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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YUT5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00787

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245355**

2.STATE VENDOR OR MEDICAID NO.
(L2) **178977500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BRIGID'S AT HI-PARK**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 05/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/07/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5355

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 03/27/14. On 05/05/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 04/21/14, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 03/27/14, effective 04/30/14. Refer to the CMS-2567B for both health and life safety code.

Effective 04/30/14, the facility is certified for 65 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number: 24-5355

Electronically Delivered: June 5, 2014

Mr. Jacob Goering, Administrator
St Brigid's at Hi-Park
213 Pioneer Road
Red Wing, Minnesota 55066

Dear Mr. Goering:

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 30, 2014, the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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 Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 30, 2014

Mr. Jacob Goering, Administrator
St Brigid's at Hi-Park
213 Pioneer Road
Red Wing, Minnesota 55066

RE: Project Number S5355024

Dear Mr. Goering:

On April 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 27, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 21, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 27, 2014, effective April 30, 2014 and therefore remedies outlined in our letter to you dated April 10, 2014, 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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245355	A. Building B. Wing	5/5/2014

Name of Facility	Street Address, City, State, Zip Code
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/30/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/30/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/30/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/30/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	05/30/2014	16022	05/05/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/27/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245355	A. Building B. Wing: 01 - MAIN BUILDING 01	4/21/2014

Name of Facility	Street Address, City, State, Zip Code
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0054	03/28/2014	ID Prefix Reg. # NFPA 101 LSC K0062	04/02/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 05/30/2014	Signature of Surveyor: 25822	Date: 04/21/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/24/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YUT5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00787

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **178977500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BRIGID'S AT HI-PARK**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds 65 (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE - NE II 04/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5355

At the time of the standard survey completed 03/27/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered: April 10, 2014

Mr. Jacob Goering, Administrator
St Brigid's At Hi-Park
213 Pioneer Road
Red Wing, Minnesota 55066

RE: Project Number S5355024

Dear Mr. Goering:

On March 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Supervisor
Metro A Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 201-3790

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 May 6, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 6, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 27, 2014 (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 27, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions about this e-Notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Telephone: (651) 201-4124
Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245355	A. BUILDING _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2014

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

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to complete an individualized, comprehensive plan of care for 1 of 2 residents (R78) with urinary incontinence. Findings include: R78 was admitted on 11/08/2013 with diagnosis including cerebellar Ataxia (dizziness), depression, dementia, difficulty walking, alcohol withdrawal, and debility. Review of R78's initial Minimum Data Set (MDS) dated 11/14/13 indicated R78 was occasionally incontinent (less that 7 episodes of incontinence in a week). Review of the Care Area Assessment (CAA) 6, Urinary Incontinence and Indwelling Catheter, with the Assessment Reference Date (ARD) of 11/14/14, documented the following causes, contributing factors, and risk factors related to the care area: inc (incontinent) of B&B (bowel and bladder) fmp (functional maintenance program) in place no skin breakdown. exs (extensive) assit (assistance) of 1 - 2 for elimination needs. see poc (plan of care) for current level of continence. Review of R78's care plan indicated the following: Problem start date :02/03/14 Potential for alteration in elimination r/t but not limited to dementia. Goal target date: 04/03/14 Res (resident) will maintain current level of continence Approach Start Date: 02/03/2014 1. B&B observation per policy and procedure 2. a1 (assist of 1) at his request 3. peri care bid (twice a day) and prn (as	F 279	St Brigids at Hi- Park routinely develops comprehensive care plans within seven days after the completion of the comprehensive assessment. Upon admission into a long- term- care facility, there are two phases of care planning; the interim care plan and the interdisciplinary care plan. An interim care plan is developed immediately after the admission. This interim care plan guides provision of care from the time of the residents transfer or admission until the interdisciplinary care plan is completed. The interim care plan is based on the admitting physician orders, interagency transfer information and the pre/admission nursing assessment. Upon completion of the comprehensive assessment a comprehensive care plan is developed by an interdisciplinary team. This team includes the attending physician, a registered nurse with responsibility for the resident and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the resident□s functional abilities, quality of life and to provide safety. The resident and family/legal representatives are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each	

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F 279	Continued From page 2 needed) 4. encourage fluids 5. observe for sxs (signs and symptoms) of infection R78's plan of care lacked type of incontinence, voiding patterns, history of incontinence, behaviors and environmental factors. Interview on 3/27/14, at 1:30 p.m., with Licensed Practical Nurse (LPN)- A, regarding R78's plan of care, indicated the initial plan of care would be completed on paper and then put into the computer, and then after the quarterly MDS, the dates on the care plan would be updated. The temporary care plan is saved and scanned into the resident's record. LPN A indicated there was no explanation as to why the care plan was so generic, and was not individualized for R78. No temporary care plan was presented to the surveyor by 6:00 p.m. on 3/27/14	F 279	assessment. 1. Resident 78 was admitted into the facility on November 8, 2013 and discharged from the facility on April 3, 2014. The interim care plan is developed per pre- admission screening, physician orders and transfer information. A 3- day bowel and bladder screen and a bowel and bladder observation/assessment is completed upon admission, quarterly, annually and with significant changes prior to developing or updating the comprehensive care plan. 2. Care plans will identify changes in condition and will reflect interventions as per policy. 3. The policy and procedures regarding interim/comprehensive care plans and changes in resident□s conditions have been reviewed with licensed nursing staff. On or before April 20, 2014 licensed nursing staff were instructed on 1) the requirement that a residents care plan must be current at all times; 2) that direct care staff share in the responsibility for updating the care plan; 3) that care plans must reflect specific approaches/interventions relating to the change in condition/problem, and 4) education on the facility policies on interim/comprehensive care plan review and updating. 4. The Interdisciplinary Care Plan Team will monitor compliance by reviewing 2 selected care plans weekly with documented changes in condition for 1-month. Charts then will be randomly	

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F 279	Continued From page 3	F 279	audited on a monthly basis for updates to the care plan. The Director of Nursing will oversee this and the plan of correction will be integrated into the quality assurance system.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to ensure 1 of 2 residents (R78) with urinary incontinence received care and services to prevent a decline in urinary incontinence. Finding include: R78's plan of care lacked type of incontinence, frequency of incontinence, and measureable goals to prevent decline. R78 was admitted on 11/08/2013 with diagnosis including cerebellar Ataxia (dizziness), depression, dementia, difficulty walking, alcohol withdrawal, and debility.	F 315	Based on the resident□s comprehensive assessment, the facility must ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. St Brigids at Hi- Park routinely develops comprehensive care plans within seven days after the completion of the comprehensive assessment. Upon admission into a long term care facility, there are two phases of care planning; the interim care plan and the interdisciplinary care plan. An interim care plan is developed	4/30/14

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F 315	Continued From page 4 Review of R78's initial Minimum Data Set (MDS) dated 11/14/13 indicated R78 was occasionally incontinent (less that 7 episodes of incontinence in a week). Review of the Care Area Assessment (CAA) 6, Urinary Incontinence and Indwelling Catheter, with the Assessment Reference Date (ARD) of 11/14/14, documented the following causes and contributing factors, and risk factors related to the care area: inc (incontinent) of B&B (bowel and bladder) fmp (functional maintenance program) in place no skin breakdown. exs (extensive) assit (assistance) of 1 - 2 for elimination needs. see poc (plan of care) for current level of continence. R78's quarterly MDS dated 2/10/14 indicated R78 was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding. Review of R78's care plan indicated the following: Problem start date :02/03/14 Potential for alteration in elimination r/t but not limited to dementia. Goal target date: 04/03/14 Res (resident) will maintain current level of continence Approach Start Date: 02/03/2014 1. B&B observation per policy and procedure 2. a1 (assist of 1) at his request 3. peri care bid (twice a day) and prn (as needed) 4. encourage fluids 5. observe for sxs (signs and symptoms) of infection Interview on 3/27/14 at 1:30 p.m., Licensed	F 315	immediately after the admission. This interim care plan guides provision of care from the time of the residents transfer or admission until the interdisciplinary care plan is completed. The interim care plan is based on the admitting physician orders, interagency transfer information and the pre/admission nursing assessment. Upon completion of the comprehensive assessment a comprehensive care plan is developed by an interdisciplinary team. This team includes the attending physician, a registered nurse with responsibility for the resident and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance, maintain or restore the resident□s functional abilities, quality of life and to provide safety. The resident and family/legal representatives are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each assessment. 1. Resident 78 was admitted into the facility on November 8, 2013 and discharged from the facility on April 3, 2014. The interim care plan is developed per pre admission screening, physician orders and transfer information. A 3- day bowel and bladder screen and a bowel and bladder observation/assessment is completed upon admission, quarterly, annually and with significant changes prior to developing or updating the comprehensive care plan. 2. Care plans will identify changes in	

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F 315	Continued From page 5 Practical Nurse (LPN)- A, regarding lack of toileting care plan, interventions and goals, indicated there was no toileting plan to prevent a decline attempted for R78. During observations, on 3/25/14, at 10:30 a.m., R78 put the call light on. A nursing assistant entered the room, R78 requested to use the bathroom, and R78 was assisted to the bathroom. Interview with Nursing Assistant (NA)- B on 3/27/14 at 2:45 p.m., indicated R78 will put the call light on when wet and wants assistance with changing the brief, or assistance with ambulation to the bathroom.	F 315	condition and will reflect interventions as per policy. 3. The policy and procedures regarding interim/comprehensive care plans and changes in resident□s conditions have been reviewed with licensed nursing staff. On or before April 20, 2014 licensed nursing staff were instructed on 1) the requirement that a residents care plan must be current at all times; 2) that direct care staff share in the responsibility for updating the care plan; 3) that care plans must reflect specific approaches/interventions relating to the change in condition/problem, and 4) education on the facility policies on interim/comprehensive care plan review and updating. 4. The Interdisciplinary Care Plan Team will monitor compliance by reviewing 2 selected care plans and MDS coding weekly for 1 month. Charts then will be randomly audited on a monthly basis for MDS coding and updates to the care plan. The Director of Nursing will oversee this and the plan of correction will be integrated into the quality assurance system.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		4/30/14

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F 431	Continued From page 6 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored and labeled properly for 7 of 15 residents (R24, R13, R4, R60, R96, R42 and R19) whose medications were observed for medication storage. Findings include: During observations of multiple medication	F 431	St Brigids at Hi- Park stores drugs and biologicals safely, securely and properly, following the manufacturer□s recommendations or those of suppliers. The medication supply is accessible only to licensed personnel, pharmacy personnel or staff members lawfully authorized to administer medications. 1. Residents numbered: 24, 13, 4, 60, 42 and 19 have discharged from the	

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F 431	Continued From page 7 storage areas throughout the facility, medications for R24, R13, R4, R60, R96, R42 and R19, which included eye drops, nasal spray and inhaler, lacked dates to indicate when they were opened or the medications were expired. During the medication storage tour on 3/26/14 at 2:25 p.m., with licensed practical nurse (LPN)-B, in the River Bluff Blvd, multiple opened, undated and incorrectly dated bottles were stored in the medication cart. Observations included the following: · R24's Ventolin (chronic airway obstruction) inhaler was opened and undated. . R13's one Systane opht eye drop bottle was expired with a date of 12/30/13. In addition, one Atropine drop bottle was opened with a date of 1/15/14. · R4's Artificial tears (tear film insufficiency) eye drop bottle was opened, used and dated on 12/30/14. · R60's Nasonex spray (allergic rhinitis) nasal spray bottle was opened and dated on 1/15/2014. During interview on 3/26/14 at 2:30 p.m. LPN-B verified the medications needed to be stored properly, with proper date when opened. Further, LPN-B stated she does not know what the expiration date is once a bottle is opened and dated, but will find out. During the medication storage tour on 3/26/14 at 2:40 p.m. the Guernsey Trail unit medication storage cart was reviewed. The following observations were made: · R96's Timolol maleate eye drop bottle was opened, used and undated. · R42's Atropine eye drop bottle was opened and undated.	F 431	facility at this time. Resident number 24□s eye drops were removed from the cart prior to discharge and a replacement was received from the pharmacy. Resident number 96□s medications have been reviewed and are currently being stored properly with correct expiration dates applied. 2. Medications that are received from the pharmacy are labeled with resident information, medication, administration instructions, dose and opening/ expiration instructions. Weber and Judd Pharmacy provide the facility with a Medication with Shortened Expiration Dates Form for licensed staff to use as a reference when opening a medication. 3. Nurses have reviewed the pharmacy policy on medication labeling, storage and expiration of medications. The Medications with shortened expiration dates form has been reviewed and is available for all licensed/authorized staff to use as a guide for application of expiration dates. 4. ST Brigids at Hi- Park has 2-medications administration carts. Both carts will be audited for proper storage and labeling of medications each week for four weeks. The Director of Nursing/Designee will oversee this and the plan of correction will be integrated into the quality assurance system.	

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F 431	Continued From page 8 · R19's artificial tears (tear film insufficiency) eye drop bottle was opened, used and undated. During interview on 3/26/14 at 2:45 p.m. registered nurse (RN)-A verified the medications needed to be labeled and stored properly. RN-A added that opened medications needed to be dated when opened and expired medications needed to be removed from the storage area. In addition, RN-A stated her expectation was for staff to date all multiple dose medication bottles when they opened them. During interview on 3/27/14 at 9:20 a.m. the director of nursing (DON) indicated, her expectation was for staff to date all multiple dose medication bottles when they opened them. In addition, DON stated, staff should check for expiration dates on the medication bottles and remove from medication cart. Further stated, " The nurses are aware of that and we have signs in the medication room that states that. We have a form in the MAR that states how many days when opened medications are expired. " Review of the policy and procedure for medications with shortened expiration dates, undated, titled: Weber & Judd Company, stated, "1. the opened date or the discarded after date should be noted on each container/vial of medication known to have a shortened beyond use date or expiration date. Alternatively, nursing staff may place a "date opened _____or " Discard Unused Portion After the expiration date of _____" sticker on the container with the applicable date written in. Staff should refer to the Medications With Shortened Expiration Dates guide, refer to a current drug references, or contact the pharmacy if uncertain as to a	F 431		

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F 431	Continued From page 9 products expiration date." " 4. For al medications, if the manufacturer 's expiration date or pharmacy's labeled expiration date occurs before the expiration date or beyond use date noted on the container, the earlier of the two dates is to be utilized." Undated guidelines for medication expiration, reads, "Eye Drops/Ear Drops, ointments, ear drops. Date opened required."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		4/30/14

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F 441	Continued From page 10 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure hand hygiene was completed for 1 of 1 resident (R12) observed during perineal cares. On 3/27/14 at 12:15 p.m., nursing assistant, (NA)-A was observed to wash her hands, don gloves and assist R12, who was lying on her back in bed, to remove her pants and disposable incontinence brief. The disposable incontinence brief was observed to have a significant amount of feces in it. NA-A used disposable wipes to clean the front perineal area and then requested R12 to roll to the side and assisted her with cleaning the back perineal area. NA-A then removed her gloves, grabbed a pad for the bed and, without washing or sanitizing hands, donned new gloves. NA-A told R12 she needed to finish washing R12's front perineal area and proceeded to use disposable wipes to clean feces off R12's perineal area. NA-A then entered the bathroom, donned new gloves, without washing or sanitizing hands. NA-A then removed pants from R12's closet, assisted her in putting them on, took R12's glasses off and moved the tray table, water and	F 441	St. Brigids at Hi- Park has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility; 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and, and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. Resident 12 was admitted into the facility on April 28, 2011. Resident is incontinent of bowel and bladder and receives 1 assist with peri-care. An observation of peri-care for this resident was completed once daily for 3-days. Staff did complete hand washing between soiled product removal and application of clean product.	

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F 441	Continued From page 11 call light near R12 before exiting the room. During interview, on 3/27/14 at 4:00 p.m. NA-A reported she was unaware she did not wash her hands between glove changes, but was aware she should have. During the same interview, the nurse manager, (RN)-A reported she would expect hands to be washed or sanitized between glove changes while staff assisted residents with perineal cares. Review of, The Handwashing policy, undated, directed staff "All staff and volunteers must wash their hands before and immediately after coming in contact with each resident and after material that may be contaminated and/or potentially infectious. It is essential after contact with a source of body fluids, mucous membranes and after removing gloves." The Instant Hand Sanitizers policy, undated, directed staff " "All staff will use proper hand hygiene after coming in contact with each resident and after contact with material which may be contaminated." and "The CDC [Centers for Disease Control and Prevention] recommends health care providers use Alcohol-based hand sanitizers instead of soap and water except when hands are visibly soiled."	F 441	The facility□s policies and procedures for hand washing were reviewed and found appropriate. Staff is aware of these policies and they are available for staff to review at any time. Hand washing, glove changing and peri-care education for nursing staff is received at orientation, at mandatory annual training and facility yearly skills fair. During the mandatory meetings on April 17, 2014 and 1-to-1 licensed staff education from April 14, 2014 to April 20, 2014. The staff was instructed on the facility policy for hand washing, peri-care and changing gloves. Audits on peri-care, glove changing and hand washing will be conducted three times weekly for four weeks then 1 time quarterly and as needed. The DON and infection control nurse will monitor for compliance.	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245355	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Brigids at Hi Park was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC ok PS 4-21-14 RECEIVED APR 18 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-6-14
EXIT: 3-27-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jacob M Guenz — TITLE: CEO/ADMINISTRATOR — (X6) DATE: 18 APRIL '14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BRIGID'S AT HI-PARK	**213 PIONEER ROAD** **RED WING, MN 55066**

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Brigids at Hi Park is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1977 and was determined to be of Type III(211) construction. In 1986, addition was constructed to the West Wing that was determined to be of Type III(211) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 55 at the time of the survey.	K 000		

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	245355	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/24/2014

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ST BRIGID'S AT HI-PARK	213 PIONEER ROAD RED WING, MN 55066

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K 054 K 054 SS=F	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Sections 7-3.2 and 7-3.2.1. The deficient practice could affect all 55 residents. Findings include: On facility tour between 1:00 PM and 4:00 PM on 03/24/2014, the review of the annual fire alarm system inspection test records indicated that it has been more than 12 months since the last test that was conducted on 03/08/2013. This deficient practice was confirmed by the Director of Maintenance (KL) at the time of discovery.	K 054 K 054	1. TransAlarm completed inspection and testing of the fire alarm system on 28 March 2014. 2. Completion date: 28 March 2014 3. The Plant Operations Manager is responsible for correction and monitoring to prevent future recurrence. 4. An electronic reminder has been programed into the Equipment Lifecycle System (TELS) to insure timely completion of the test hereafter.	03/28/14
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	1. Olympic conducted a) an interna check of valves, and b) an internal inspection of system pipes on 2 April 2014. 2. Completion Date: 2 April 2014. 3. The Plant Operations Manager is responsible for correction	04/02/14

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 9-4.2.1 and 10-2.2. This deficient practice could affect all 55 residents. Findings include: On facility tour between 1:00 PM and 4:00 PM on 03/24/2014, a review of the annual fire sprinkler inspection records showed: 1. More than 12 months passed between the inspection conducted on 10-14-12 and the inspection conducted on 11-12-13. 2. The fire sprinkler inspection report from Olympic dated 11/21/2013, indicated: a. There was no 5 year internal check of the valves. b. There was no 5 year internal inspection of the system pipes. These deficient practices were confirmed by the Director of Maintenance (KL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	Continued K 062 and monitoring to prevent future recurrence. 4. An electronic reminder has been programmed into the Equipment Lifecycle System (TELS) to insure timely completion of the test hereafter.	