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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZXDT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00675

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245487**
2.STATE VENDOR OR MEDICAID NO.
(L2) **394347000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ELIZABETH MEDICAL CENTER**
(L4) **1200 FIFTH GRANT BOULEVARD WEST**
(L5) **WABASHA, MN** (L6) **55981**

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 **10/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **100** (L18)

13.Total Certified Beds **100** (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
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/14/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 8, 2015

Mr. Tom Crowley, Administrator
St Elizabeth Medical Center
1200 Fifth Grant Boulevard West
Wabasha, Minnesota 55981

RE: Project Number S5487027

Dear Mr. Crowley:

On September 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 20, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 5, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 26, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 20, 2015, effective September 26, 2015 and therefore remedies outlined in our letter to you dated September 8, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245487	A. Building B. Wing	10/5/2015

Name of Facility	Street Address, City, State, Zip Code
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

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 **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **09/26/2015**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **09/26/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/26/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/26/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/26/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/26/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/26/2015**	ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **09/26/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/26/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/26/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/26/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	10/08/2015	25822	09/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/20/2015			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245487	02 - ST. ELIZABETHS CARE CENTER	9/24/2015

Name of Facility	Street Address, City, State, Zip Code
ST ELIZABETH MEDICAL CENTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981

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 K0076	08/21/2015	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GN/kfd	Date: 10/08/2015	Signature of Surveyor: 10160	Date: 09/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/19/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZXDT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00675

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245487**
2.STATE VENDOR OR MEDICAID NO.
(L2) **394347000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST ELIZABETH MEDICAL CENTER**
(L4) **1200 FIFTH GRANT BOULEVARD WEST**
(L5) **WABASHA, MN** (L6) **55981**

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 **08/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **100** (L18)

13.Total Certified Beds **100** (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
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey (Krebs), HFE NE II 09/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/14/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 8, 2015

Mr. Tom Crowley, Administrator
St Elizabeth Medical Center
1200 Fifth Grant Boulevard West
Wabasha, Minnesota 55981

RE: Project Number S5487027

Dear Mr. Crowley:

On August 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 26, 2015, 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 November 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING _____ B. WING _____	08/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159		9/26/15

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

Electronically Signed | 09/16/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING _____ B. WING _____	08/20/2015

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

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F 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents had access to monies in their personal trust fund accounts after admissions office hours during the evenings and weekends. This had the potential effect all 92 residents. Findings include: Admissions employee-G was interviewed on 8/20/15, at 8:20 a.m. stated admissions office hours were Monday through Friday from 6:30 a.m. to 5:00 p.m. and weekends from 8:00 a.m.	F 159	*Reviewed and revised policy "Resident Trust Funds" *Updated resident addmission packet to reflect changes made to policy "Resident Trust Funds" by 9/26/15. *Revisions to policy to be shared at resident council and family council (when held) meetings September 22, 2015 and October meetings when dates determined. *Educated licensed nursing team members on new process via internal memo and discussion at team meetings	

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F 159	Continued From page 2 to 4:00 p.m., if a resident wanted access to money they would have had to do it when the admissions office is open. Patient accounts employee-H was interviewed on 8/20/15, at 8:32 a.m. stated residents had been informed during admission when they could get money from their account and verified residents did not have access to money after the admission office closed. During interview on 8/20/15, at 12:58 p.m. executive assistant (EA)-I verified the facility did not have an evening or weekend petty cash account and stated, "If we know they (residents) will need it we leave it with the nurses to be locked up. If we don't know they get it over at the admissions desk at the hospital." EA-I was unable to report where residents would access money after admission office hours. EA-I stated families would have had to provide the money for the resident and the facility would have reimbursed them. EA-I further stated the social worker would have informed the resident on admission when they would have access to money. During interview on 8/20/15, at 1:23 p.m. licensed social worker (LSW)-A stated if residents had needed money on a weekend they would have had to get it on Friday when the admissions office was open. LSW-A further stated, "Or they can go to the hospital admissions (this is located at a deferent location than the nursing home) to get it." LSW-A verified residents would not have access to money after admission office hours. Review of the facility policy Resident Trust Funds last reviewed 4/11 identified the following:	F 159	by 9/26/15. *Educated front office team members and patient account team members of change in process by 9/26/15. *DON/Designee to conduct random audits 1x week for 4 weeks, 2x month x1 month to verify front office team members, patient account team members and licensed team members are able to identify new process for providing access for residents' personal funds on evenings and weekend hours.	

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F 159	Continued From page 3 "POLICIES 9. Funds will be accessible at the admissions desk, 8 am - 4 pm Monday through Friday, and by prior arrangements in both buildings. For unexpected needs outside of these hours funds may be accessed from petty cash at the admissions office at Saint Elizabeth Medical Center. PROCEDURES 2. On weekends or after hours, nursing staff should call admissions office at Medical Center. Money can then be accessed by resident, resident's representative or facility staff from the admission office." Review of the facility admission packet Personal Funds Agreement page 18, undated, specified "A resident or authorized person(s) shall have access to a resident's personal funds account and financial statement, Monday-Friday, 8 a.m.- 4 p.m. and weekends/holidays with prior arrangements."	F 159		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the most	F 167	*Most recent survey results relocated to lower edge of bulletin board at the nursing	9/26/15

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F 167	Continued From page 4 current survey results were accessible to all residents located at the hospital Nursing Home unit. This had the potential to effect 19 out of 19 residents. Findings include: On 8/17/15, at 10:05 a.m. during an initial tour of the nursing home unit located on the second floor of the hospital, results for the previous survey had been observed on a bulletin board across from the nursing station. The results were attached by a metal ring which was hanging on a small hook approximately five feet up from the floor. The surveyor was unable to read the results without reaching up and removing them from the hook. During resident council interview on 8/19/15, at 5:59 p.m. resident 23 was unable to report where the most recent survey results were located. When asked stated, "I have no idea." During an interview on 8/20/15, at 10:25 a.m. registered nurse (RN)-F verified the most recent survey results were not easily accessible to residents, and/or visitors to examine without having to ask for staffs' assistance. RN-F stated the results should be lower, and further verified persons in a wheelchair would have had difficulty viewing the notice.	F 167	home (second floor of hospital campus). Sign placed to please not move survey results 8/27/15. *Sign placed directing interested individuals to binder holding the most recent survey results located on bookshelf in nursing home sun room by 9/26/15. *Changes to placement of most recent survey results shared with R23 and residents at resident council meeting by 9/26/15. *Weekly audit X4 to be completed to verify acceptable placement/location of most recent survey results.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		9/26/15

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F 241	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 4 of 6 residents (R42, R76, R80, R55) were assisted with eating in a dignified manner. Findings include: R42 and R76 were observed on 8/19/15, at 5:22 p.m. nursing assistant (NA)-F was observed sitting between R42 and R72 wearing rubber barrier gloves while assisting R42 and R76 to eat. Neither R42 or R76 had a sandwich or finger food. Both residents had a puree diet. R76 was admitted to the facility on 2/27/2013, according to the facility admission record. R76's quarterly Minimum Data Set (MDS) dated 6/26/15 indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Downs Syndrome, and required a mechanically altered diet. In addition the MDS indicated R76 held food in mouth/cheeks or had residual food in mouth after meals and coughed or choked during meals or when swallowing medications. R76's care plan was provided by the facility on 8/20/15. The copy provided had a print date of 3/21/13, the "feeding" plan of care plan informed staff, R76 was dependent on staff for eating, required pudding thick liquids, and was on a pureed diet. The care plan identified R76 had dysphagia and history of cerebral vascular accident (stroke). R42 was admitted to the facility on 3/13/2009, according to the facility admission record. R42's	F 241	*Appropriate use of gloves during mealtimes reviewed at team meetings August/September. Internal memo sent out reviewing expectation of when to and when not to wear gloves when assisting a resident with food by 9/26/15. *Audits to be completed weekly x4 weeks, x2 every two weeks and x1 monthly x2 to verify understanding and compliance with principles of dignity and dining in relation to appropriate use of gloves. *Findings from audits will be reported and reviewed at future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.	

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annual MDS dated 5/24/15, indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Alzheimer disease, and required a mechanically altered diet.
R42's care plan was provided by the facility on 8/20/15. The copy provided had a print date of 5/26/15, the nutritional status care plan informed staff, R42 was fed for all meals, required nectar thick liquids, and was on a pureed diet. The care plan identified R42 had and advanced dementia.

During an Interview on 8/19/15, at 6:29 p.m. NA-F stated she had worn gloves because "I 'honestly' thought we had to." NA-F acknowledged that wearing gloves to assist a resident to eat the entire meal could be a dignity issue.

During an interview on 8/20/15 at 7:27 a.m. the director of nurses stated she would expect staff to have a barrier of some sort if they were going to touch food, if the resident was having a lot of drool or coughing. However, the wearing gloves for an entire meal is not the norm and I would not expect staff to do so.
R80 had been observed 8/19/15, at 5:43 p.m. located on the 200 Wing dining hall being assisted with eating. NA-C was seen to be offering fluids and assisting with eating, all the while wearing barrier gloves. NA-C did not remove her gloves during the entire dining experience for R80.
R55 had been observed while being assisted to eat on 8/19/15 at 5:25 p.m. R55 was being assisted with eating by a NA. The NA then stopped assisting and got up, applied gloves, and returned to assisting R55 with the rest of meal. The other two NA's assisting residents with eating then stopped assisting and applied gloves.

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F 241	Continued From page 7 During an interview on 8/20/15, at 10:04 a.m. Registered Nurse (RN)-D Infection control nurse, stated that the expectation for use of gloves when assisting residents to eat was if there were a lot of secretions. Staff are told they can wear gloves when they want to, just let the residents know why. RN-D then said, "If it is wet and not yours wear gloves." RN-D questioned why they chose to wearing gloves during the entire meal time. Policy was requested for use of gloves when assisting resident to eat and none was provided.	F 241		
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		9/26/15

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F 279	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that care plan interventions related to kidney dialysis were developed for 1 of 1 resident (R67) reviewed for dialysis, failed to develop a care plan that included monitoring for side effects of an anti-coagulant medication (Warfarin) for 1 of 7 residents (R7) reviewed for skin, and failed to develop a complete dysphagia care plan for 1 of 1 resident (R76) reviewed for mechanical altered diets. Findings include: R67's current care plan dated 4/30/14 indicated R67 had been diagnosed with unspecific type Diabetes Mellitus with renal manifestations and was hemodialysis dependent. The care plan approach included documentation which read, "See dialysis care plan and standing orders in chart for contact numbers and direction for care, ok to use standing house orders with exception of MOM [milk of magnesia] and Antacid. Do not take blood pressure on left arm, short sleeves on dialysis days, NSG [nursing] staff to check fistula site for bruit every shift, monitor pre-post weight and BP [blood pressure] on dialysis." Further review of the record had not revealed the dialysis care plan as indicated, and did not include monitoring for complications, and did not include a plan to guide staff response to an emergency. During interview on 8/20/15, at 7:20 a.m. nursing assistant (NA)-G was unable to report complications that would be monitored for a resident receiving dialysis, and what procedure	F 279	*Care plans for resident 67, 7 and 76 reviewed and updated to include identified areas by September 26. *Policy "Resident Care Plans, Development, Implementation and Revision" reviewed. *Care plans to be reviewed and revised at a minimum quarterly and as needed for all residents. *Team meeting August/September and LTC department head meeting August/September provided discussion of importance of ensuring care plans being developed and updated in a timely manner to reflect current needs of resident by 9/26/15. *DON/designee to complete random audits 1x week for 4 weeks, 2x month for 1 month and then monthly x2 months to verify compliance with inclusion of specific individualized resident needs on care plan. *Findings will be reported and reviewed at future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.	

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F 279	Continued From page 9 would be followed if an emergency occurred. During interview on 8/20/15, at 7:55 a.m. NA-H stated dialysis education had not been provided and was unable to report what would be monitored. NA-H was unable to report where information would be located to guide staff response to an emergency. On 8/20/15, at 9:35 a.m. during interview clinical manager registered nurse (RN)-B reported licensed nursing staff monitor daily weight, blood pressure and fistula site for thrill. RN-B stated, "We don't have any specific emergency procedures it's just like anyone else." RN-B was unable to provide a working dialysis care plan. During phone interview on 8/20/15, at 10:52 a.m. Mayo Clinic Dialysis Nurse Supervisor reported the dialysis center had sent an information sheet to the facility after each dialysis session and stated monitoring should have included pain and swelling for infection, and further stated the access site should have been monitored specifically for bleeding. During interview on 8/20/15, at 1:03 p.m. director of nursing verified dialysis care had not been included in R67's comprehensive care plan and stated dialysis information should have been accessible to staff. Dialysis policy was requested but not provided. R7 had been observed on 8/19/15, at 2:00 p.m. multiple areas of bruising had been noted on R7's right forearm. Upon interview R7 stated the bruising had been present the past week and had occurred "When they [phlebotomist] tried to get	F 279		

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blood." R7 reported bruising had been a frequent occurrence.

According to current physician orders, R7 received Warfarin (an anti-coagulant-blood thinning medication) 6 mg (milligram) by mouth on Wednesdays and Saturdays, and received 4 mg by mouth on Sunday, Monday, Tuesday, Thursday and Friday for diagnosis of atrial fibrillation.

Review of R7's current care plan dated 12/4/14 identified R7 as alert and oriented with increased risk for skin breakdown secondary to urinary incontinence, impaired mobility, arthritic pain and history of pressure ulcers upon admission. The care plan had not addressed risk factors and interventions for excessive bleeding or bruising associated with the use of Warfarin in order to alert care givers the need to report bruising and bleeding timely to the nurse.

During interview on 8/20/15 at 1:03 p.m. the director of nursing (DON) stated, "Care plans should include, reflect the care needs of the resident at the time and should provide enough information to care for that resident." The DON further stated, "I want my aids [NAs] to treat everyone as if they are at high risk of bruising and bleeding." DON verified R7's current care plan lacked risks, goals or interventions related to the Warfarin therapy and high risk of bleeding and bruising.

Request made for care plan policy however none provided.

R76 was admitted to the facility on 2/27/2013 according to the facility admission record. R76's

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quarterly Minimum Data Set (MDS) dated 6/26/15 indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Downs Syndrome, and required a mechanically altered diet. In addition the MDS indicated R76 held food in mouth/cheeks or had residual food in mouth after meals and coughed or choked during meals or when swallowing medications.
R76's Care Area Assessment (CAA) last completed 1/12/15 with annual MDS indicated resident was totally dependent on staff for feeding and required pudding thick liquids and had a pureed diet. The CAA did not identify R76 had a diagnosis of dysphagia (difficulty swallowing).
R76's care plan provided by the facility on 8/20/15. The copy provided had a print date of 3/21/13, the "feeding" plan of care had hand written changes in the margins that were difficult to follow because changes since 2013 were not in chronological order and hand writing was difficult to read. It was determined the current care plan had informed staff R76 was dependent on staff for eating, required pudding thick liquids, and was on a pureed diet. The care plan identified R76 had dysphagia and history of cerebral vascular accident (stroke). The care plan did not identify risk for aspiration/choking and did not include the evaluation from the quarterly MDS indicating R76 held food in mouth and coughed/choked during meals and/or when swallowing medications.
R76's nursing assistant care sheet provided by the facility on 8/20/15 informed staff R76 required pureed diet with pudding thick liquids. The nursing assist care sheet did not include the information from the MDS that indicated R76 held food in mouth or coughed/choked during meal times or when swallowing medications.
Furthermore, the care sheet did not include

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F 279	Continued From page 12 interventions for either identified swallowing difficulty issues. R76's physician orders provided by the facility on 8/20/15 read, "diet: 1500 calorie, pureed with added protein with pudding thick liquids." Nutritional assessment dated 6/23/15 indicated R76 had a pureed diet with pudding thick liquids and required assistance from staff. The assessment also read, "does do some coughing with meals". During an interview on 8/20/15, at 10:48 a.m. RN-B stated R76's diet was changed to pudding thick after a dietician's recommendation on 8/6/2014 because of increased coughing during meal times. RN-B verified diagnoses of dysphagia had been in the care plan without any interventions for episodes of choking/coughing/aspiration. RN-B further explained "we assume people are aspiration risk if they are on a therapeutic liquid consistency". During an interview on 8/20/15, at 12:13 p.m. director of nursing (DON) stated, ideally the care plan would identify aspiration/coughing and include the appropriate interventions. Facility policy Liberalized Diet Guidelines for Long Term Care last reviewed 6/2014 read, "A qualified R.D. [registered dietician] will assess residents' nutritional status and appropriateness of the prescribed diet order so that each nutrition care plan is individualized for each resident ....the goal of the consistency alteration is to prevent choking and aspiration, to maintain normal nutritional status ....Dysphagia-primarily used for residents with diagnosed, documented swallowing impairment/problems ....all thickened liquids and food texture stages are provided at the degree to texture that the resident can safely tolerate as directed by the professional monitoring the dysphagia".	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise a care plan that included ongoing plan of care for contractures and assistance required for eating for 1 of 20 residents (R55) care plans reviewed and failed to revise the skin care plan for 1 of 7 residents (R72) reviewed for skin alterations. Findings Include: R55 was admitted to the facility on 9/20/11 with diagnoses including, diabetes, neurotic depression, hypertension, chronic right hip pain,	F 280	*Care plans for residents 55 and 72 revised to reflect current resident condition by September 26, 2015. *Policy "Resident Care Plans, Development, Implementation and Revision" reviewed September 10, 2015. *Care plans to be reviewed and revised at a minimum quarterly and as needed for all residents. *Team meeting August/September and LTC department head meeting August/September provided review of importance of ensuring care plans reflect	9/26/15

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F 280	Continued From page 14 and chronic right hip infection according to the admission form. On 8/18/15 at 11:44 a.m. R55 was observed to require complete assist with her noon meal and did not attempt to eat herself. On 8/19/15 at 5:25 p.m. R55 was observed to require partial assist with eating. The nursing assistant (NA) assisting R55 handed R55 a sandwich, which R55 was able to hold and independently eat. The NA fed R55 bites of fruit and handed her a cup from which R55 could take a drink then the NA would set back down. On 8/20/15 at 10:35 a.m. registered nurse (RN)-C stated, "Some days she [R55] can totally feed herself, or you get her started and she finishes and other days we have to totally feed her. It depends on her day. Needs lots of encouragement." On 08/20/15 at 11:47 a.m. the director of nursing (DON) reviewed R55's care plan and ADL care plan. "I would have to agree the care plan does not match MDS. The change of eating should certainly be on the ADL care plan. The contracture's being that she refused treatment, it should be at least acknowledged, reporting increased pain." The DON verified contracture's should be care planned and were not included on the current care plan. Quarterly Minimum Data Set (MDS) dated 2/22/15 indicated R55 required a limited assist with eating, resident was highly involved in eating, staff provided guided maneuvering of limbs or other non-weight bearing assist. R55 also had a functional limitation in range of motion with lower	F 280	current needs of residents and that revisions to care plan be made timely in response to changes in resident condition by 9/26/15. *DON/designee to complete random audits 1x week for 4 weeks, 2x month for 1 month and then monthly x2 months to verify compliance with inclusion of specific individualized resident needs on care plan. *Findings will be reported and reviewed at future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.	

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F 280	Continued From page 15 extremity impairment on both sides Significant change MDS dated 5/18/15 revealed R55 required an extensive 1 person physical assist with eating, staff provided weight bearing support. ADL [activities of daily living] Care Plan dated 6/14/15 indicated R55 needed staff set up, assist of 1 as needed with eating, and to eat one item at a time. Care plan dated, 12/13/12 revealed an identified problem of potential for self care deficit with eating: "I eat all meals independently after setup needing occasional cueing and assist. I am on cardiac, diabetic diet 1800 calorie diet. I need to be given one item at a time." R72 was admitted to the facility on 3/13/14, with diagnoses including but not limited to dementia, constipation, recurrent urinary tract infections, history of a stroke and deep vein thrombosis according to the admission form. On 8/18/15, at 9:58 a.m. R72 was observed sitting in the units day room. R72 had a bruise located on the top of right hand and sterri strips on left hand. R72's Medications include but not limited to, hydrochlorothiazide (an antihypertensive that is also a diuretic), Budesonide (an inhaled medication to improve breathing) and Tylenol (a pain medication). Drugs.com identified bruising is a side effect of each of these medications. During interview on 8/19/15, at 6:56 p.m. Licensed practical nurse (LPN)-E stated 2 weeks ago nursing assistants were getting R72 ready for	F 280		

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F 280	Continued From page 16 bed. R72 became combative, striking out at staff and R72 grabbed own hand and caused two skin tears. Progress note dated 8/10/2015, 11:29 a.m. "Noted Various discolored areas on R72 right hand and lower arm." Review of charting indicates that she has had multiple episodes of being combative, hitting and throwing items during cares which may increase her risk of bruising. It is also noted that her skin is very fragile on her lower arms and tops of hands with vessels being very close surface of skin, increasing her risk for any bumps to result in bruising. Care plan dated 7/1/2014 read, "All Staff-----SKIN: I am at increased risk for skin breakdown secondary to inc , impaired mobility and use of coumadin which increases my risk for bruising..." During interview on 8/20/15, at 8:10 a.m. DON reviewed R72's skin care plan. DON stated resident is not currently on coumadin and should be removed from care plan. DON had acknowledged that care plan for skin did not reflect residents fragile skin, or base line discoloration, combativeness, or other risk factors for bruising or skin tears. DON pulled up progress note on computer and showed assessment of skin and risks for bruising or injury dated 8/10/15 11:29 a.m. Policy for updating care plans was requested and none provided.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		9/26/15

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F 309	Continued From page 17 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive monitoring system was in place to include care of dialysis access site, and failed to establish emergency medical interventions for 1 of 1 residents (R67) reviewed for dialysis. Findings include: R67's current care plan dated 4/30/14 indicated R67 had been diagnosed with unspecific type Diabetes Mellitus with renal manifestations and was hemodialysis dependent. The care plan approach included documentation which read, "See dialysis care plan and standing orders in chart for contact numbers and direction for care, ok to use standing house orders with exception of MOM [milk of magnesia] and Antacid. Do not take blood pressure on left arm, short sleeves on dialysis days, NSG [nursing] staff to check fistula site for bruit every shift, monitor pre-post weight and BP [blood pressure] on dialysis." Further review of the chart had not revealed the dialysis care plan as indicated, and did not include monitoring for complications, and did not include a plan to guide staff response to an emergency.	F 309	*Care plan for R67 reviewed and revised to reflect comprehensive monitoring related to dialysis needs by 9/26/15. *Staff education for nursing assistants and licensed team members including reviewing form "Reminders for the Dialysis Patient with a Fistula" which provides immediate intervention and care for dialysis complication of bleeding completed 9/26/15. *Staff education included review of location of "Memorandum of Understanding" in R67 medical record which includes directions for care of resident receiving dialysis and medical emergency interventions related to resident receiving dialysis treatment by 9/26/15. *DON/Designee to complete random audits of team members' knowledge of location of forms identified and emergency procedure for resident receiving dialysis above 2x week for 2 weeks, 1x week for 2 weeks and 1x month for 2 months to verify understanding. *Findings will be reported and reviewed at	

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F 309	Continued From page 18 During interview on 8/20/15, at 7:20 a.m. nursing assistant (NA)-G was unable to report complications that would be monitored for a resident receiving dialysis, and what procedure would be followed if an emergency occurred. During interview on 8/20/15, at 7:55 a.m. NA-H stated dialysis education had not been provided and was unable to report what would be monitored. NA-H was unable to report where information would be located to guide staff response to an emergency. Further review of R67's chart identified a Memorandum of Understanding dated 5/29/2015, which indicated vascular access site should have been monitored for clotting, infection, and excessive bleeding. The memorandum included an emergency procedure for excessive bleeding. Review of facility dialysis binder located at the nurses' station revealed a 40 page educational pamphlet. Page 20 and 21 of the pamphlet identified possible access site problems and interventions to include site monitoring for infiltration, swelling and pain, bleeding, infection and clotting. On 8/20/15, at 9:35 a.m. during interview clinical manager (CM)-B reported licensed nursing staff monitor daily weight, blood pressure and fistula site for thrill. CM-B stated "we don't have any specific monitoring for bleeding or emergency procedures it's just like anyone else." CM-B had been unaware a Memorandum of Understanding that had included specific instructions for monitoring had been in R67's chart, and had been unaware an educational pamphlet included monitoring for infiltration, swelling and pain,	F 309	future QA&A (QAPI) team meetings to direct future audits and training.	

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F 309	Continued From page 19 bleeding, infection and clotting had been located in a dialysis binder. CM-B verified nursing staff had not monitored complications to include infiltration, swelling, pain, bleeding, infection and clotting. During phone interview on 8/20/15, at 10:52 a.m. Mayo Clinic Dialysis Nurse Supervisor reported the dialysis center had sent an information sheet to the facility after each dialysis session and stated monitoring should have included pain and swelling for infection, and further stated the access site should have been monitored specifically for bleeding. During interview on 8/20/15, at 1:03 p.m. director of nursing verified dialysis care had not been monitored and that the facility lacked an emergency medical plan. A policy and/or procedure on emergency medical interventions for residents receiving dialysis treatments had been requested and none provided.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		9/26/15

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F 329	Continued From page 20 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 5 residents (R80) had a dose titration or a physician's justification for why a dose reduction was contraindicated at this time and failed to ensure documentation of non-pharmacological measures were used prior to the administration of PRN (as needed) medication for 1 of 3 residents (R21) reviewed. Findings included: R21 was admitted to the facility on 2/28/2014 according to the facility admission record and had the following diagnoses according to the facilities electronic medical record: mononeuritis, varicose veins with lower leg edema, arthropathy, and osteoarthrosis. R21's electronic physician's orders provided by the facility on 8/19/15 included Ultram (narcotic-like pain medication) 50 milligrams by mouth as needed two times a day as needed (PRN) for pain. R21's care plan provided by the facility on 8/19/15	F 329	*Staff education of importance of documenting non-pharmacological interventions offered prior to administering PRN medication for licensed nurses and trained medication aides provided at staff meetings (Aug/Sept), via internal memo 8/24/15, state survey preliminary result posting August 20, 2015. *Reviewed and revised policy "Administration of Medications" and reviewed "Consultant Pharmacist in LTC" September 14, 2015. *DON/Designee to complete random audits for residents receiving PRN medication ordered each week x4 weeks. *R80 is not referenced in F329 "findings", verified with G Nederhoff, Unit Supervisor MDH on 9/18/15. *Findings will be reported and reviewed at future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.	

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F 329	Continued From page 21 informed staff R21 had chronic pain in right foot, ankle, and shoulder. The care plan directed staff to offer warm/cold packs for break through pain. R21's medication administration record was reviewed from 6/7/15 through 8/20/15; the record indicated a total of twelve doses of PRN Ultram had been administered. Of the twelve doses that were administered it was not evident in the medical record if non-pharmacological intervention had been attempted prior to use of the medication for eight of twelve doses given. During an interview on 8/19/15, at 2:43 p.m. registered nurse (RN)-F stated, "PRN medications should be documented with non-pharmacological interventions and what the effectiveness was." During an interview on 8/19/15, at 3:31 p.m. the director of nursing (DON) stated her expectation had been to attempt and document effectiveness of non-pharmacological interventions prior to the administration of all PRN medications. Facility policy that was obtained did not reflect current standards of the utilization of non-pharmacological interventions prior to the administration of PRN medications.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the physician ordered therapeutic diet for 1 of 1 resident (R76) reviewed for therapeutic diets.	F 367	*R76 diet adjusted to reflect "pudding thick consistency" for all food and liquids. *R76 care plan reviewed and revised to reflect current therapuetic diet needs.	9/26/15

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F 367	Continued From page 22 Findings included: R76 had been observed during an evening meal on 8/19/15, at 5:38 p.m. R76 had two coughing episode that lasted 45 seconds each after nursing assistant (NA)-F had given bites of food. During the coughing episode R76's tongue had been protruding and eyes were moist. R76 had been served regular consistency tomato soup with chunks of tomatoes. At 5:57 p.m. dietary assistant (DA)-C verified the consistency of the soup was wrong and stated it should have been pudding thick. At 5:59 p.m. DA-D indicated she had prepared the soup incorrectly and stated, "It was not supposed to have the chunks [referencing the tomato soup with solid tomato pieces]" and explained it should have been pureed and then thickened. At 6:29 p.m. NA-F indicated she had given R76 a bite of soup that had a piece of tomato, then realized after R76 coughed the soup was supposed to be pureed, NA-F then gave R76 a bite of only the liquid soup then realized it had been the wrong consistency. NA-F further stated she had not replaced the soup with the correct consistency because thought it had been too late in the meal service to get a new bowl of soup. NA-F stated she had not notified the nurse of the coughing episode. At 6:48 p.m. registered (RN)-G stated she had not been made aware of the coughing episode during meal time and followed up with a respiratory assessment. During a breakfast meal observation on 8/20/15, at 7:57 a.m. R76's meal tray included hot cereal and diet butterscotch pudding both with a consistency of applesauce. NA-I gave bite of butterscotch pudding, R76 coughed a couple of	F 367	*Education related to dysphagia provided to nursing team members 9/9/15, regularly scheduled team members not in attendance to view recorded session and complete "Dysphagia Quiz". *Findings reviewed during nursing and dietary team meetings (Aug/Sept) including importance of accuracy of therepuetic diets being served and steps to be taken if consistency of fluids/food determined to be incorrect by 9/26/15. *DON/Designee to complete audits on residents on therapeutic diet including thickened liquids to verify accuracy of items being served. 1x week for 4 weeks. *Findings will be reported and reviewed at future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.	

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F 367	Continued From page 23	F 367		

times and given a bite of thickened water. NA-I gave another bite of butterscotch pudding, R76 again coughed. When NA-I was asked the consistency of the butterscotch pudding, NA-I picked up the spoon and tipped it, butterscotch pudding dripped off the spoon and stated, "It's pudding thick, it could be a little thicker." NA-I tested the hot cereal and made the same remark. NA-I stated the consistency of the food is supposed to be checked prior to giving to residents. During an interview at 8:33 a.m. with the certified dietary manager (CDM)-E stated pudding consistency is correct when food stays on the spoon when tipped and beverages in a glass, stays in the glass when tipped upside down.

R76's quarterly Minimum Data Set (MDS) dated 6/26/15 indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Downs Syndrome, and required a mechanically altered diet. In addition the MDS indicated R76 held food in mouth/cheeks or had residual food in mouth after meals and coughed or choked during meals or when swallowing medications.

R76's Care Area Assessment (CAA) last completed 1/12/15 with annual MDS indicated resident was totally dependent on staff for feeding and required pudding thick liquids and had a pureed diet. The CAA did not identify R76 had a diagnosis of dysphagia (difficulty swallowing).

R76's care plan provided by the facility on 8/20/15. The copy provided had a print date of 3/21/13, the "feeding" plan of care had hand written changes in the margins that were difficult to follow because changes since 2013 were not in

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F 367	Continued From page 24	F 367		

chronological order and hand writing was difficult to read. It was determined the current care plan informed staff R76 was dependent on staff for eating, required pudding thick liquids, and was on a pureed diet. The care plan identified R76 had dysphagia and history of cerebral vascular accident (stroke). The care plan did not identify risk for aspiration/choking and did not include the evaluation from the quarterly MDS indicating R76 held food in mouth and coughed/choked during meals and/or when swallowing medications.

R76's nursing assistant care sheet provided by the facility on 8/20/15 informed staff R76 required pureed diet with pudding thick liquids. The nursing assist care sheet did not include the information from the MDS that indicated R76 held food in mouth or coughed/choked during meal times or when swallowing medications. Furthermore, the care sheet did not include interventions for either identified swallowing difficulty issues.

R76's physician orders provided by the facility on 8/20/15 read, "diet: 1500 calorie, pureed with added protein with pudding thick liquids." Nutritional assessment dated 6/23/15 indicated R76 had a pureed diet with pudding thick liquids and required assistance from staff. The assessment also read, "does do some coughing with meals".
During an interview on 8/20/15, at 10:48 a.m. RN-B stated R76's diet was changed to pudding thick after a dietician's recommendation on 8/6/14 because of increased coughing during meal times. RN-B verified diagnoses of dysphagia had been in the care plan without any interventions for episodes of choking/coughing/aspiration. RN-B further explained, "We assume people are

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F 367	Continued From page 25 aspiration risk if they are on a therapeutic liquid consistency." RN-B stated speech had not been involved related to preference of medical power of attorney. During an interview on 8/20/15, at 12:13 p.m. director of nursing (DON) stated the correct diet consistency should have been served. DON stated, ideally the care plan would identify aspiration/coughing and include the appropriate interventions. Facility policy Liberalized Diet Guidelines for Long Term Care last reviewed 6/2014 read, "A qualified R.D. [registered dietician] will assess residents' nutritional status and appropriateness of the prescribed diet order so that each nutrition care plan is individualized for each resident ....the goal of the consistency alteration is to prevent choking and aspiration, to maintain normal nutritional status ....Dysphagia-primarily used for residents with diagnosed, documented swallowing impairment/problems ....all thickened liquids and food texture stages are provided at the degree to texture that the resident can safely tolerate as directed by the professional monitoring the dysphagia."	F 367		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		9/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING _____ B. WING _____	08/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consulting pharmacist identified irregularities for as needed (PRN) medication documentation for 1 of 3 residents (R21) reviewed for unnecessary medication use. Findings included: R21 was admitted to the facility on 2/28/2014 according to the facility admission record and had the following diagnoses according to the facilities electronic medical record: mononeuritis, varicose veins with lower leg edema, arthropathy, and osteoarthrosis. R21's electronic physician's orders provided by the facility on 8/19/15 included Ultram (narcotic-like pain medication) 50 milligrams by mouth as needed two times a day as needed (PRN) for pain. R21's care plan provided by the facility on 8/19/15 informed staff R21 had chronic pain in right foot, ankle, and shoulder. The care plan directed staff to offer warm/cold packs for break through pain. R21's medication administration record was reviewed from 6/7/15 through 8/20/15; the record indicated a total of twelve doses of PRN Ultram had been administered. Of the twelve doses that were administered it was not evident in the medical record non-pharmacological intervention had been attempted and/or documented for eight of the doses. It was not evident in the medical record the consulting pharmacist had identified the lack of documentation of attempting non-pharmacological interventions to control pain	F 428	*Staff education of documentation of non-pharmacological interventions offered prior to administering PRN medication for licensed nurses and trained medication aides provided at staff meetings (Aug/Sept), via internal memo 8/24/15, state survey preliminary result posting August 20, 2015. *Reviewed and revised policy "Administration of Medications" and reviewed "Consultant Pharmacist in LTC". *DON/Designee to complete random audits for residents receiving PRN medications to verify documentation of non-pharmacological measures offered. Audits to be completed on 4 residents with PRN medication ordered each week x4 weeks. *Findings will be reported and reviewed at future QA&A (QAPI_ team meetings to direct future audits, training and policy revision needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 27 prior to the administration of a narcotic pain medication. During an interview on 8/19/15, at 2:43 p.m. registered nurse (RN)-F stated, "PRN medications should be documented with non-pharmacological interventions and what the effectiveness was." During an interview on 8/19/15, at 3:31 p.m. the director of nursing (DON) stated her expectation had been to attempt and document effectiveness of non-pharmacological interventions prior to the administration of all PRN medications. Multiple and unsuccessful attempts were made to contact the consulting pharmacist for interview. Facility policy that was obtained did not reflect current standards of the utilization of non-pharmacological interventions prior to the administration of PRN medications.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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	F 431		9/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING _____ B. WING _____	08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 28 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 record review facility failed to ensure non-licensed staff did not have unsupervised access to 1 of 3 medication rooms. Findings include: On 8/20/15, at 9:28 a.m. During a random observation a housekeeper was observed mopping the floor of the Medication room located behind the nurses station. There was not a facility nurse or trained medication aide at the nurses station or in the medication room. Licensed practical nurse (LPN)-B was observed at that time in the dayroom talking with residents During interview on 8/20/15, at 9:30 a.m. LPN-B stated, "It is my normal practice to let the housekeeper be in the drug room without a nurse or TMA [trained medication assistant] present."	F 431	*Policy "Receiving and Storing Medication" reviewed and revised. *Staff education of policy provided at team meetings (August/September), via internal memo and posting of preliminary state survey results by 9/26/15. *Random audits to be conducted by DON/designee to verify compliance with medication storage and access to medications by authorized individuals only 2x week for 4 weeks, 1x week for 2 weeks and as needed. *Findings to be reported and reviewed at future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.	

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F 431	Continued From page 29 LPN-B verified the medication cart, located in the medication room, was unlocked while the housekeeper was in the medication room. LPN-B stated that the medication cart contained Coumadin, antibiotics, antipsychotics, antianxiety, Tylenol, aspirin, and insulin along with other resident medications. During an interview on 08/20/2015, at 12:19 the director of nursing (DON) stated medications need to be secured. In addition, The stated it is the expectation the nurse would be in the vicinity to supervise unlicensed staff while in the medication room. Policy provided by facility staff, Receiving and Storing of Medications dated 7/16/13, instructs staff: "POLICIES: All medications are to be kept locked in a designated area when received until able to be distributed to the appropriate medication. Medications are not to be left unattended on a counter or nurses desk."	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	F 441		9/26/15

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	245487	A. BUILDING _____ B. WING _____	08/20/2015

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F 441	Continued From page 30 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (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 observations interview and record review, facility failed to ensure proper hand hygiene practice was used to prevent the spread of infection for 1 of 1 resident (R72) observed for hour of sleep (HS) cares. Findings include: R72 had been observed on 8/19/15 at 7:00 p.m. during continuous observation of staff getting R72 ready for bed. Nursing assistant (NA)-A removed the wet incontinence brief. E-A was wearing gloves, brief fell to the floor, NA-A picked the brief	F 441	Proper hand hygiene reviewed at team meetings (August /September) by 9/26/15. *Policy "Hand Washing, Hand Hygiene and Hand Care" reviewed and posted for staff to review by September 26, 2015. *Hand Hygiene audits during provision of cares to be completed by DON/designee 2x week for 4 weeks, 1x week for 2 weeks and monthly thereafter as part of facility's comprehensive infection control and prevention program. *Findings to be reported and reviewed at	

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F 441	Continued From page 31 up and threw it in waste basket, without washing hands NA-A continued to wear the soiled gloves then removed R72's glasses, gathered clean towels from bedside table, dried R72's eyes with towel, removed R72's shirt and put a gown on R72. NA-A continued to wear soiled gloves than removed R72's pants and washed her perineal area than removed her contaminated gloves and washed her hands. During interview on 8/19/15, at 7:25 p.m. NA-A, stated the correct way to do hand washing was "get hands wet, apply soap, scrub for 20 seconds, rinse, take towel dry hands, get new towel and turn water off." During interview on 8/20/15, at 8:10 a.m. DON stated, "I expect staff to turn off the water with a clean dry towel after washing their hands. I would expect staff to change their gloves and wash their hands after picking a soiled incontinence pad from the floor." During interview on 8/20/15, at 10:04 a.m. Registered Nurse (RN)-D the Infection control nurse, when asked her expectation for glove change and hand hygiene during R72's cares she stated NA-A should have taken off her gloves before touching the glasses and wash her hands because she was going from dirty to clean.	F 441	future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **01** B. WING _____	**08/19/2015**

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

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K 000	INITIAL COMMENTS 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. Elizabeths Medical Center was found 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. This facility will be surveyed as four separate buildings, which are located at two different street addresses. St. Elizabeths Medical Center building # 1 is located at 1200 Fifth Grant Boulevard West. This facility is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type II(222) construction. In 1939, an addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1961, an addition was constructed to the North Wing that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/18/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING 01 B. WING _____	08/19/2015

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K 000	Continued From page 1 notification. The facility has a capacity of 20 beds and had a census of 19 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING _____	**08/19/2015**

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

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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. Elizabeths Medical Center , Building #2, 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 St Paul, MN 55101-5145, or	K 000	EPOC	

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

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	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING _____	**08/19/2015**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Elizabeths Medical Center, Building # 2, is located at 626 Shields Avenue South. This is a 1-story building and has a partial basement. This building was constructed in 1970 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 74 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		9/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **02 - ST. ELIZABETHS CARE CENTER** B. WING _____	**08/19/2015**

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K 076 SS=D	Continued From page 2 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Sections 8-3.1.11.1 and 4-3.1.1.2(a) 4. This deficient practice could 10 out 74 residents. FINDINGS INCLUDE: On facility tour between 8:15 AM and 12:15 PM on 08/19/2015, observation revealed that the basement oxygen storage (over 3000 cubic feet) / transfill room, the light switch is located lass than 5 feet off of floor. This deficient practice was confirmed by the Director of Maintenance (JF) at the time of discovery.	K 076	The light switch on the wall was raised above 5 feet minimum. This was completed on 8/21/15. Correction was verified by John Fillmore, Facilities Director	

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K 076	Continued From page 3 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **03 - CHAPEL ADDITION** B. WING _____	**08/19/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Elizabeths Medical Center , Building #3 Chapel Addition, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. St. Elizabeths Medical Center, Building # 3 Chapel Addition, is located at 626 Shields Avenue South. The Chapel is a 1-story addition to Building #2, and has a full basement. The chapel addition was constructed in December 2003 and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 74 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION*	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING **03 - CHAPEL ADDITION** B. WING _____	**08/19/2015**

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

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K 000	Continued From page 1 Gary Schroeder, Life Safety Code Spc.	K 000		

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	245487	A. BUILDING **04 - 4 SEASON SUN ROOM** B. WING _____	**08/19/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Elizabeths Medical Center , Building #4 Four Season Sun Room Addition, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. St. Elizabeths Medical Center, Building # 4 - Four Season Sun Room Addition, is located at 626 Shields Avenue South. The Four Season Sun Room is a 1-story addition to Building #2, and has a no basement. The Four Season Sun Room Addition was constructed in December 2012 and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 74 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

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

Electronically Signed | 09/18/2015

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

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K 000	Continued From page 1 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
September 8, 2015

Mr. Tom Crowley, Administrator
St Elizabeth Medical Center
1200 Fifth Grant Boulevard West
Wabasha, Minnesota 55981

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5487027

Dear Mr. Crowley:

The above facility was surveyed on August 17, 2015 through August 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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	00675	A. BUILDING: _____ B. WING _____	08/20/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 17, 18, 19, & 20, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that care plan interventions related to kidney dialysis were developed for 1 of 1 resident (R67) reviewed for dialysis, failed to develop a care plan that included monitoring for side effects of an anti-coagulant medication (Warfarin) for 1 of 7 residents (R7) reviewed for skin, and failed to develop a complete dysphagia care plan for 1 of 1 resident (R76) reviewed for mechanical altered diets. Findings include: R67's current care plan dated 4/30/14 indicated R67 had been diagnosed with unspecific type Diabetes Mellitus with renal manifestations and was hemodialysis dependent. The care plan	2 560	Corrected	9/26/15

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2 560	Continued From page 3 approach included documentation which read, "See dialysis care plan and standing orders in chart for contact numbers and direction for care, ok to use standing house orders with exception of MOM [milk of magnesia] and Antacid. Do not take blood pressure on left arm, short sleeves on dialysis days, NSG [nursing] staff to check fistula site for bruit every shift, monitor pre-post weight and BP [blood pressure] on dialysis." Further review of the record had not revealed the dialysis care plan as indicated, and did not include monitoring for complications, and did not include a plan to guide staff response to an emergency. During interview on 8/20/15, at 7:20 a.m. nursing assistant (NA)-G was unable to report complications that would be monitored for a resident receiving dialysis, and what procedure would be followed if an emergency occurred. During interview on 8/20/15, at 7:55 a.m. NA-H stated dialysis education had not been provided and was unable to report what would be monitored. NA-H was unable to report where information would be located to guide staff response to an emergency. On 8/20/15, at 9:35 a.m. during interview clinical manager registered nurse (RN)-B reported licensed nursing staff monitor daily weight, blood pressure and fistula site for thrill. RN-B stated, "We don't have any specific emergency procedures it's just like anyone else." RN-B was unable to provide a working dialysis care plan. During phone interview on 8/20/15, at 10:52 a.m. Mayo Clinic Dialysis Nurse Supervisor reported the dialysis center had sent an information sheet to the facility after each dialysis session and stated monitoring should have included pain and	2 560		

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2 560	Continued From page 4 swelling for infection, and further stated the access site should have been monitored specifically for bleeding. During interview on 8/20/15, at 1:03 p.m. director of nursing verified dialysis care had not been included in R67's comprehensive care plan and stated dialysis information should have been accessible to staff. Dialysis policy was requested but not provided. R7 had been observed on 8/19/15, at 2:00 p.m. multiple areas of bruising had been noted on R7's right forearm. Upon interview R7 stated the bruising had been present the past week and had occurred "When they [phlebotomist] tried to get blood." R7 reported bruising had been a frequent occurrence. According to current physician orders, R7 received Warfarin (an anti-coagulant-blood thinning medication) 6 mg (milligram) by mouth on Wednesdays and Saturdays, and received 4 mg by mouth on Sunday, Monday, Tuesday, Thursday and Friday for diagnosis of atrial fibrillation. Review of R7's current care plan dated 12/4/14 identified R7 as alert and oriented with increased risk for skin breakdown secondary to urinary incontinence, impaired mobility, arthritic pain and history of pressure ulcers upon admission. The care plan had not addressed risk factors and interventions for excessive bleeding or bruising associated with the use of Warfarin in order to alert care givers the need to report bruising and bleeding timely to the nurse. During interview on 8/20/15 at 1:03 p.m. the	2 560		

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2 560	Continued From page 5 director of nursing (DON) stated, "Care plans should include, reflect the care needs of the resident at the time and should provide enough information to care for that resident." The DON further stated, "I want my aids [NAs] to treat everyone as if they are at high risk of bruising and bleeding." DON verified R7's current care plan lacked risks, goals or interventions related to the Warfarin therapy and high risk of bleeding and bruising. Request made for care plan policy however none provided. R76 was admitted to the facility on 2/27/2013 according to the facility admission record. R76's quarterly Minimum Data Set (MDS) dated 6/26/15 indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Downs Syndrome, and required a mechanically altered diet. In addition the MDS indicated R76 held food in mouth/cheeks or had residual food in mouth after meals and coughed or choked during meals or when swallowing medications. R76's Care Area Assessment (CAA) last completed 1/12/15 with annual MDS indicated resident was totally dependent on staff for feeding and required pudding thick liquids and had a pureed diet. The CAA did not identify R76 had a diagnosis of dysphagia (difficulty swallowing). R76's care plan provided by the facility on 8/20/15. The copy provided had a print date of 3/21/13, the "feeding" plan of care had hand written changes in the margins that were difficult to follow because changes since 2013 were not in chronological order and hand writing was difficult to read. It was determined the current care plan had informed staff R76 was dependent on staff	2 560		

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2 560	Continued From page 6 for eating, required pudding thick liquids, and was on a pureed diet. The care plan identified R76 had dysphagia and history of cerebral vascular accident (stroke). The care plan did not identify risk for aspiration/choking and did not include the evaluation from the quarterly MDS indicating R76 held food in mouth and coughed/choked during meals and/or when swallowing medications. R76's nursing assistant care sheet provided by the facility on 8/20/15 informed staff R76 required pureed diet with pudding thick liquids. The nursing assist care sheet did not include the information from the MDS that indicated R76 held food in mouth or coughed/choked during meal times or when swallowing medications. Furthermore, the care sheet did not include interventions for either identified swallowing difficulty issues. R76's physician orders provided by the facility on 8/20/15 read, "diet: 1500 calorie, pureed with added protein with pudding thick liquids." Nutritional assessment dated 6/23/15 indicated R76 had a pureed diet with pudding thick liquids and required assistance from staff. The assessment also read, "does do some coughing with meals". During an interview on 8/20/15, at 10:48 a.m. RN-B stated R76's diet was changed to pudding thick after a dietician's recommendation on 8/6/2014 because of increased coughing during meal times. RN-B verified diagnoses of dysphagia had been in the care plan without any interventions for episodes of choking/coughing/aspiration. RN-B further explained "we assume people are aspiration risk if they are on a therapeutic liquid consistency". During an interview on 8/20/15, at 12:13 p.m. director of nursing (DON) stated, ideally the care plan would identify aspiration/coughing and include the appropriate interventions.	2 560		

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2 560	Continued From page 7 Facility policy Liberalized Diet Guidelines for Long Term Care last reviewed 6/2014 read, "A qualified R.D. [registered dietician] will assess residents' nutritional status and appropriateness of the prescribed diet order so that each nutrition care plan is individualized for each resident ....the goal of the consistency alteration is to prevent choking and aspiration, to maintain normal nutritional status ....Dysphagia-primarily used for residents with diagnosed, documented swallowing impairment/problems ....all thickened liquids and food texture stages are provided at the degree to texture that the resident can safely tolerate as directed by the professional monitoring the dysphagia". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan development. The DON or designee, could provide training for all nursing staff related to the timeliness of the development of care plans. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the	2 570		9/26/15

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2 570	Continued From page 8 participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise a care plan that included ongoing plan of care for contractures and assistance required for eating for 1 of 20 residents (R55) care plans reviewed and failed to revise the skin care plan for 1 of 7 residents (R72) reviewed for skin alterations. Findings Include: R55 was admitted to the facility on 9/20/11 with diagnoses including, diabetes, neurotic depression, hypertension, chronic right hip pain, and chronic right hip infection according to the admission form. On 8/18/15 at 11:44 a.m. R55 was observed to require complete assist with her noon meal and did not attempt to eat herself. On 8/19/15 at 5:25 p.m. R55 was observed to require partial assist with eating. The nursing assistant (NA) assisting R55 handed R55 a sandwich, which R55 was able to hold and independently eat. The NA fed R55 bites of fruit and handed her a cup from which R55 could take a drink then the NA would set back down. On 8/20/15 at 10:35 a.m. registered nurse (RN)-C stated, "Some days she [R55] can totally feed herself, or you get her started and she finishes	2 570	Corrected	

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2 570	Continued From page 9 and other days we have to totally feed her. It depends on her day. Needs lots of encouragement." On 08/20/15 at 11:47 a.m. the director of nursing (DON) reviewed R55's care plan and ADL care plan. "I would have to agree the care plan does not match MDS. The change of eating should certainly be on the ADL care plan. The contracture's being that she refused treatment, it should be at least acknowledged, reporting increased pain." The DON verified contracture's should be care planned and were not included on the current care plan. Quarterly Minimum Data Set (MDS) dated 2/22/15 indicated R55 required a limited assist with eating, resident was highly involved in eating, staff provided guided maneuvering of limbs or other non-weight bearing assist. R55 also had a functional limitation in range of motion with lower extremity impairment on both sides Significant change MDS dated 5/18/15 revealed R55 required an extensive 1 person physical assist with eating, staff provided weight bearing support. ADL [activities of daily living] Care Plan dated 6/14/15 indicated R55 needed staff set up, assist of 1 as needed with eating, and to eat one item at a time. Care plan dated, 12/13/12 revealed an identified problem of potential for self care deficit with eating: "I eat all meals independently after setup needing occasional cueing and assist. I am on cardiac, diabetic diet 1800 calorie diet. I need to be given one item at a time."	2 570		

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2 570	Continued From page 10 R72 was admitted to the facility on 3/13/14, with diagnoses including but not limited to dementia, constipation, recurrent urinary tract infections, history of a stroke and deep vein thrombosis according to the admission form. On 8/18/15, at 9:58 a.m. R72 was observed sitting in the units day room. R72 had a bruise located on the top of right hand and sterri strips on left hand. R72's Medications include but not limited to, hydrochlorothiazide (an antihypertensive that is also a diuretic), Budesonide (an inhaled medication to improve breathing) and Tylenol (a pain medication). Drugs.com identified bruising is a side effect of each of these medications. During interview on 8/19/15, at 6:56 p.m. Licensed practical nurse (LPN)-E stated 2 weeks ago nursing assistants were getting R72 ready for bed. R72 became combative, striking out at staff and R72 grabbed own hand and caused two skin tears. Progress note dated 8/10/2015, 11:29 a.m. "Noted Various discolored areas on R72 right hand and lower arm." Review of charting indicates that she has had multiple episodes of being combative, hitting and throwing items during cares which may increase her risk of bruising. It is also noted that her skin is very fragile on her lower arms and tops of hands with vessels being very close surface of skin, increasing her risk for any bumps to result in bruising. Care plan dated 7/1/2014 read, "All Staff-----SKIN: I am at increased risk for skin breakdown secondary to inc , impaired mobility	2 570		

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2 570	Continued From page 11 and use of coumadin which increases my risk for bruising..." During interview on 8/20/15, at 8:10 a.m. DON reviewed R72's skin care plan. DON stated resident is not currently on coumadin and should be removed from care plan. DON had acknowledged that care plan for skin did not reflect residents fragile skin, or base line discoloration, combativeness, or other risk factors for bruising or skin tears. DON pulled up progress note on computer and showed assessment of skin and risks for bruising or injury dated 8/10/15 11:29 a.m. Policy for updating care plans was requested and none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		9/26/15

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2 830	Continued From page 12 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive monitoring system was in place to include care of dialysis access site, and failed to establish emergency medical interventions for 1 of 1 residents (R67) reviewed for dialysis. Findings include: R67's current care plan dated 4/30/14 indicated R67 had been diagnosed with unspecific type Diabetes Mellitus with renal manifestations and was hemodialysis dependent. The care plan approach included documentation which read, "See dialysis care plan and standing orders in chart for contact numbers and direction for care, ok to use standing house orders with exception of MOM [milk of magnesia] and Antacid. Do not take blood pressure on left arm, short sleeves on dialysis days, NSG [nursing] staff to check fistula site for bruit every shift, monitor pre-post weight and BP [blood pressure] on dialysis." Further review of the chart had not revealed the dialysis care plan as indicated, and did not include monitoring for complications, and did not include a plan to guide staff response to an emergency. During interview on 8/20/15, at 7:20 a.m. nursing	2 830	Corrected	

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2 830	Continued From page 13 assistant (NA)-G was unable to report complications that would be monitored for a resident receiving dialysis, and what procedure would be followed if an emergency occurred. During interview on 8/20/15, at 7:55 a.m. NA-H stated dialysis education had not been provided and was unable to report what would be monitored. NA-H was unable to report where information would be located to guide staff response to an emergency. Further review of R67's chart identified a Memorandum of Understanding dated 5/29/2015, which indicated vascular access site should have been monitored for clotting, infection, and excessive bleeding. The memorandum included an emergency procedure for excessive bleeding. Review of facility dialysis binder located at the nurses' station revealed a 40 page educational pamphlet. Page 20 and 21 of the pamphlet identified possible access site problems and interventions to include site monitoring for infiltration, swelling and pain, bleeding, infection and clotting. On 8/20/15, at 9:35 a.m. during interview clinical manager (CM)-B reported licensed nursing staff monitor daily weight, blood pressure and fistula site for thrill. CM-B stated "we don't have any specific monitoring for bleeding or emergency procedures it's just like anyone else." CM-B had been unaware a Memorandum of Understanding that had included specific instructions for monitoring had been in R67's chart, and had been unaware an educational pamphlet included monitoring for infiltration, swelling and pain, bleeding, infection and clotting had been located in a dialysis binder. CM-B verified nursing staff	2 830		

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2 830	Continued From page 14 had not monitored complications to include infiltration, swelling, pain, bleeding, infection and clotting. During phone interview on 8/20/15, at 10:52 a.m. Mayo Clinic Dialysis Nurse Supervisor reported the dialysis center had sent an information sheet to the facility after each dialysis session and stated monitoring should have included pain and swelling for infection, and further stated the access site should have been monitored specifically for bleeding. During interview on 8/20/15, at 1:03 p.m. director of nursing verified dialysis care had not been monitored and that the facility lacked an emergency medical plan. A policy and/or procedure on emergency medical interventions for residents receiving dialysis treatments had been requested and none provided. SUGGESTED METHOD OF CORRECTION: The facility could review/revise dialysis policies and procedures. The facility could provide staff education on emergency services and the monitoring of a dialysis resident. The facility could review the care plans of dialysis residents to ensure completeness. The quality assurance committee could develop and implement an auditing system that would help maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		9/26/15

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2 965	Continued From page 15 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the physician ordered therapeutic diet for 1 of 1 resident (R76) reviewed for therapeutic diets. Findings included: R76 had been observed during an evening meal on 8/19/15, at 5:38 p.m. R76 had two coughing episode that lasted 45 seconds each after nursing assistant (NA)-F had given bites of food. During the coughing episode R76's tongue had been protruding and eyes were moist. R76 had been served regular consistency tomato soup with chunks of tomatoes. At 5:57 p.m. dietary assistant (DA)-C verified the consistency of the soup was wrong and stated it should have been pudding thick. At 5:59 p.m. DA-D indicated she had prepared the soup incorrectly and stated, "It was not supposed to have the chunks [referencing the tomato soup with solid tomato pieces]" and explained it should have been pureed and then thickened. At 6:29 p.m. NA-F indicated she had given R76 a bite of soup that had a piece of tomato, then realized after R76 coughed the soup was supposed to be pureed, NA-F then gave R76 a bite of only the liquid soup	2 965	Corrected	

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2 965	Continued From page 16	2 965		

then realized it had been the wrong consistency. NA-F further stated she had not replaced the soup with the correct consistency because thought it had been too late in the meal service to get a new bowl of soup. NA-F stated she had not notified the nurse of the coughing episode. At 6:48 p.m. registered (RN)-G stated she had not been made aware of the coughing episode during meal time and followed up with a respiratory assessment.

During a breakfast meal observation on 8/20/15, at 7:57 a.m. R76's meal tray included hot cereal and diet butterscotch pudding both with a consistency of applesauce. NA-I gave bite of butterscotch pudding, R76 coughed a couple of times and given a bite of thickened water. NA-I gave another bite of butterscotch pudding, R76 again coughed. When NA-I was asked the consistency of the butterscotch pudding, NA-I picked up the spoon and tipped it, butterscotch pudding dripped off the spoon and stated, "It's pudding thick, it could be a little thicker." NA-I tested the hot cereal and made the same remark. NA-I stated the consistency of the food is supposed to be checked prior to giving to residents. During an interview at 8:33 a.m. with the certified dietary manager (CDM)-E stated pudding consistency is correct when food stays on the spoon when tipped and beverages in a glass, stays in the glass when tipped upside down.

R76's quarterly Minimum Data Set (MDS) dated 6/26/15 indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Downs Syndrome, and required a mechanically altered diet. In addition the MDS indicated R76 held food in mouth/cheeks or had residual food in mouth

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2 965	Continued From page 17 after meals and coughed or choked during meals or when swallowing medications. R76's Care Area Assessment (CAA) last completed 1/12/15 with annual MDS indicated resident was totally dependent on staff for feeding and required pudding thick liquids and had a pureed diet. The CAA did not identify R76 had a diagnosis of dysphagia (difficulty swallowing). R76's care plan provided by the facility on 8/20/15. The copy provided had a print date of 3/21/13, the "feeding" plan of care had hand written changes in the margins that were difficult to follow because changes since 2013 were not in chronological order and hand writing was difficult to read. It was determined the current care plan informed staff R76 was dependent on staff for eating, required pudding thick liquids, and was on a pureed diet. The care plan identified R76 had dysphagia and history of cerebral vascular accident (stroke). The care plan did not identify risk for aspiration/choking and did not include the evaluation from the quarterly MDS indicating R76 held food in mouth and coughed/choked during meals and/or when swallowing medications. R76's nursing assistant care sheet provided by the facility on 8/20/15 informed staff R76 required pureed diet with pudding thick liquids. The nursing assist care sheet did not include the information from the MDS that indicated R76 held food in mouth or coughed/choked during meal times or when swallowing medications. Furthermore, the care sheet did not include interventions for either identified swallowing difficulty issues. R76's physician orders provided by the facility on 8/20/15 read, "diet: 1500 calorie, pureed with	2 965		

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2 965	Continued From page 18 added protein with pudding thick liquids." Nutritional assessment dated 6/23/15 indicated R76 had a pureed diet with pudding thick liquids and required assistance from staff. The assessment also read, "does do some coughing with meals". During an interview on 8/20/15, at 10:48 a.m. RN-B stated R76's diet was changed to pudding thick after a dietician's recommendation on 8/6/14 because of increased coughing during meal times. RN-B verified diagnoses of dysphagia had been in the care plan without any interventions for episodes of choking/coughing/aspiration. RN-B further explained, "We assume people are aspiration risk if they are on a therapeutic liquid consistency." RN-B stated speech had not been involved related to preference of medical power of attorney. During an interview on 8/20/15, at 12:13 p.m. director of nursing (DON) stated the correct diet consistency should have been served. DON stated, ideally the care plan would identify aspiration/coughing and include the appropriate interventions. Facility policy Liberalized Diet Guidelines for Long Term Care last reviewed 6/2014 read, "A qualified R.D. [registered dietician] will assess residents' nutritional status and appropriateness of the prescribed diet order so that each nutrition care plan is individualized for each resident ....the goal of the consistency alteration is to prevent choking and aspiration, to maintain normal nutritional status ....Dysphagia-primarily used for residents with diagnosed, documented swallowing impairment/problems ....all thickened liquids and food texture stages are provided at the degree to texture that the resident can safely tolerate as directed by the professional monitoring the dysphagia."	2 965		

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2 965	Continued From page 19 SUGGESTED METHOD OF CORRECTION: The facility could develop and present mechanically altered diet education to dietary and nursing staff. The certified dietary manager could develop and perform period audits of staff to ensure meals are being served with the appropriate texture(s). TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and	21390		9/26/15

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21390	Continued From page 20 incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observations interview and record review, facility failed to ensure proper hand hygiene practice was used to prevent the spread of infection for 1 of 1 resident (R72) observed for hour of sleep (HS) cares. Findings include: R72 had been observed on 8/19/15 at 7:00 p.m. during continuous observation of staff getting R72 ready for bed. Nursing assistant (NA)-A removed the wet incontinence brief. E-A was wearing gloves, brief fell to the floor, NA-A picked the brief up and threw it in waste basket, without washing hands NA-A continued to wear the soiled gloves then removed R72's glasses, gathered clean towels from bedside table, dried R72's eyes with towel, removed R72's shirt and put a gown on R72. NA-A continued to wear soiled gloves than removed R72's pants and washed her perineal area than removed her contaminated gloves and washed her hands. During interview on 8/19/15, at 7:25 p.m. NA-A, stated the correct way to do hand washing was "get hands wet, apply soap, scrub for 20 seconds, rinse, take towel dry hands, get new towel and turn water off." During interview on 8/20/15, at 8:10 a.m. DON stated, "I expect staff to turn off the water with a clean dry towel after washing their hands. I would expect staff to change their gloves and wash their	21390	Corrected	

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21390	Continued From page 21 hands after picking a soiled incontinence pad from the floor." During interview on 8/20/15, at 10:04 a.m. Registered Nurse (RN)-D the Infection control nurse, when asked her expectation for glove change and hand hygiene during R72's cares she stated NA-A should have taken off her gloves before touching the glasses and wash her hands because she was going from dirty to clean. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the basic hand hygiene practice to prevent the spread of infection when caring for residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		9/26/15

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21426	Continued From page 22 This MN Requirement is not met as evidenced by: READY FOR REVIEW Based on interview and document review the facility failed to ensure a two step tuberculin skin testing (TST) was administered for 2 of 6 residents (R45, R90); failed to ensure 4 of 6 residents (R57, R90, R115, R117)) received two-step TST with both induration and interpretation reading results; and failed to ensure 1 of 6 residents (R45) had a completed a baseline tuberculosis screen; in addition the facility failed to ensure 4 of 6 employees (E-A, E-B, E-C, E-D) received two-step tuberculin skin testing with both induration and interpretation reading results; and failed to ensure 1 of 6 employees (E-E) received a two-step TST. This had the potential to effect all 73 residents in the facility, staff, and visitors. Findings Include: R45 was admitted to the facility on 2/23/15. R45 received her first TST on 2/23/15, the results of this TST were not recorded. A baseline tuberculosis symptom screen was requested but not received. R90 was admitted to the facility on 7/22/15. R90's medication administration record (MAR) for July 2015 indicated a "step 2 Tubersol PPD" was administered on 7/25/15 and read on 7/27/15 with a 0 mm reading, lacking interpretation. The date and results for a step one TST was not found.	21426	Corrected	

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21426	Continued From page 23 R57 was admitted to the facility on 7/27/15. Record review indicated a first and second step TST was administered on 4/27/15 and 5/11/15. A note in the chart written by clinical manager (CM)-A, dated 7/27/15, indicated; "PPD [purified protein derivative, method used to diagnosis latent TB] both step 1 and 2 given at previous facility and were negative." No induration [millimeter reading] and interpretation [positive/negative] reading results were provided. R115 was admitted to the facility on 7/1/15. R115's MAR revealed "Tubersol PPD step two" was administered on 7/15/15 and read on 7/17/15 with a negative reading, lacking induration. R117 was admitted to the facility on 8/10/15. R117's MAR revealed "Tubersol PPD step one" was administered on 8/10/15 and read on 8/12/15 with a negative reading, lacking induration. E-A started at the facility on 3/23/15. E-A received a TST on 3/19/15 with no interpretation results. E-B started at the facility on 4/29/15. E-B received a first step TST on 4/29/15 which lacked interpretation. A second TST was given 6/5/15 which lacked interpretation and induration. E-C started at the facility on 7/1/15. E-C received a first step TST on 6/27/15 and a second step TST on 7/10/15. Both TST's lacked interpretation. E-D started at the facility on 3/23/15. E-D received a first step TST on 3/13/15 and a second step TST on 4/15/15. Both TST's lacked interpretation. E-E started at the facility on 7/20/15. E-E received	21426		

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21426	Continued From page 24 a first step TST on 2/23/15, which was outside of the time frame prior to starting at the facility. The first step TST also lacked any reading results. A second step TST was administered and read on 7/18/15. On 8/19/15 at 6;55 p.m. the director of nursing (DON) stated, "If the reading is negative there wouldn't be a measurement." On 8/20/15 at 9:43 p.m. the DON was asked about R57's TST results from a previous facility; "I would have to call to know what their note means. The expectation would be that they would tell us if there was a problem." On 8/20/15 at 11:42 a.m. the DON verified that she did not know the results of E-E's first TST and the second TST was documented/administered incorrectly. The DON also verified R45 did not have her first TST read. "I thought we were following MDH [Minnesota Department of Health] guidelines." The DON added she was unaware the results required both the measurement and interpretation. St. Elizabeth's Medical Center, Tuberculosis Control Plan dated 5/20/2014 Page 11, "Baseline TB Screening: All new associates except known positive reactors are required to begin two-step tuberculin skin testing at the time of the preplacement evaluation...The test must be read 48-72 hours later by a nurse or physician....If associate provides written evidence of having a negative TST within the past year, this will be considered the first step TST. St. Elizabeth's policy, Resident Tuberculin Skin Test dated 7/20/11 "Policies 3. Induration only is considered in	21426		

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21426	Continued From page 25 interpreting the test. Procedures: 3. The diameter of induration should be measured and recorded in millimeters." Minnesota Department of Health, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis infection control regulation in your facility, dated July 2013. Page 10, Screening Health Care Workers, General principles, "TST documentation should include the date of the test (i.e.month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). Baseline TB screening, "An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. Page 23, Screening Residents, General principles, "Screening should be initiated within 72 hours of admission or 90 days prior to admission...TST documentation for residents should include the date (i.e., month, date, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative). SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate nursing staff to their policies and procedures for employee and resident tuberculosis skin tests and tuberculosis screens and provide all staff ongoing tuberculosis training. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		9/26/15

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21530	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the consulting pharmacist identified irregularities for as needed (PRN) medication documentation for 1 of 3 residents (R21) reviewed for unnecessary medication use. Findings included: R21 was admitted to the facility on 2/28/2014 according to the facility admission record and had the following diagnoses according to the facilities electronic medical record: mononeuritis, varicose veins with lower leg edema, arthropathy, and osteoarthrosis. R21's electronic physician's orders provided by the facility on 8/19/15 included Ultram (narcotic-like pain medication) 50 milligrams by mouth as needed two times a day as needed (PRN) for pain. R21's care plan provided by the facility on 8/19/15 informed staff R21 had chronic pain in right foot, ankle, and shoulder. The care plan directed staff to offer warm/cold packs for break through pain. R21's medication administration record was reviewed from 6/7/15 through 8/20/15; the record indicated a total of twelve doses of PRN Ultram had been administered. Of the twelve doses that were administered it was not evident in the medical record non-pharmacological intervention had been attempted and/or documented for eight of the doses. It was not evident in the medical record the consulting pharmacist had identified the lack of documentation of attempting non-pharmacological interventions to control pain prior to the administration of a narcotic pain medication.	21530	Corrected	

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21530	Continued From page 28 During an interview on 8/19/15, at 2:43 p.m. registered nurse (RN)-F stated, "PRN medications should be documented with non-pharmacological interventions and what the effectiveness was." During an interview on 8/19/15, at 3:31 p.m. the director of nursing (DON) stated her expectation had been to attempt and document effectiveness of non-pharmacological interventions prior to the administration of all PRN medications. Multiple and unsuccessful attempts were made to contact the consulting pharmacist for interview. Facility policy that was obtained did not reflect current standards of the utilization of non-pharmacological interventions prior to the administration of PRN medications. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration;	21535		9/26/15

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21535	Continued From page 29 C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 5 residents (R80) had a dose titration or a physician's justification for why a dose reduction was contraindicated at this time and failed to ensure documentation of non-pharmacological measures were used prior to the administration of PRN (as needed) medication for 1 of 3 residents (R21) reviewed. Findings included: R21 was admitted to the facility on 2/28/2014 according to the facility admission record and had the following diagnoses according to the facilities electronic medical record: mononeuritis, varicose veins with lower leg edema, arthropathy, and osteoarthrosis. R21's electronic physician's orders provided by the facility on 8/19/15 included Ultram (narcotic-like pain medication) 50 milligrams by	21535	Corrected	

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21535	Continued From page 30 mouth as needed two times a day as needed (PRN) for pain. R21's care plan provided by the facility on 8/19/15 informed staff R21 had chronic pain in right foot, ankle, and shoulder. The care plan directed staff to offer warm/cold packs for break through pain. R21's medication administration record was reviewed from 6/7/15 through 8/20/15; the record indicated a total of twelve doses of PRN Ultram had been administered. Of the twelve doses that were administered it was not evident in the medical record if non-pharmacological intervention had been attempted prior to use of the medication for eight of twelve doses given. During an interview on 8/19/15, at 2:43 p.m. registered nurse (RN)-F stated, "PRN medications should be documented with non-pharmacological interventions and what the effectiveness was." During an interview on 8/19/15, at 3:31 p.m. the director of nursing (DON) stated her expectation had been to attempt and document effectiveness of non-pharmacological interventions prior to the administration of all PRN medications. Facility policy that was obtained did not reflect current standards of the utilization of non-pharmacological interventions prior to the administration of PRN medications. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for medication use the need for a dose reduction annually. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

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21610	Continued From page 31	21610		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review facility failed to ensure non-licensed staff did not have unsupervised access to 1 of 3 medication rooms. Findings include: On 8/20/15, at 9:28 a.m. During a random observation a housekeeper was observed mopping the floor of the Medication room located behind the nurses station. There was not a facility nurse or trained medication aide at the nurses station or in the medication room. Licensed practical nurse (LPN)-B was observed at that time in the dayroom talking with residents During interview on 8/20/15, at 9:30 a.m. LPN-B stated, "It is my normal practice to let the housekeeper be in the drug room without a nurse or TMA [trained medication assistant] present." LPN-B verified the medication cart, located in the medication room, was unlocked while the housekeeper was in the medication room. LPN-B stated that the medication cart contained Coumadin, antibiotics, antipsychotics, antianxiety, Tylenol, aspirin, and insulin along with other resident medications. During an interview on 08/20/2015, at 12:19 the	21610	Corrected	9/26/15

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21610	Continued From page 32 director of nursing (DON) stated medications need to be secured. In addition, The stated it is the expectation the nurse would be in the vicinity to supervise unlicensed staff while in the medication room. Policy provided by facility staff, Receiving and Storing of Medications dated 7/16/13, instructs staff: "POLICIES: All medications are to be kept locked in a designated area when received until able to be distributed to the appropriate medication. Medications are not to be left unattended on a counter or nurses desk." SUGGESTED METHOD OF CORRECTION: The facility could review/revise policies and procedures. The facility could develop and present staff education. The quality assurance committee could develop and implement audits to be performed periodically to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 4 of 6 residents	21805	Corrected	9/26/15

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21805	Continued From page 33 (R42, R76, R80, R55) were assisted with eating in a dignified manner. Findings include: R42 and R76 were observed on 8/19/15, at 5:22 p.m. nursing assistant (NA)-F was observed sitting between R42 and R72 wearing rubber barrier gloves while assisting R42 and R76 to eat. Neither R42 or R76 had a sandwich or finger food. Both residents had a puree diet. R76 was admitted to the facility on 2/27/2013, according to the facility admission record. R76's quarterly Minimum Data Set (MDS) dated 6/26/15 indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Downs Syndrome, and required a mechanically altered diet. In addition the MDS indicated R76 held food in mouth/cheeks or had residual food in mouth after meals and coughed or choked during meals or when swallowing medications. R76's care plan was provided by the facility on 8/20/15. The copy provided had a print date of 3/21/13, the "feeding" plan of care plan informed staff, R76 was dependent on staff for eating, required pudding thick liquids, and was on a pureed diet. The care plan identified R76 had dysphagia and history of cerebral vascular accident (stroke). R42 was admitted to the facility on 3/13/2009, according to the facility admission record. R42's annual MDS dated 5/24/15, indicated severe cognitive impairment, was dependent on staff for eating, had diagnoses that included but was not limited to Alzheimer disease, and required a mechanically altered diet. R42's care plan was provided by the facility on	21805		

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21805	Continued From page 34 8/20/15. The copy provided had a print date of 5/26/15, the nutritional status care plan informed staff, R42 was fed for all meals, required nectar thick liquids, and was on a pureed diet. The care plan identified R42 had and advanced dementia. During an Interview on 8/19/15, at 6:29 p.m. NA-F stated she had worn gloves because "I 'honestly' thought we had to." NA-F acknowledged that wearing gloves to assist a resident to eat the entire meal could be a dignity issue. During an interview on 8/20/15 at 7:27 a.m. the director of nurses stated she would expect staff to have a barrier of some sort if they were going to touch food, if the resident was having a lot of drool or coughing. However, the wearing gloves for an entire meal is not the norm and I would not expect staff to do so. R80 had been observed 8/19/15, at 5:43 p.m. located on the 200 Wing dining hall being assisted with eating. NA-C was seen to be offering fluids and assisting with eating, all the while wearing barrier gloves. NA-C did not remove her gloves during the entire dining experience for R80. R55 had been observed while being assisted to eat on 8/19/15 at 5:25 p.m. R55 was being assisted with eating by a NA. The NA then stopped assisting and got up, applied gloves, and returned to assisting R55 with the rest of meal. The other two NA's assisting residents with eating then stopped assisting and applied gloves. During an interview on 8/20/15, at 10:04 a.m. Registered Nurse (RN)-D Infection control nurse, stated that the expectation for use of gloves when assisting residents to eat was if there were a lot	21805		

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21805	Continued From page 35 of secretions. Staff are told they can wear gloves when they want to, just let the residents know why. RN-D then said, "If it is wet and not yours wear gloves." RN-D questioned why they chose to wearing gloves during the entire meal time. Policy was requested for use of gloves when assisting resident to eat and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees on the need to promote dignity in all settings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		