic fire de	corridors that are m epartment notification apacity of 105 certifie	onitored n.				
		apacity of 100 certifie					
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	ENTATIVE'S SIG	NATURE	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.

	MENT OF HEALTH				F5610023	FORM	03/14/2017 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION G 03 - BLDG THREE NEW ADDITION	(X3) DATE S COMPLE	
		245610				03/10/2017	
	ROVIDER OR SUPPLIER		1850 SA	RESS, CITY, S RAZIN S PEE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Divisio (Facility name) was requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 18 Existing St. Gertrudes Healt is a 2-story building addition was constr be of Type II(222) c The building is prote system. The facility full corridor smoke spaces open to the for automatic fire de	at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code 9 Health Care. h Center, in 2011 thi with a full basemen ucted and was deter	- State survey, with the 2012 diation (LSC), s addition t. The mined to rinkler tem with boms and onitored n.				
					TITLE		(X6) DATE
LABURATUP	RY DIRECTOR'S OR PROVI	IDERIOUFPLIER REPRESE	INTATIVE'S SIG	MATURE	TITLE		(AU) 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.