DEPARTMENT OF HEALTH			D CERTIFIC	CATION	CENTERS FOR MEE AND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: ZXDT
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00675
1. MEDICARE/MEDICAID PROVIDER           (L1)         245487           2.STATE VENDOR OR MEDICAID NO           (L2)         394347000		<ol> <li>NAME AND AI</li> <li>(L3) ST ELIZAB</li> <li>(L4) 1200 FIFTH</li> <li>(L5) WABASHA,</li> </ol>	ETH MEDICA I GRANT BOU	AL CENT		4. TYPE OF ACTION: <u>7</u> (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
<ol> <li>EFFECTIVE DATE CHANGE OF OV (L9)</li> <li>DATE OF SURVEY 10/05/2</li> <li>ACCREDITATION STATUS:         <ul> <li>0 Unaccredited</li> <li>1 TJC</li> <li>2 AOA</li> <li>3 Other</li> </ul> </li> </ol>		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/II 12 RHC	14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12. Total Facility Beds</li> </ul>	<b>100</b> (L18)	Complianc	nce With equirements te Based On: .cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
13.Total Certified Beds	<b>100</b> (L17)	X B. Not in Con Requirem	ents and/or Appli	gram ed Waivers	$: * Code: \mathbf{B}$	(L12)
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS	
18 SNF 18/19 SNF 100	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gary Nederhoff, Unit Supe	ervisor	1	0/09/2015	(L19)	Kamala Fiske-Downing, I	Enforcement Specialist 10/09/2015 (L20)
PAR	Г II - ТО ВЕ	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILIT</li> <li>1. Facility is Eligible to Par</li> <li>2. Facility is not Eligible</li> </ol>			IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>02/14/1986</b>	BEGINNING	<b>J DATE</b>	ENDING DAT	ГЕ	VOLUNTARY         00           01-Merger, Closure         0	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	8
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active
(L27)	B. Rescind S	uspension Date:	. ,			
			(L45)			
28. TERMINATION DATE:	29	9. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



#### 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 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,

Kumala Fiske Downing

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

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245487	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/5/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
ST	ELIZABETH MEDICAL CENTER		1200 FIFTH GRANT BOULEVA WABASHA, MN 55981	RD WEST

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
ID Prefix Reg. #	F0159 483.10(c)(2)-(5)	Correction Completed 09/26/2015	ID Prefix Reg. #	<u>F0167</u> 483.10(g)(1)	Correction Completed 09/26/2015		ix <u>F0241</u> # 483.15(a)		Correction Completed 09/26/2015
LSC							C		_
	F0279 483.20(d), 483.20(k)		ID Prefix Reg. #		Correction Completed 09/26/2015	ID Pref Reg.	<b>F0309</b> # <b>483.25</b> C		Correction Completed 09/26/2015
ID Prefix Reg. # LSC	F0329 483.25(I)	Correction Completed 09/26/2015		F0367 483.35(e)	Correction Completed 09/26/2015	Reg.	ix <b>F0428</b> # <b>483.60(c)</b> C		Correction Completed 09/26/2015
	F0431 483.60(b), (d), (e)	Correction Completed 09/26/2015	Reg. #	F0441 483.65	Correction Completed 09/26/2015	Reg.	x #		
ID Prefix Reg. # LSC			Reg. #				x #		
Reviewed I State Agen Reviewed I CMS RO	cy GS/kf	ved By d ved By	Date: 10/08/202 Date:	Signature of Sur 15 Signature of Sur	•	25822		Date: 09/2 Date:	4/2015
Followup t	o Survey Completed 8/20/2015	l on:		Check for any Unco Uncorrected Defic				YES	NO

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245487	(Y2) Multiple Cons A. Building B. Wing	ELIZABETHS CARE CENTER	(Y3) Date of Revisit 9/24/2015
Name of Facility		Street Address, City, State, Zip Code	
ST ELIZABETH MEDICAL CENTER		1200 FIFTH GRANT BOULEVA WABASHA, MN 55981	RD WEST

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		Correction Completed 08/21/2015	ID Prefix		Correction Completed		ID Prefix			Correction Completed
	NFPA 101		Reg. #				Reg. #			
LSC	K0076		LSC				LSC			
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Bea #							
							LSC			
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #										
LSC										
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #										
							LSC			
		Correction Completed			Correction Completed					Correction Completed
ID Prefix			ID Prefix		Completed		ID Prefix			
Reg. #			Reg. #				Reg. #			
LSC							LSC _			
Reviewed I	By Review	red By	Date:	Signature of Sur	vevor:				Date:	
State Agen		-	10/08/2015	e.g		1016	50			09/24/2015
	By Review		Date:	Signature of Sur	veyor:				Date:	
CMS RO										
Followup t	o Survey Completed 8/19/2015	on:	0	Check for any Uncor Uncorrected Defic	rected Deficiencies (CN	ciencie IS-256	es. Was a S 7) Sent to t	Summary of he Facility?	YES	NO

DEPARTMENT OF HEAL						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL TE SURVEY AGENCY	ID: ZXDT
1. MEDICARE/MEDICAID PROVI           (L1)         245487           2.STATE VENDOR OR MEDICAID           (L2)         394347000	DER NO.	3. NAME AND AI (L3) ST ELIZAB (L4) 1200 FIFTH (L5) WABASHA,	DDRESS OF FAC ETH MEDICA I GRANT BOU	ULITY AL CENT	ER	Facility ID: 00675         4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE O (L9)</li> <li>6. DATE OF SURVEY 08/</li> <li>8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ol>	<b>20/2015</b> (L34)(L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/III 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
<ul> <li>11LTC PERIOD OF CERTIFICATI</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	ON 100 (L18) 100 (L17)	Complianc 1. A X B. Not in Con	nce With equirements te Based On: cceptable POC	ram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
14. LTC CERTIFIED BED BREAKI	NOW N	_		İ	15. FACILITY MEETS	
18 SNF 18/19 SN		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
18 SNF 18/19 SN 100 (L37) (L38)	(L39)	(L42)	(L43)		1801 (c) (1) 01 1801 (j) (1).	
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Lisa Carey (Krebs), HF	E NE II	0	09/19/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 10/08/2015 (L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	STATE AGENCY
<ol> <li>DETERMINATION OF ELIGIE</li> <li>1. Facility is Eligible to</li> <li>2. Facility is not Eligit</li> </ol>	Participate		IPLIANCE WITH TTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION <b>02/14/1986</b>	BEGINNINC	6 DATE	ENDING DAT	ΓE	VOLUNTARY     00       01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	8
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
(L27)	-	n of Admissions:	(L44)		04-0ther Reason for windrawar	07-Provider Status Change 00-Active
	B. Rescind St	spension Date:	(1.45)			
28. TERMINATION DATE:	20	. INTERMEDIARY	(L45)		30. REMARKS	
26. TERMINATION DATE:	25		CARRIER NO.		50. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539		. DETERMINATION	I OF APPROVAL			
	(L32)			(L33)	DETERMINATION APP	ROVAL



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;

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

## <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

#### **DEPARTMENT CONTACT**

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

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. St Elizabeth Medical Center September 8, 2015 Page 4

#### 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

St Elizabeth Medical Center September 8, 2015 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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 St Elizabeth Medical Center September 8, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY IPLETED
		245487	B. WING			08/	20/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CEN	NTER			200 FIFTH GRANT BOULEVARD WEST ABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an					
F 159 SS=E	validate that substa regulations has bee your verification.	ur facility may be conducted to initial compliance with the en attained in accordance with CILITY MANAGEMENT OF S	F 1	59			9/26/15
	facility must hold, sa account for the pers	rization of a resident, the afeguard, manage, and sonal funds of the resident facility, as specified in 8) of this section.					
	funds in excess of s account (or account the facility's operation all interest earned of account. (In pooled	posit any resident's personal \$50 in an interest bearing ts) that is separate from any of ng accounts, and that credits on resident's funds to that d accounts, there must be a g for each resident's share.)					
	funds that do not ex	aintain a resident's personal kceed \$50 in a non-interest terest-bearing account, or					
		stablish and maintain a system and complete and separate					
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/18/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245487	B. WING			08/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	BETH MEDICAL CEN	ITER			200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 159	accounting principle funds entrusted to t behalf. The system must p resident funds with of any person other The individual finan through quarterly st the resident or his of The facility must no Medicaid benefits w resident's account r SSI resource limit for section 1611(a)(3)(I amount in the account the resident's other reaches the SSI resource the resident's other reaches the SSI resource This REQUIREMEN by: Based on interview facility failed to ensu- monies in their pers admissions office h weekends. This had residents. Findings include: Admissions employ 8/20/15, at 8:20 a.m hours were Monday	ge 1 ng to generally accepted es, of each resident's personal he facility on the resident's reclude any commingling of facility funds or with the funds than another resident. cial record must be available atements and on request to or her legal representative. tify each resident that receives then the amount in the reaches \$200 less than the or one person, specified in B) of the Act; and that, if the unt, in addition to the value of nonexempt resources, source limit for one person, the digibility for Medicaid or SSI. NT is not met as evidenced and document review the ure residents had access to sonal trust fund accounts after ours during the evenings and d the potential effect all 92	F 1	159	*Reviewed and revised policy "Res Trust Funds" *Updated resident addmission pack reflect changes made to policy "Res Trust Funds" by 9/26/15. *Revisions to policy to be shared at resident council and family council held) meetings September 22, 2019 October meetings when dates determined. *Educated licensed nursing team members on new process via interr memo and discussion at team mee	ket to sident (when 5 and nal	
				<b>F</b>		e de la constante de la consta	Dama 0

Facility ID: 00675

If continuation sheet Page 2 of 32

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	O CONTLETION	IDENTIFICATION NUMBER.	A. BUILDI	NG _		COM	
		245487	B. WING _			08/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CE	NTER			200 FIFTH GRANT BOULEVARD WEST /ABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 159	Continued From pa	age 2	F 1	59			
	money they would admissions office is Patient accounts en 8/20/15, at 8:32 a.r informed during ad money from their a did not have access office closed. During interview or executive assistant not have an evenin account and stated will need it we leav locked up. If we do admissions desk at unable to report wh money after admissi families would have the resident and the reimbursed them. If worker would have admission when the money. During interview or	sident wanted access to have had to do it when the s open. mployee-H was interviewed on m. stated residents had been mission when they could get account and verified residents is to money after the admission M 8/20/15, at 12:58 p.m. t (EA)-I verified the facility did ag or weekend petty cash d, "If we know they (residents) e it with the nurses to be in't know they get it over at the t the hospital." EA-I was here residents would access sion office hours. EA-I stated e had to provide the money for e facility would have EA-I further stated the social informed the resident on ey would have access to M 8/20/15, at 1:23 p.m. licensed V)-A stated if residents had			by 9/26/15. *Educated front office team mem patient account team members o in process by 9/26/15. *DON/Designee to conduct rando 1x week for 4 weeks, 2x month x to verify front office team members a licensed team members are able identify new process for providing for residents' personal funds on e and weekend hours.	f change om audits 1 month rs, nd to access	
	needed money on had to get it on Fric was open. LSW-A to the hospital adm deferent location th it." LSW-A verified	a weekend they would have day when the admissions office further stated, "Or they can go hissions (this is located at a han the nursing home) to get residents would not have fter admission office hours.					

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		AND HUMAN SERVICES			FORM	09/18/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245487	B. WING	 	08/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CEN	NTER		200 FIFTH GRANT BOULEVARD WEST ABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 159 F 167 SS=C	"POLICIES 9. Fund admissions desk, 8 Friday, and by prior buildings. For unex hours funds may be the admissions offic Center. PROCEDU hours, nursing staff at Medical Center. If by resident, resider staff from the admis Review of the facilit Funds Agreement p resident or authoriz access to a residen and financial statem p.m. and weekends arrangements." 483.10(g)(1) RIGHT READILY ACCESS A resident has the r the most recent sur Federal or State su correction in effect The facility must ma examination and m accessible to resid their availability. This REQUIREMEN by: Based on observat	ds will be accessible at the a m - 4 pm Monday through r arrangements in both pected needs outside of these e accessed from petty cash at ce at Saint Elizabeth Medical IRES 2. On weekends or after should call admissions office Money can then be accessed nt's representative or facility ssion office." ty admission packet Personal bage 18, undated, specified "A ted person(s) shall have nt's personal funds account nent, Monday-Friday, 8 a.m 4 s/holidays with prior T TO SURVEY RESULTS -	F 1	*Most recent survey results relocate lower edge of bulletin board at the n	ed to	9/26/15

Facility ID: 00675

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	( )	PLE CONSTRUCTION		0938-039 SURVEY PLETED
	of COnnection	IDENTIFICATION NOMBER.	A. BUILDING	3	COIVI	FLETED
		245487	B. WING		08/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEI	NTER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 167	residents located a unit. This had the p residents. Findings include: On 8/17/15, at 10:0 the nursing home u of the hospital, resu been observed on a the nursing station. a metal ring which approximately five surveyor was unab reaching up and re During resident cou 5:59 p.m. resident	Its were accessible to all t the hospital Nursing Home botential to effect 19 out of 19 05 a.m. during an initial tour of unit located on the second floor ults for the previous survey had a bulletin board across from The results were attached by was hanging on a small hook feet up from the floor. The le to read the results without moving them from the hook. uncil interview on 8/19/15, at 23 was unable to report where rvey results were located.	F 167	<ul> <li>home (second floor of hospital car Sign placed to please not move su results 8/27/15.</li> <li>*Sign placed directing interested individuals to binder holding the m recent survey results located on b in nursing home sun room by 9/26</li> <li>*Changes to placement of most re survey results shared with R23 an residents at resident council meet 9/26/15.</li> <li>*Weekly audit X4 to be completed verify acceptable placement/locati most recent survey results.</li> </ul>	ost ookshelf /15. ccent d ing by to	
F 241 SS=E	registered nurse (F survey results were residents, and/or vi having to ask for st the results should b persons in a wheel viewing the notice. 483.15(a) DIGNITY INDIVIDUALITY The facility must pr manner and in an e enhances each res	on 8/20/15, at 10:25 a.m. RN)-F verified the most recent e not easily accessible to sitors to examine without affs' assistance. RN-F stated be lower, and further verified chair would have had difficulty Y AND RESPECT OF omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.	F 241			9/26/15

Facility ID: 00675

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	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	TPLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245487	B. WING _			20/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEN	NTER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 241	Continued From pa	ige 5	F 24	41		
	This REQUIREMEN	NT is not met as evidenced				
	Based on observation review, the facility f	tion, interview, and record ailed to ensure 4 of 6 residents 55) were assisted with eating er.		*Appropriate use of gloves dur mealtimes reviewed at team me August/September. Internal me out reviewing expectation of wh when not to wear gloves when	eetings emo sent en to and	
	Findings include:			resident with food by 9/26/15. *Audits to be completed weekly	x4 weeks,	
	p.m. nursing assist sitting between R42 barrier gloves while	observed on 8/19/15, at 5:22 ant (NA)-F was observed 2 and R72 wearing rubber e assisting R42 and R76 to eat. 6 had a sandwich or finger s had a puree diet.		x2 every two weeks and x1 mo verify understanding and comp principles of dignity and dining to appropriate use of gloves. *Findings from audits will be re reviewed at future QA&A (QAP meetings to direct future audits	ekly x4 weeks, monthly x2 to mpliance with ng in relation reported and API) team	
	according to the fac quarterly Minimum indicated severe co	to the facility on 2/27/2013, cility admission record. R76's Data Set (MDS) dated 6/26/15 ognitive impairment, was		and policy revision needs.	-	
	included but was no and required a med addition the MDS in mouth/cheeks or ha meals and coughed when swallowing m	for eating, had diagnoses that ot limited to Downs Syndrome, chanically altered diet. In indicated R76 held food in ad residual food in mouth after d or choked during meals or redications. s provided by the facility on				
	8/20/15. The copy p 3/21/13, the "feedin staff, R76 was deperequired pudding the pureed diet. The ca	s provided by the facility on provided had a print date of ng" plan of care plan informed endent on staff for eating, nick liquids, and was on a ure plan identified R76 had pry of cerebral vascular				
		to the facility on 3/13/2009, cility admission record. R42's				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245487 B. WING 08/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER WABASHA, MN 55981 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 6 F 241 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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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245487	B. WING			08/:	20/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CEN	ITER			1200 FIFTH GRANT BOULEVARD WEST NABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From pa	ge 7	F 2	241			
F 279 SS=D	Registered Nurse (I stated that the expe- assisting residents of secretions. Staff when they want to, why. RN-D then sai wear gloves." RN-D to wearing gloves of Policy was requester assisting resident to 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each resider objectives and time	É CARE PLANS the results of the assessment and revise the resident's	F 2	279			9/26/15
	assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under § due to the resident	tified in the comprehensive t describe the services that are ttain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment .).					

Facility ID: 00675

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ENCIES TION	(X1) PROVIDER/SUPPLIER/CLIA				
	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	E SURVEY PLETED
	245487	B. WING		08/20/201	
OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EDICAL CE	NTER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981	EST	
H DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	) BE	(X5) COMPLETION DATE
ed From pa	age 8	F 2	79		
QUIREME	NT is not met as evidenced				
ailed to ensitions relate ed for 1 of failed to de l monitoring gulant med s (R7) revi- a complete nt (R76) re s include: urrent care l been diag s Mellitus v nodialysis care f contact nu e standing nilk of mag ressure on days, NSG pruit every [blood press of the recorn n as indica ng for comp o guide state	plan dated 4/30/14 indicated plan dated 4/30/14 indicated plan dated 4/30/14 indicated plan dated 4/30/14 indicated prosed for mechanical altered plan dated 4/30/14 indicated plan dated 4/30/14 indicated prosed with unspecific type with renal manifestations and dependent. The care plan documentation which read, plan and standing orders in umbers and direction for care, house orders with exception of nesia] and Antacid. Do not take left arm, short sleeves on [nursing] staff to check fistula shift, monitor pre-post weight ssure] on dialysis." Further d had not revealed the dialysis ted, and did not include plications, and did not include ff response to an emergency.		<ul> <li>reviewed and updated to include id areas by September 26.</li> <li>*Policy "Resident Care Plans, Development, Implementation and Revision" reviewed.</li> <li>*Care plans to be reviewed and rev a minimum quarterly and as needer residents.</li> <li>*Team meeting August/September LTC department head meeting August/September provided discuss importance of ensuring care plans developed and updated in a timely manner to reflect current needs of resident by 9/26/15.</li> <li>*DON/designee to complete rando audits 1x week for 4 weeks, 2x mo 1 month and then monthly x2 mont verify compliance with inclusion of individualized resident needs on ca plan.</li> <li>*Findings will be reported and revie future QA&amp;A (QAPI) team meeting</li> </ul>	vised at d for all and ssion of being m nth for ths to specific are ewed at s to	
	ed From pa acQUIREME on interview ailed to ens tions relate ed for 1 of failed to de d monitoring gulant med a complete at (R7) revie a complete nt (R76) re s include: urrent care d been diag s Mellitus v nodialysis care in contact nu e standing nilk of magin ressure on days, NSG pruit every [blood press of the record in as indication of guide state of the record in a for com of guide state of the record in a complete s fulletus v nodialysis care in contact nu e standing nilk of magin ressure on days, NSG pruit every [blood press of the record in as indication of guide state of the record in a complete in as indication of the record in a complete in a c	EDICAL CENTER EDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION) ed From page 8 CQUIREMENT is not met as evidenced on interview and document review, the ailed to ensure that care plan tions related to kidney dialysis were ed for 1 of 1 resident (R67) reviewed for failed to develop a care plan that d monitoring for side effects of an gulant medication (Warfarin) for 1 of 7 is (R7) reviewed for skin, and failed to a complete dysphagia care plan for 1 of ont (R76) reviewed for mechanical altered	DR SUPPLIER         EDICAL CENTER         SUMMARY STATEMENT OF DEFICIENCIES BH DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION)       D PREFU TAG         ed From page 8       F 2         QUIREMENT is not met as evidenced       on interview and document review, the ailed to ensure that care plan tions related to kidney dialysis were ed for 1 of 1 resident (R67) reviewed for failed to develop a care plan that d monitoring for side effects of an gulant medication (Warfarin) for 1 of 7 is (R7) reviewed for skin, and failed to a complete dysphagia care plan for 1 of int (R76) reviewed for mechanical altered         s include:       urrent care plan dated 4/30/14 indicated d been diagnosed with unspecific type is Mellitus with renal manifestations and modialysis dependent. The care plan th included documentation which read, alysis care plan and standing orders in r contact numbers and direction for care, e standing house orders with exception of nilk of magnesia] and Antacid. Do not take ressure on left arm, short sleeves on days, NSG [nursing] staff to check fistula pruit every shift, monitor pre-post weight [blood pressure] on dialysis." Further of the record had not revealed the dialysis in as indicated, and did not include ing for complications, and did not include ing for complications, and did not include to guide staff response to an emergency.	DR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         EDICAL CENTER       TREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       INPERIAL         SUMMARY STATEMENT OF DEFICIENCIES       INPERIAL         SUMMARY STATEMENT OF DEFICIENCIES       INPERIAL         SUMMARY STATEMENT OF DEFICIENCY       INPERIAL         BURKING STREET ADDRESS, CITY, STATE, ZIP CODE       1200 FIFTH GRANT BOULEVARD WEST         WABASHA, MN 55981       INPERIAL         ULATORY OR LSC IDENTIFYING INFORMATION)       INPERIAL         ed F To T page 8       F 279         QUIREMENT is not met as evidenced       F 279         QUIREMENT is not met as evidenced       F 279         Gar 1 of 1 resident (R67) reviewed for failed to develop a care plan that a monitoring for skin, and failed to a complete dysphagia care plan that a complete dysphagia care plan to to f s (R7) reviewed and reviewed.       "Care plans to be reviewed.         S include:       INPERIAL       "Team meeting August/September Provided Sizon a contact numbers and direction for care, e standing house orders with exception of hilk of magnesia] and Antacid. Do not take essure on left arm, sho	DR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         EDICAL CENTER       1200 FIFTH GRANT BOULEVARD WEST         WABASHA, MN 55981       WABASHA, MN 55981         SUMMARY STATEMENT OF DEFICIENCIES IN DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)       ID PREFX TAG         ed From page 8       F 279         QUIREMENT is not met as evidenced on interview and document review, the alled to ensure that care plan failed to develop a care plan that inonitoring for side effects of an gulant medication (Warfarin) for 1 of 7 s (R7) reviewed for skin, and failed to a complete dysphagia care plan that is include:       F 279         s include:       "Care plans to be reviewed and revised at a minimum quarterly and as needed for all residents."       "Care plans to be reviewed and revised at a minimum quarterly and as needed for all residents."         s include:       "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.         s include:       "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 (OAPI) team meetings to direct future audits, training and policy revision needs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245487 B. WING 08/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER WABASHA, MN 55981 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 Continued From page 9 F 279 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

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CENTEI STATEMENT AND PLAN C	RS FOR MEDICARE		A. BUILD	S	O LE CONSTRUCTION	FORM. MB NO. (X3) DATE COM 08/2	09/18/2015 APPROVED 0938-0391 E SURVEY PLETED 20/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	blood." R7 reported occurrence. According to curren received Warfarin ( thinning medication on Wednesdays an mg by mouth on Su Thursday and Frida fibrillation. Review of R7's curr identified R7 as ale risk for skin breakd incontinence, impai history of pressure care plan had not a interventions for ex associated with the alert care givers the bleeding timely to th During interview on director of nursing ( should include, refle resident at the time information to care further stated, "I wa everyone as if they bleeding." DON ve lacked risks, goals Warfarin therapy ar bruising. Request made for o provided. R76 was admitted t	A bruising had been a frequent at physician orders, R7 an anti-coagulant-blood b) 6 mg (milligram) by mouth and Saturdays, and received 4 anday, Monday, Tuesday, ay for diagnosis of atrial rent care plan dated 12/4/14 rt and oriented with increased own secondary to urinary ired mobility, arthritic pain and ulcers upon admission. The addressed risk factors and cessive bleeding or bruising a use of Warfarin in order to a need to report bruising and	F2	279			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
		245487	B. WING	i	08	/20/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
ST ELIZ	ABETH MEDICAL CEI	NTER		1200 FIFTH GRANT BOULEVARE WABASHA, MN 55981	) WEST	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
F 279	indicated severe co dependent on staff included but was ne and required a med addition the MDS in mouth/cheeks or he meals and coughed when swallowing m R76's Care Area As completed 1/12/15 resident was totally and required puddi pureed diet. The Ca diagnosis of dyspha R76's care plan pro 8/20/15. The copy p 3/21/13, the "feedir written changes in to follow because of chronological order to read. It was dete had informed staff for eating, required on a pureed diet. Th had dysphagia and accident (stroke). T risk for aspiration/c evaluation from the held food in mouth meals and/or when R76's nursing assis the facility on 8/20/ pureed diet with punursing assist care information from the food in mouth or co times or when swall	Data Set (MDS) dated 6/26/15 ognitive impairment, was for eating, had diagnoses that ot limited to Downs Syndrome, chanically altered diet. In indicated R76 held food in ad residual food in mouth after d or choked during meals or	F 2	279			

Facility ID: 00675

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245487 B. WING 08/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER WABASHA, MN 55981 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 Continued From page 12 F 279 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 gualified 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".

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		245487	B. WING			08/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER	•		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	BETH MEDICAL CEN	NTER			1200 FIFTH GRANT BOULEVARD WEST		
					WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=D	The resident has the incompetent or othe incapacitated under participate in planni changes in care and A comprehensive car within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as detern and, to the extent p the resident, the resi legal representative	NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F 2	280			9/26/15
	by: Based on observat review, the facility fa included ongoing pl and assistance req residents (R55) ca to revise the skin ca (R72) reviewed for s Findings Include: R55 was admitted t diagnoses including	to the facility on 9/20/11 with g, diabetes, neurotic ension, chronic right hip pain,	1	Fa	*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, 2 *Care plans to be reviewed and revi a minimum quarterly and as needed residents. *Team meeting August/September a LTC department head meeting August/September provided review importance of ensuring care plans r	2015. ised at d for all and of eflect	Page 14 of 32

		I AND HUMAN SERVICES			OMB NO.	APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	· · /	E SURVEY PLETED
		245487	B. WING _		08/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ST ELIZ	ABETH MEDICAL CE	NTER		1200 FIFTH GRANT BOULEVARD WE WABASHA, MN 55981	EST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	Continued From pa	age 14	F 28	30		
	and chronic right hi admission form.	ip infection according to the		current needs of residents an revisions to care plan be ma response to changes in resid	de timely in	
		4 a.m. R55 was observed to ssist with her noon meal and eat herself.	was observed to er noon meal andby 9/26/15. *DON/designee to complete rand audits 1x week for 4 weeks, 2x m 1 month and then monthly x2 month verify compliance with inclusion of	random 2x month for		
re a s ir a	require partial assis	p.m. R55 was observed to st with eating. The nursing sting R55 handed R55 a			ion of specific	
	independently eat. and handed her a c	55 was able to hold and The NA fed R55 bites of fruit cup from which R55 could take A would set back down.		*Findings will be reported an future QA&A (QAPI) team m direct future audits, training a revision needs.	eetings to	
	stated, "Some days herself, or you get	5 a.m. registered nurse (RN)-C s she [R55] can totally feed her started and she finishes have to totally feed her. It y. Needs lots of				
	(DON) reviewed RS plan. "I would have not match MDS. Th certainly be on the contracture's being should be at least a increased pain." T	47 a.m. the director of nursing 55's care plan and ADL care to agree the care plan does he change of eating should ADL care plan. The that she refused treatment, it acknowledged, reporting he DON verified contracture's nned and were not included on an.				
	2/22/15 indicated F with eating, resider staff provided guide other non-weight b	a Data Set (MDS) dated R55 required a limited assist at was highly involved in eating, ed maneuvering of limbs or earing assist. R55 also had a in range of motion with lower				

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	-	AND HUMAN SERVICES				FORM	: 09/18/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245487	B. WING	à		08/	20/2015
NAME OF F	PROVIDER OR SUPPLIER	•		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CEN	NTER			1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG F 280	Continued From parextremity impairme Significant change R55 required an exassist with eating, support. ADL [activities of da 6/14/15 indicated R of 1 as needed with a time. Care plan dated, 12 problem of potentia eating: "I eat all me needing occasional cardiac, diabetic die be given one item a R72 was admitted t diagnoses including constipation, recurr history of a stroke a according to the ad On 8/18/15, at 9:58 sitting in the units d located on the top of on left hand. R72's Medications hydrochlorothiazide also a diuretic), Bu medication to impro- pain medication). I	ge 15 nt on both sides MDS dated 5/18/15 revealed tensive 1 person physical staff provided weight bearing ally living] Care Plan dated 55 needed staff set up, assist neating, and to eat one item at 2/13/12 revealed an identified I for self care deficit with als independently after setup cueing and assist. I am on et 1800 calorie diet. I need to at a time." to the facility on 3/13/14, with g but not limited to dementia, ent urinary tract infections, and deep vein thrombosis	р П	a 280	DEFICIENCY)	PRIATE	
	Licensed practical r	8/19/15, at 6:56 p.m. nurse (LPN)-E stated 2 weeks ints were getting R72 ready for					

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		AND HUMAN SERVICES				FORM	09/18/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245487	B. WING			08/	20/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST ELIZA	ABETH MEDICAL CEN	NTER			200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	and R72 grabbed o tears. Progress note date "Noted Various disc hand and lower arm indicates that she h being combative, hi during cares which bruising. It is also r fragile on her lower vessels being very increasing her risk bruising. Care plan dated 7/1 StaffSKIN: I an breakdown second and use of coumad bruising" During interview on reviewed R72's skin resident is not curre be removed from c acknowledged that reflect residents fra discoloration, comb for bruising or skin progress note on co assessment of skin dated 8/10/15 11:25	d 8/10/2015, 11:29 a.m. colored areas on R72 right n." Review of charting as had multiple episodes of itting and throwing items may increase her risk of noted that her skin is very arms and tops of hands with close surface of skin, for any bumps to result in 1/2014 read, "All n at increased risk for skin ary to inc , impaired mobility in which increases my risk for 8/20/15, at 8:10 a.m. DON n care plan. DON stated ently on coumadin and should are plan. DON had care plan for skin did not agile skin, or base line pativeness, or other risk factors tears. DON pulled up omputer and showed and risks for bruising or injury	F	280			
F 309 SS=D	none provided. 483.25 PROVIDE (	CARE/SERVICES FOR	F	309			9/26/15

Facility ID: 00675

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		AND HUMAN SERVICES				FORM	
			(X2) MULT		E CONSTRUCTION		
-	FCORRECTION	IDENTIFICATION NUMBER:					
		245487	B. WING			00//	0/0015
	PROVIDER OR SUPPLIER	243407	D. WING_			08/2	20/2015
					200 FIFTH GRANT BOULEVARD WEST		
ST ELIZA	ABETH MEDICAL CEN	NTER			/ABASHA, MN 55981		
(X4) ID		TEMENT OF DEFICIENCIES	ID				(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(			COMPLETION DATE
IAG			IAG		DEFICIENCY)		
			1				
F 309	Continued From pa	ge 17	F 30	09			
						ADDRESS, CITY, STATE, ZIP CODE TH GRANT BOULEVARD WEST SHA, MN 55981 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE RROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY) COMPLETION DATE DEFICIENCY COMPLETION COMPLETION DATE COMPLETION COMPLETION DATE COMPLETION COMPLETION COMPLETION DATE COMPLETION COMPLETION COMPLETION DATE COMPLETION COMPLETION COMPLETION COMPLETION COMPLETION DATE COMPLETION COMPLETIO	
		receive and the facility must					
		ary care and services to attain nest practicable physical,					
		social well-being, in					
		e comprehensive assessment					
	and plan of care.						
		NT is not met as evidenced					
	by:				*O		
		and document review the ure a comprehensive					
		was in place to include care of			related to dialysis needs by 9/26/15		
	dialysis access site	, and failed to establish					
		l interventions for 1 of 1			licensed team members including		
	residents (R67) rev	iewed for dialysis.				h	
	Findings include:						
	- <b>3</b>				for dialysis complication of bleeding		
		plan dated 4/30/14 indicated			completed 9/26/15.		
		nosed with unspecific type ith renal manifestations and					
		lependent. The care plan				ord	
		documentation which read,			which includes directions for care o		
	"See dialysis care p	blan and standing orders in			resident receiving dialysis and med		
		mbers and direction for care,			emergency interventions related to		
		house orders with exception of nesia] and Antacid. Do not take			9/26/15.	l Dy	
		eft arm, short sleeves on			*DON/Designee to complete rando	m	
		[nursing] staff to check fistula			audits of team members' knowledg		
		shift, monitor pre-post weight			location of forms identified and		
		sure] on dialysis." Further				* 0	
		had not revealed the dialysis ted, and did not include					
		olications, and did not include			month for 2 months to verify	•	
		f response to an emergency.			understanding.		
					*Findings will be reported and revie	wed at	

Facility ID: 00675

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245487	B. WING _		08	20/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST ELIZ	ABETH MEDICAL CE	NTER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 309	assistant (NA)-G w complications that resident receiving of would be followed if During interview or stated dialysis educ and was unable to monitored. NA-H w information would b response to an em Further review of F Memorandum of U which indicated vas been monitored for excessive bleeding an emergency proo Review of facility di nurses' station reve pamphlet. Page 20 identified possible a interventions to inc infiltration, swelling and clotting. On 8/20/15, at 9:35 manager (CM)-B re monitor daily weigh site for thrill. CM-B specific monitoring procedures it's just been unaware a M that had included s monitoring had bee been unaware an emergency and the second second second second second second second second second second	a 8/20/15, at 7:20 a.m. nursing vas unable to report would be monitored for a dialysis, and what procedure f an emergency occurred. a 8/20/15, at 7:55 a.m. NA-H cation had not been provided report what would be vas unable to report where be located to guide staff	F 30	99 future QA&A (QAPI) team meetin direct future audits and training.	gs to	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/18/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245487	B. WING		08/:	20/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CEN	ITER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309 F 329 SS=D	bleeding, infection a in a dialysis binder. had not monitored o infiltration, swelling, clotting. During phone interv Mayo Clinic Dialysis the dialysis center h to the facility after e stated monitoring si swelling for infection access site should specifically for bleed During interview on of nursing verified o monitored and that emergency medical A policy and/or prod interventions for res treatments had bee provided. 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in of duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the	and clotting had been located CM-B verified nursing staff complications to include pain, bleeding, infection and view on 8/20/15, at 10:52 a.m. is Nurse Supervisor reported had sent an information sheet each dialysis session and hould have included pain and n, and further stated the have been monitored ding. 8/20/15, at 1:03 p.m. director lialysis care had not been the facility lacked an I plan. edure on emergency medical sidents receiving dialysis in requested and none EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 309			9/26/15

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		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245487	B. WING _		08/2	20/2015
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	ЭЕ	
T ELIZ	ABETH MEDICAL CEN	NTER		1200 FIFTH GRANT BOULEVARD WES WABASHA, MN 55981	EST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 329	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	ge 20 must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 32	29		
	by: Based on observat review the facility fa (R80) had a dose t justification for why contraindicated at t documentation of n were used prior to t needed) medication reviewed. Findings included: R21 was admitted t according to the fac the following diagno electronic medical r veins with lower leg osteoarthrosis. R21's electronic ph the facility on 8/19/1 (narcotic-like pain n	NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 5 residents itration or a physician's a dose reduction was his time and failed to ensure on-pharmacological measures he administration of PRN (as n for 1 of 3 residents (R21) to the facility on 2/28/2014 cility admission record and had bees according to the facilities record: mononeuritis, varicose g edema, arthropathy, and ysician's orders provided by 15 included Ultram nedication) 50 milligrams by wo times a day as needed		*Staff education of importance documenting non-pharmacolo interventions offered prior to a PRN medication for licensed of trained medication aides prove meetings (Aug/Sept), via inter 8/24/15, state survey prelimin posting August 20, 2015. *Reviewed and revised policy "Administration of Medications reviewed "Consultant Pharma September 14, 2015. *DON/Designee to complete r audits for residents receiving medication ordered each wee *R80 is not referenced in F32: verified with G Nederhoff, Uni MDH on 9/18/15. *Findings will be reported and future QA&A (QAPI) team me	gical dministering nurses and ided at staff nal memo ary result s" and cist in LTC" andom PRN k x4 weeks. 9 "findings", t Supervisor reviewed at	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/18/2015 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245487	B. WING		08/2	20/2015	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
ST ELIZA	ABETH MEDICAL CEN	ITER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329 F 367 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Facility policy that was obtained be by the attending physician. Therapeutic diets must be prescribed by the attending physician.		F 329	29		9/26/15	

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	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MELT	IPLE CONSTRUCTION		FORM APPROVED <u>MB NO. 0938-039</u> (X3) DATE SURVEY		
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA 1DENTIFICATION NUMBER: 245487				. BUILDING		COMPLETED 08/20/2015		
		B. WING _						
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
ST ELIZA	ABETH MEDICAL CEN	NTER		1200 FIFTH GRANT BOULEVARD WE WABASHA, MN 55981	ST			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 367	Continued From page 22		F 36	67				
	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			*Education related to dysphay to nursing team members 9/9 regularly scheduled team me	9/15,			
				attendance to view recorded complete "Dysphagia Quiz". *Findings reviewed during nu dietary team meetings (Aug/S including importance of accur therepuetic diets being server to be taken if consistency of f determined to be incorrect by *DON/Designee to complete residents on therapeutic diet thickened liquids to verify accu items being served. 1x week *Findings will be reported and future QA&A (QAPI) team me direct future audits, training a revision needs.	rsing and Sept) racy of d and steps luids/food 9/26/15. audits on including suracy of for 4 weeks. d reviewed at setings to			
	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.							
	at 7:57 a.m. R76's and diet butterscoto consistency of appl	meal observation on 8/20/15, meal tray included hot cereal ch pudding both with a lesauce. NA-I gave bite of ng, R76 coughed a couple of						

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		AND HUMAN SERVICES					FORM	09/18/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245487	B. WING	i			08/	20/2015
NAME OF	PROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP COL	)E		
ST ELIZABETH MEDICAL CENTER					1200 FIFTH GRANT BOULEVARD WES WABASHA, MN 55981	3T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	) BE	(X5) COMPLETION DATE
F 367	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 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			367				

Facility ID: 00675

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245487 B. WING 08/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER WABASHA, MN 55981 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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 guarterly 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245487 B. WING 08/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER WABASHA, MN 55981 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 367 Continued From page 25 F 367 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 gualified 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." 483.60(c) DRUG REGIMEN REVIEW, REPORT F 428 F 428 9/26/15 IRREGULAR, ACT ON SS=D 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.

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PRINTED: 09/18/2015

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245487	B. WING		08/	20/2015	
NAME OF I	PROVIDER OR SUPPLIER	2.0.07		STREET ADDRESS, CITY, STATE, ZIP (		20/2015	
	ABETH MEDICAL CEI	NTER	1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 428	Continued From pa	age 26	F 42	28			
	by: Based on interview facility failed to ensi- identified irregularit medication docume (R21) reviewed for Findings included: R21 was admitted according to the fac- the following diagne electronic medical veins with lower leg- osteoarthrosis. R21's electronic ph the facility on 8/19/ (narcotic-like pain r mouth as needed t (PRN) for pain. R21's care plan pro- informed staff R21 ankle, and shoulde to offer warm/cold p R21's medication a reviewed from 6/7/ indicated a total of had been administered medical record nor- had been attempte of the doses. It was not evident in consulting pharmace	medication) 50 milligrams by wo times a day as needed ovided by the facility on 8/19/15 had chronic pain in right foot, r. The care plan directed staff packs for break through pain. Idministration record was 15 through 8/20/15; the record twelve doses of PRN Ultram ered. Of the twelve doses that it was not evident in the n-pharmacological intervention d and/or documented for eight n the medical record the cist had identified the lack of		*Staff education of docume non-pharmacological interv prior to administering PRN licensed nurses and trained aides provided at staff mee (Aug/Sept), via internal men state survey preliminary res August 20, 2015. *Reviewed and revised poli "Administration of Medication reviewed "Consultant Pharn *DON/Designee to complet audits for residents receivin medications to verify docum non-pharmacological meas Audits to be completed on 4 with PRN medication order x4 weeks. *Findings will be reported a future QA&A (QAPI_ team direct future audits, training revision needs.	entions offered medication for d medication tings mo 8/24/15, sult posting cy ons" and macist in LTC". te random ng PRN nentation of sures offered. 4 residents ed each week nd reviewed at meetings to		

If continuation sheet Page 27 of 32

		AND HUMAN SERVICES				FORM	09/18/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245487	B. WING	i		08/:	20/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	BETH MEDICAL CEN	NTER			200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	medication.	uge 27 tration of a narcotic pain r on 8/19/15, at 2:43 p.m.	F 4	428			
F 431 SS=D	registered nurse (R medications should non-pharmacologic effectiveness was." During an interview director of nursing ( had been to attemp of non-pharmacologic administration of all Multiple and unsucc contact the consulti Facility policy that w current standards o non-pharmacologic administration of PF 483.60(b), (d), (e) D LABEL/STORE DR	N)-F stated, "PRN be documented with al interventions and what the on 8/19/15, at 3:31 p.m. the (DON) stated her expectation of and document effectiveness gical interventions prior to the I PRN medications. cessful attempts were made to ing pharmacist for interview. vas obtained did not reflect of the utilization of cal interventions prior to the RN medications. DRUG RECORDS, UGS & BIOLOGICALS	F٤	431			9/26/15
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order	nploy or obtain the services of cist who establishes a system at and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordan professional princip appropriate access	als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when					
	In accordance with	State and Federal laws, the					

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		AND HUMAN SERVICES				FORM	09/18/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATI			E SURVEY PLETED	
		245487	B. WING			08/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEN	ITER			200 FIFTH GRANT BOULEVARD WEST /ABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	locked compartmer controls, and permi have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review facility failed did not have unsup medication rooms. Findings include: On 8/20/15, at 9:28 observation a hous mopping the floor o behind the nurses s facility nurse or train nurses station or in Licensed practical r at that time in the d During interview on stated, "It is my nor housekeeper be in	Ill drugs and biologicals in hts under proper temperature t only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the hinimal and a missing dose can	F 4	431	*Policy "Receiving and Storing Medication" reviewed and revised. *Staff education of policy provided a meetings (August/September), via ir memo and posting of preliminary sta survey results by 9/26/15. *Random audits to be conducted by DON/designee to verify compliance medications by authorized individual 2x week for 4 weeks, 1x week for 2 and as needed. *Findings to be reported and reviewe future QA&A (QAPI) team meetings direct future audits, training and poli revision needs.	nternal ate with Is only weeks ed at to	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245487 B. WING 08/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST ST ELIZABETH MEDICAL CENTER WABASHA, MN 55981 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 29 F 431 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." 483.65 INFECTION CONTROL, PREVENT F 441 F 441 9/26/15 SPREAD, LINENS SS=D 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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245487	B. WING _		08/	20/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST ELIZ	ABETH MEDICAL CEN	NTER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 441	<ul> <li>(3) Maintains a reco actions related to in</li> <li>(b) Preventing Spree</li> <li>(1) When the Infect determines that a reprevent the spread isolate the resident.</li> <li>(2) The facility mus communicable dise from direct contact direct contact will tr</li> <li>(3) The facility mus hands after each di hand washing is inco professional practice</li> <li>(c) Linens Personnel must hand</li> </ul>	ad of Infection ion Control Program esident needs isolation to of infection, the facility must to prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted	F 44	1		
	by: Based on observat review, facility faile hygiene practice wa of infection for 1 of hour of sleep (HS) Findings include: R72 had been obse during continuous of ready for bed. Nurs the wet incontinence	NT is not met as evidenced tions interview and record d to ensure proper hand as used to prevent the spread 1 resident (R72) observed for cares. erved on 8/19/15 at 7:00 p.m. observation of staff getting R72 ing assistant (NA)-A removed e brief. E-A was wearing the floor, NA-A picked the brief		Proper hand hygiene reviewed meetings (August /September) 9/26/15. *Policy "Hand Washing, Hand H and Hand Care" reviewed and p staff to review by September 26 *Hand Hygiene audits during pri cares to be completed by DON/ 2x week for 4 weeks, 1x week f and monthly thereafter as part of comprehensive infection contro prevention program. *Findings to be reported and rev	by lygiene posted for , 2015. ovision of designee or 2 weeks of facility's and	

Facility ID: 00675

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245487       B. WING       08/20/2015         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981       1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981       (X3) DATE SURVEY COMPLETED			AND HUMAN SERVICES			FORM	: 09/18/2015 APPROVED . 0938-0391	
NAME OF PROVIDER OF SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ST ELIZABETH MEDICAL CENTER     ID       Image: Strength of the strengt of the strength of the strength of the strength of the str	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ST ELIZABETH MEDICAL CENTER     1200 FIFTH GRANT BOULEVARD WEST WABSHA, MN 55981       Multip PREFX     ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WEST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX     PROVIDERS PLAN OF CORRECTION (EACH ODRECTION Y WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFX     PROVIDERS PLAN OF CORRECTION (EACH OORECTIVE ACTION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     0(9)       F 441     Continued From page 31 up and threw it in waste basket, without washing hands NA-A continued to wear the solied gloves then removed R72's glasses, gathered clean towels from bedside table, dried R72's eyes with towel, removed R72's pants and washed her prineal area than removed R72's pants and washed her prineal area than removed her contaminated gloves and washed her hands.     F 441     future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.       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, " expect staff to thange their gloves and wash their hands after picking a solied 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 of the rgloves before touching the glasses and wash her hands			245487	B. WING _		08/	20/2015	
STELIZABETH MEDICAL CENTER     WABASHA, MN 55981       (%1) PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST 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)     0(29)       F 441     Continued From page 31 up and threw it in waste basket, without washing hands NA-A continued to wear the solied gloves then removed R72's glasses, gathered clean towels from bedside table, dried R72's eyes with towel, removed R72's pants and washed her perineal area than removed Her contaminated gloves and washed her hands.     F 441     F 441       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."     Nuring interview on 8/20/15, at 8:10 a.m. DON stated, "I expect staff to thurn off the water with a clean dry towel after washing their hands. I would expect staff to change their gloves and wash her hands     Nuring 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 ther gloves before touching the glasses and wash her hands     ID	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH DEFICIENCY AND FURTHER DEFICIENCY)       CONVERTING INFORMATION)       PREFIX TAG         F 441       Continued From page 31 up and threw it in waste basket, without washing hands NA-A continued to wear the solied gloves then removed R72's glasses, gathered clean towels from bedside table, dried R72's eyes with towel, removed R72's parts and washed her perineal area than removed Her contaminated gloves and washed her hands.       F 441       future QA&A (QAPI) team meetings to direct future audits, training and policy revision needs.         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       Here All and the prefixed and th	ST ELIZA	ABETH MEDICAL CEN	NTER					
<ul> <li>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.</li> <li>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."</li> <li>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."</li> <li>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</li> </ul>	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION	
		Continued From pa up and threw it in w hands NA-A continu- then removed R72's towels from bedside towel, removed R72 R72. NA-A continue removed R72's pan area than removed washed her hands. During interview on stated the correct w "get hands wet, app rinse, take towel dr turn water off." During interview on stated, "I expect stat clean dry towel afte expect staff to charn hands after picking from the floor." During interview on Registered Nurse (I nurse, when asked change and hand h stated NA-A should before touching the	age 31 waste basket, without washing ued to wear the soiled gloves s glasses, gathered clean e table, dried R72's eyes with 2's shirt and put a gown on ed to wear soiled gloves than nts and washed her perineal her contaminated gloves and 8/19/15, at 7:25 p.m. NA-A, vay to do hand washing was oly soap, scrub for 20 seconds, ry hands, get new towel and 8/20/15, at 8:10 a.m. DON aff to turn off the water with a er washing their hands. I would nge their gloves and wash their a soiled incontinence pad	ľ	DEFICIENCY) 41 future QA&A (QAPI) team meeting direct future audits, training and po	js to		

Facility ID: 00675

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		AND HUMAN SERVICES & MEDICAID SERVICES	75	487027	FORM	: 09/22/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY
		245487	B. WING		08	/19/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
ST ELIZ	ABETH MEDICAL CEN	ITER		1200 FIFTH GRANT BOULEVARD WE WABASHA, MN 55981	51	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ARAGA PEREPENOED TO THE AL	HOULD BE	(X5) COMPLETION DATE
K 000	Minnesota Departm Fire Marshal Divisio St. Elizabeths Medi- substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA) Code (LSC), Chapte This facility will be so buildings, which are addresses. St. Eliza # 1 is located at 120 West. This facility is a 2-st basement. The build different times. The constructed in 1919 Type II(222) constru- was constructed to determined to be of 1961, an addition w Wing that was dete construction. Becau	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, cal Center was found in nce with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 19 Existing Health Care. Surveyed as four separate e located at two different street abeths Medical Center building 00 Fifth Grant Boulevard cory building with a full ding was constructed at 3 original building was and was determined to be of uction. In 1939, an addition the West Wing that was Type II(222) construction. In as constructed to the North rmined to be of Type II(222) use the original building and	K			
	allowed for existing as one building. The building is fully fire alarm system w detection and space	sprinklered. The facility has a ith full corridor smoke es open to the corridor that is natic fire department		EPO		
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically 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.

PRINTED: 09/22/2015

PRINTED:	09/22/2015
FORM	APPROVED
OMB NO	0938-0391

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG 01		E SURVEY
		245487	B. WING_		08/	19/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CEN	ITER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	Continued From pa notification.	ge 1	K 01	00		
	The facility has a ca census of 19 at the	apacity of 20 beds and had a time of the survey.				
	The requirement at MET.	42 CFR, Subpart 483.70(a) is				
	*TEAM COMPOSI Gary Schroeder, Lit					

Facility ID: 00675

		AND HUMAN SERVICES	Ŧ	548202		FORM	09/21/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC	1	(X3) DAT	E SURVEY PLETED
		245487	B. WING			08/	19/2015
NAME OF F	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE		
ST, ELIZA	ABETH MEDICAL CEN	NTER		1200 FIFTH GF WABASHA, I	RANT BOULEVARD WEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PR	OVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CROSS	H CORRECTIVE ACTION SHOUL -REFERENCED TO THE APPRO	.D BE PRIATE	COMPLETION DATE
TAG	REGULATORY ORE			e <sup>2</sup>	DEFICIENCY)		
K 000	INITIAL COMMENT	٢S	кc	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.		8			
	Minnesota Departm Fire Marshal Divisio St. Elizabeths Medi found not in substal requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					
	DEFICIENCIES (K-TAGS) TO: Health Care Fire In:	R THE FIRE SAFETY			EPO	C	
	State Fire Marshal 445 Minnesota St.,						
	St Paul, MN 55101-						
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE
	ically 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.

PRINTED: 09/21/2015 FORM APPROVED OMB NO 0938-0391

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

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			C C		. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 02 - ST. ELIZABETHS CARE CENTER		E SURVEY IPLETED
		245487	B. WING			08/	19/2015
	PROVIDER OR SUPPLIER	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) 8E	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian.Whitney@s Angela.Kappenma	tate.mn.us and	K	000			
	DEFICIENCY MUS FOLLOWING INFO						
	1. A description of to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	St. Elizabeths Med located at 626 Shie	ical Center, Building # 2, is Ids Avenue South.					
	basement. This built	uilding and has a partial Iding was constructed in 1970 d to be of Type II(111)					
	fire alarm system w and spaces open to	sprinklered. The facility has a vith corridor smoke detection the corridor that is monitored epartment notification.					
		apacity of 80 beds and had a at the time of the survey.					
	NOT MET as evide	•					0/19/15
K 076	NFPA 101 LIFE SA	FETY CODE STANDARD	K(	)76			9/18/15
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: ZXDT2	1	Fa	cility ID: 00675 If contin	uation she	eet Page 2 of 4

PRINTED: 09/21/2015 FORM APPROVED OMB NO. 0938-0391

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

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 02 - ST. ELIZABETHS CARE CENTER	(X3) DATE SURVEY COMPLETED	
		245487	B. WING		08/1	19/2015
	PROVIDER OR SUPPLIER	ITER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 076 SS=D	<ul> <li>protected in accordation</li> <li>for Health Care Factoria</li> <li>(a) Oxygen storage</li> <li>3,000 cu.ft. are enciseparation.</li> <li>(b) Locations for su</li> <li>3,000 cu.ft. are venitive</li> <li>4.3.1.1.2, 19.3.2.4</li> </ul> This STANDARD is Based on observation Finitive facility was storing in the storage of the s	e and administration areas are ance with NFPA 99, Standards illities. locations of greater than losed by a one-hour pply systems of greater than ted to the outside. NFPA 99 s not met as evidenced by: ion and staff interview, the nedical gas cylinders in a ormance with NFPA 99 (1999 3.1.11.1 and 4-3.1.1.2(a) 4. ce could 10 out 74 residents.	K 076		was	

		AND HUMAN SERVICES			FOR	D: 09/21/2015 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING 02 - ST. ELIZABETHS CARE CENTER		TE SURVEY MPLETED
		245487	B. WING			8/19/2015
NAME OF F	PROVIDER OR SUPPLIER	<b></b>		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ELIZA	BETH MEDICAL CEN	ITER		1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHO	DULD BE	(X5) COMPLETION DATE
K 076	*TEAM COMPOSIT	-	K	076		

Event ID: ZXDT21

Facility ID: 00675

If continuation sheet Page 4 of 4

		AND HUMAN SERVICES	Ŧ	5487027		ORM APPROVED 3 NO. 0938-0391
	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G 03 - CHAPEL ADDITIO	N	COMPLETED
		245487	B. WING _			08/19/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,		
ST ELIZ	ABETH MEDICAL CEN	ITER		1200 FIFTH GRANT BO WABASHA, MN 5598		
	CUMMARX STA	TEMENT OF DEFICIENCIES	ID		PLAN OF CORRECTION	(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORREC	CTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORT OR L	SCIDENTIF HING INFORMATION)	IAG		DEFICIENCY)	
14 000			K 00			
K 000	INITIAL COMMENT	15	K O			
	FIRE SAFETY					
	A Life Safety Code	Survey was conducted by the				
		nent of Public Safety - State				
		on. At the time of this survey, cal Center , Building #3				
	Chapel Addition, wa	as found in substantial				
		e requirements for participation id at 42 CFR, Subpart				
	483.70(a), Life Safe	ety from Fire, and the 2000				
		Fire Protection Association 01, Life Safety Code (LSC),				
	Chapter 18 New He					
		cal Center, Building # 3				
	South.	located at 626 Shields Avenue				
		story addition to Building #2,				
		ment. The chapel addition was ember 2003 and was				
		Type II(111) construction.				
	The facility has a fir	e alarm system with smoke				
	detection in the corr	ridors and spaces open to the				
	department notifical	itored for automatic fire tion.				
		apacity of 80 beds and had a at the time of the survey.			POC	
	The requirement of	42 CFR, Subpart 483.70(a) is			<b>FUU</b>	
	MET.	42 UFN, Subpart 403.70(a) 15				
	*TEAM COMPOSIT	ION*				
		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE
Electron	ically 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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PRINTED:	09/21/2015
FORM	APPROVED
OMB NO	0938-0391

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION - CHAPEL ADDITION	(X3) DAT COM	E SURVEY
		245487	B. WING			/19/2015
	PROVIDER OR SUPPLIER		120	REET ADDRESS, CITY, STATE, ZIP CO 10 FIFTH GRANT BOULEVARD WE ABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	•	age 1 fe Safety Code Spc.	К 000			

		AND HUMAN SERVICES	FSYE	37027 c		APPROVED 0938-0391
STATEMENT	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION 04 - 4 SEASON SUN ROOM	(X3) DAT	E SURVEY PLETED
		245487	B. WING		08/	19/2015
NAME OF	PROVIDER OR SUPPLIER		9.0256	TREET ADDRESS, CITY, STATE, ZIP CODE	2	
ST ELIZ	ABETH MEDICAL CEN	ITER		200 FIFTH GRANT BOULEVARD WEST VABASHA, MN 55981		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 000			
	FIRE SAFETY					
	Minnesota Departm Fire Marshal Divisio St. Elizabeths Medi Season Sun Room substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, cal Center , Building #4 Four Addition, was found in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 18 New Health Care.				
	St. Elizabeths Medi Season Sun Room Shields Avenue Sou	cal Center, Building <b>#</b> 4 - Four Addition, is located at 626 uth.				
	to Building #2, and Season Sun Room	Sun Room is a 1-story addition has a no basement. The Four Addition was constructed in d was determined to be of uction.			]	
	detection in the cor	e alarm system with smoke ridors and spaces open to the itored for automatic fire tion.		POC		
	The facility has a ca census of 74 beds a	apacity of 80 beds and had a at the time of the survey.				
	The requirement at MET.	42 CFR, Subpart 483.70(a) is			642	
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 09/18/2015
Electron	ically Signed					09/10/2018

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PRINTED: 09/21/2015

		AND HUMAN SERVICES			FORM	: 09/21/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION NG 04 - 4 SEASON SUN ROO	201	E SURVEY IPLETED
		245487	B. WING		08/	19/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST		
ST EL 17/		NTER		1200 FIFTH GRANT BOUL	EVARD WEST	
				WABASHA, MN 55981		η
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
K 000	Continued From pa	ige 1	K 0	00		
	*TEAM COMPOSIT Gary Schroeder, Lit	ΓΙΟΝ* fe Safety Code Spc.				
				Facility ID: 00675	If continuation she	



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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

St Elizabeth Medical Center September 8, 2015 Page 2

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,

Kumalu Fiske Downing

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

Minneso	ota Department of He	alth				
-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00675	B. WING		08/2	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEN	ITER	H GRANT B A, MN 5598 <sup>-</sup>	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 09/16/15

Electronically Signed STATE FORM

If continuation sheet 1 of 36

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00675	B. WING		08/	20/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE	00/20/2010	
	ABETH MEDICAL CE	NTER 1200 FIF	TH GRANT BC	OULEVARD WEST		
	SUMMARY ST		HA, MN 55981	PROVIDER'S PLAN OF (		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "con text. You must ther State licensure pro completion date, th corrected prior to e Minnesota Departr On August 17, 18, this Department's s and the following c Please indicate in y correction that you	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic iccess, under the heading ne date your orders will be electronically submitting to the nent of Health. 19, & 20, 2015 surveyors of staff, visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, te when they will be completed				
	the State Licensing federal software. T	nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "II statute/rule out of o "Summary Stateme and replaces the " correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CEN	NIER	TH GRANT E IA, MN 5598	OULEVARD WEST 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			9/26/15
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on interview facility failed to ens interventions relate developed for 1 of dialysis, failed to de included monitoring anti-coagulant med residents (R7) revie develop a complete	ent is not met as evidenced and document review, the ure that care plan d to kidney dialysis were 1 resident (R67) reviewed for evelop a care plan that g for side effects of an ication (Warfarin) for 1 of 7 ewed for skin, and failed to e dysphagia care plan for 1 of viewed for mechanical altered		Corrected		
	Findings include:					
	R67 had been diag Diabetes Mellitus w	plan dated 4/30/14 indicated nosed with unspecific type ith renal manifestations and lependent. The care plan				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/2	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CE	NIFR	TH GRANT BC HA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 3	2 560			
	"See dialysis care chart for contact nu ok to use standing MOM [milk of mag blood pressure on dialysis days, NSG site for bruit every and BP [blood press review of the recor care plan as indica monitoring for com a plan to guide stat During interview or assistant (NA)-G w complications that resident receiving of would be followed During interview or stated dialysis edu and was unable to monitored. NA-H w information would I response to an em On 8/20/15, at 9:35 manager registered licensed nursing st pressure and fistul "We don't have am procedures it's just unable to provide a During phone inter Mayo Clinic Dialysi the dialysis center to the facility after of	documentation which read, plan and standing orders in umbers and direction for care, house orders with exception o nesia] and Antacid. Do not take left arm, short sleeves on a [nursing] staff to check fistula shift, monitor pre-post weight ssure] on dialysis." Further d had not revealed the dialysis ted, and did not include plications, and did not include ff response to an emergency. n 8/20/15, at 7:20 a.m. nursing vas unable to report would be monitored for a dialysis, and what procedure if an emergency occurred. n 8/20/15, at 7:55 a.m. NA-H cation had not been provided report what would be vas unable to report where be located to guide staff ergency. 5 a.m. during interview clinical d nurse (RN)-B reported caff monitor daily weight, blood a site for thrill. RN-B stated, y specific emergency t like anyone else." RN-B was a working dialysis care plan. view on 8/20/15, at 10:52 a.m. is Nurse Supervisor reported had sent an information sheet each dialysis session and should have included pain and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			E SURVEY PLETED
		00675	B. WING		08/20/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
		1200 EIE		OULEVARD WEST		
	ABETH MEDICAL CE	WABASI	HA, MN 55981			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 4	2 560			
		on, and further stated the have been monitored eding.				
	of nursing verified included in R67's c	n 8/20/15, at 1:03 p.m. director dialysis care had not been comprehensive care plan and rmation should have been				
	Dialysis policy was	requested but not provided.				
	multiple areas of b right forearm. Upon bruising had been occurred "When th	rved on 8/19/15, at 2:00 p.m. ruising had been noted on R7's n interview R7 stated the present the past week and hac ley [phlebotomist] tried to get d bruising had been a frequent	1			
	received Warfarin thinning medication on Wednesdays ar mg by mouth on So	nt physician orders, R7 (an anti-coagulant-blood n) 6 mg (milligram) by mouth nd Saturdays, and received 4 unday, Monday, Tuesday, ay for diagnosis of atrial				
	identified R7 as ale risk for skin breakd incontinence, impa history of pressure care plan had not a interventions for ex associated with the	rrent care plan dated 12/4/14 ert and oriented with increased down secondary to urinary lired mobility, arthritic pain and ulcers upon admission. The addressed risk factors and kcessive bleeding or bruising e use of Warfarin in order to e need to report bruising and the nurse.				
		n 8/20/15 at 1:03 p.m. the				

	a Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
		1200 FIF		ULEVARD WEST		
	BETH MEDICAL CE	WABASH	IA, MN 55981			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 5	2 560			
	should include, refl resident at the time information to care further stated, "I wa everyone as if they bleeding." DON ve lacked risks, goals Warfarin therapy at bruising.	(DON) stated, "Care plans ect the care needs of the e and should provide enough for that resident." The DON ant my aids [NAs] to treat are at high risk of bruising and erified R7's current care plan or interventions related to the nd high risk of bleeding and care plan policy however none				
	according to the fac quarterly Minimum indicated severe co dependent on staff included but was no and required a med addition the MDS in mouth/cheeks or ha meals and cougher when swallowing m R76's Care Area As completed 1/12/15 resident was totally and required puddi pureed diet. The Ca diagnosis of dyspha R76's care plan pro 8/20/15. The copy 3/21/13, the "feedir written changes in	to the facility on 2/27/2013 cility admission record. R76's Data Set (MDS) dated 6/26/15 ognitive impairment, was for eating, had diagnoses that ot limited to Downs Syndrome, chanically altered diet. In ndicated R76 held food in ad residual food in mouth after d or choked during meals or nedications. ssessment (CAA) last with annual MDS indicated v dependent on staff for feeding ng thick liquids and had a AA did not identify R76 had a agia (difficulty swallowing). ovided by the facility on provided had a print date of ng" plan of care had hand the margins that were difficult changes since 2013 were not in	3			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED				
		00675	75 B. WING							
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST							
ST ELIZABETH MEDICAL CENTER 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981										
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)				
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE				
2 560	Continued From pa	age 6	2 560							
	risk for aspiration/c evaluation from the held food in mouth meals and/or when R76's nursing assis the facility on 8/20/ pureed diet with pu nursing assist care information from th food in mouth or co	The care plan did not identify shoking and did not include the e quarterly MDS indicating R76 and coughed/choked during swallowing medications. stant care sheet provided by 15 informed staff R76 required dding thick liquids. The sheet did not include the e MDS that indicated R76 held bughed/choked during meal llowing medications.								
	Furthermore, the c interventions for eit difficulty issues. R76's physician ord 8/20/15 read, "diet: added protein with Nutritional assessm R76 had a pureed	are sheet did not include ther identified swallowing ders provided by the facility on 1500 calorie, pureed with pudding thick liquids." nent dated 6/23/15 indicated diet with pudding thick liquids tance from staff. The								
	assessment also re with meals". During an interview RN-B stated R76's thick after a dieticia 8/6/2014 because meal times. RN-B	ead, "does do some coughing of on 8/20/15, at 10:48 a.m. diet was changed to pudding an's recommendation on of increased coughing during verified diagnoses of								
	interventions for ep choking/coughing/a explained "we assu if they are on a the During an interview director of nursing	aspiration. RN-B further ime people are aspiration risk rapeutic liquid consistency". v on 8/20/15, at 12:13 p.m. (DON) stated, ideally the care aspiration/coughing and								

Minnesota Department of Health STATE FORM

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00075	B. WING			
		00675			08/	20/2015
	PROVIDER OR SUPPLIER	1200 FIF	DRESS, CITY, ST	ULEVARD WEST		
ST ELIZ	ABETH MEDICAL CE	NIER	A, MN 55981			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 7	2 560			
	Term Care last revi R.D. [registered dia nutritional status an prescribed diet ord plan is individualize of the consistency and aspiration, to r statusDysphagi with diagnosed, do impairment/probler food texture stages texture that the res	ralized Diet Guidelines for Long iewed 6/2014 read, "A qualified etician] will assess residents' nd appropriateness of the er so that each nutrition care ed for each residentthe goal alteration is to prevent choking maintain normal nutritional a-primarily used for residents cumented swallowing msall thickened liquids and s are provided at the degree to ident can safely tolerate as fessional monitoring the				
	The director of nur- develop and impler related to care plan designee, could pro- staff related to the of care plans. The assurance committa audits to ensure committa					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 570	Plan of Care; Revis		2 570			9/26/15
	care must be revie interdisciplinary tea physician, a registe for the resident, an disciplines as deter	<ul> <li>A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs, practicable, with the</li> </ul>				

If continuation sheet 8 of 36

Minnesc	ta Department of He	alth			
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00675	B. WING		08/20/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
ST ELIZ	ABETH MEDICAL CEI	ITER	TH GRANT B A, MN 5598	OULEVARD WEST 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 570	Continued From pa	ge 8	2 570		
	guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.			
	by: Based on observati review, the facility f included ongoing p and assistance red residents (R55) ca	ent is not met as evidenced on, interview, and document ailed to revise a care plan that lan of care for contractures juired for eating for 1 of 20 are plans reviewed and failed are plan for 1 of 7 residents skin alterations.		Corrected	
	Findings Include:				
	diagnoses including depression, hyperte	to the facility on 9/20/11 with g, diabetes, neurotic ension, chronic right hip pain, p infection according to the			
		a.m. R55 was observed to ssist with her noon meal and at herself.			
Vinnessis	require partial assis assistant (NA) assis sandwich, which R independently eat. and handed her a c a drink then the NA On 8/20/15 at 10:33 stated, "Some days	p.m. R55 was observed to st with eating. The nursing sting R55 handed R55 a 55 was able to hold and The NA fed R55 bites of fruit sup from which R55 could take would set back down. 5 a.m. registered nurse (RN)-C s she [R55] can totally feed her started and she finishes			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/	20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEI	NIFR	TH GRANT BC IA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 570	Continued From pa	age 9	2 570			
	and other days we depends on her da encouragement."	have to totally feed her. It y. Needs lots of				
	(DON) reviewed RS plan. "I would have not match MDS. Th certainly be on the contracture's being should be at least a increased pain." T	47 a.m. the director of nursing 55's care plan and ADL care to agree the care plan does ne change of eating should ADL care plan. The that she refused treatment, it acknowledged, reporting he DON verified contracture's need and were not included on an.				
	2/22/15 indicated F with eating, resider staff provided guide other non-weight be	Data Set (MDS) dated R55 required a limited assist at was highly involved in eating ed maneuvering of limbs or earing assist. R55 also had a in range of motion with lower ent on both sides	,			
	R55 required an ex	MDS dated 5/18/15 revealed tensive 1 person physical staff provided weight bearing				
	6/14/15 indicated F	aily living] Care Plan dated 855 needed staff set up, assist n eating, and to eat one item at				
	problem of potentia eating: "I eat all me needing occasional	2/13/12 revealed an identified al for self care deficit with eals independently after setup I cueing and assist. I am on et 1800 calorie diet. I need to at a time."				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CE	NIFR	TH GRANT BC HA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 10	2 570			
	diagnoses includin constipation, recur	to the facility on 3/13/14, with g but not limited to dementia, rent urinary tract infections, and deep vein thrombosis dmission form.				
	sitting in the units of	3 a.m. R72 was observed day room. R72 had a bruise of right hand and sterri strips				
	hydrochlorothiazide also a diuretic), Bu medication to impr pain medication).	include but not limited to, e (an antihypertensive that is udesonide (an inhaled ove breathing) and Tylenol (a Drugs.com identified bruising each of these medications.				
	Licensed practical ago nursing assista bed. R72 became	n 8/19/15, at 6:56 p.m. nurse (LPN)-E stated 2 weeks ants were getting R72 ready fo combative, striking out at staff own hand and caused two skin	r			
	"Noted Various dis hand and lower arr indicates that she l being combative, h during cares which bruising. It is also fragile on her lowe vessels being very	ed 8/10/2015, 11:29 a.m. colored areas on R72 right m." Review of charting has had multiple episodes of nitting and throwing items a may increase her risk of noted that her skin is very r arms and tops of hands with close surface of skin, for any bumps to result in				
anesota D		1/2014 read, "All m at increased risk for skin lary to inc , impaired mobility				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/	20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEI	NIFR	FTH GRANT BC HA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 11	2 570			
	and use of coumac bruising"	lin which increases my risk for				
	reviewed R72's ski resident is not curre be removed from c acknowledged that reflect residents fra discoloration, comb for bruising or skin progress note on c	care plan for skin did not agile skin, or base line pativeness, or other risk factor tears. DON pulled up omputer and showed and risks for bruising or injury	s			
	Policy for updating none provided.	care plans was requested and	ł			
	The director of nurs develop and impler related to care plan designee, could pro staff related to the revisions. The qual	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures a revisions. The DON or povide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			9/26/15
	receive nursing car custodial care, and individual needs an	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and	1			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
AME OF F	ROVIDER OR SUPPLIER		DDBESS CITY	STATE, ZIP CODE		20/2010
		1200 FIF		BOULEVARD WEST		
I ELIZA	BETH MEDICAL CE	WABASH WABASH	IA, MN 5598	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE <sup>-</sup> DATE
2 830	Continued From pa	age 12	2 830			
	4658.0405. A nurs of bed as much as written order from t	scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on interview facility failed to ens monitoring system dialysis access site	ent is not met as evidenced and document review the sure a comprehensive was in place to include care of and failed to establish al interventions for 1 of 1 viewed for dialysis.		Corrected		
	Findings include:					
	R67 had been diag Diabetes Mellitus w was hemodialysis of approach included "See dialysis care p chart for contact nu ok to use standing MOM [milk of mage blood pressure on dialysis days, NSG site for bruit every s and BP [blood press review of the chart care plan as indica monitoring for com	plan dated 4/30/14 indicated prosed with unspecific type vith renal manifestations and dependent. The care plan documentation which read, plan and standing orders in umbers and direction for care, house orders with exception of nesia] and Antacid. Do not take left arm, short sleeves on [nursing] staff to check fistula shift, monitor pre-post weight ssure] on dialysis." Further had not revealed the dialysis ted, and did not include plications, and did not include ff response to an emergency.				
		n 8/20/15, at 7:20 a.m. nursing				

IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00675	B. WING		- 08/20/201	
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	1200 FIF	TH GRANT BO	ULEVARD WEST		
	WABASH	IA, MN 55981			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE
Continued From pa	age 13	2 830			
assistant (NA)-G w complications that resident receiving c	as unable to report would be monitored for a dialysis, and what procedure				
stated dialysis educ and was unable to monitored. NA-H w information would b	cation had not been provided report what would be vas unable to report where be located to guide staff				
Memorandum of U which indicated vas been monitored for excessive bleeding	nderstanding dated 5/29/2015, scular access site should have clotting, infection, and . The memorandum included				
nurses' station reve pamphlet. Page 20 identified possible a interventions to incl	ealed a 40 page educational and 21 of the pamphlet access site problems and lude site monitoring for				
manager (CM)-B re monitor daily weigh site for thrill. CM-B specific monitoring procedures it's just been unaware a Me that had included s monitoring had bee been unaware an e monitoring for infiltr	eported licensed nursing staff it, blood pressure and fistula stated "we don't have any for bleeding or emergency like anyone else." CM-B had emorandum of Understanding pecific instructions for en in R67's chart, and had educational pamphlet included ration, swelling and pain,				
	OF CORRECTION PROVIDER OR SUPPLIER ABETH MEDICAL CEI SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From para assistant (NA)-G w complications that resident receiving of would be followed if During interview or stated dialysis educ and was unable to monitored. NA-H w information would be response to an em Further review of F Memorandum of U which indicated vas been monitored for excessive bleeding an emergency proc Review of facility din nurses' station reverse pamphlet. Page 200 identified possible at interventions to inc infiltration, swelling and clotting. On 8/20/15, at 9:35 manager (CM)-B re- monitor daily weigh site for thrill. CM-B specific monitoring procedures it's just been unaware an em- monitoring had been been unaware an em- monitoring for infiltration	OF CORRECTION       IDENTIFICATION NUMBER:         00675       00675         PROVIDER OR SUPPLIER       STREET AI         ABETH MEDICAL CENTER       1200 FIF         WABASH       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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	OF CORRECTION         IDENTIFICATION NUMBER: 00675         A. BUILDING: B. WING           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, ST 200 FIFTH GRANT BC WABASHA, MN 55981           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           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.         2 830           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 ch	OF CORRECTION       IDENTIFICATION NUMBER:       A.BUILDING:         00675       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         XBETH MEDICAL CENTER       1200 FIFTH GRANT BOULEVARD WEST WABASHA, NN 55981         SUMMARY STATEMENT OF DEFICIENCIES REQUATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIDERS PLAN OF (EACH DEFICIENCY WIST EP RECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION)       PREVIDER'S PLAN OF (EACH CORRECTIVE ACT (CROSS-REFERENCED TO D DEFICIENC         Continued From page 13       2 830         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.       PREVIDENT 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 where information would be located to guide staff response to an emergency.         Further review of R67's chart identified a Memorandum of Understanding diated 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 nurse's station revealed a 40 page educational pamphiet. 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 dialy weight, blood pressure and fistula site	OF CORRECTION       IDENTIFICATION NUMBER:       A BULDING:       COM         00675       B. WING       087         PROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE       1200 FIFTH GRANT BOULEVARD WEST         MARCH DEPICENCY MUST BE PROVIDERS PLAND OF CORRECTION RECURNOY ON LSC DESTRICTEDED BY FILL REGULATORY ON LSC DESTRICTEDED BY FILL REGULATORY ON LSC DESTRICTION NUMBER:       PROVIDERS PLAND OF CORRECTION (EXCH CORRECTION NUST BE PROVIDED BY FILL REGULATORY ON LSC DESTRICTEDED BY FILL REGULATORY ON LSC DESTRICTION SUPPOPULATE DEFICIENCY MUST BE PROVIDERS and What procedure would be followed if an emergency occurred.       PROVIDERS PLAND OF CORRECTION (EXCH CORRECTION SHOULD BE resident receiving dialysis, and what procedure would be followed if an emergency occurred.       2 830         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 where information would be located to guide staff response to an emergency.       2 830         Further review of R67's chart identified a Memorandum of Understanding dated 5/29/2015, which indicated vascular access site bould have been monitored for clotting, infection, and excessive beeding. The memorandum included an emergency procedure if page educational pamphiet. Page 20 and 21 of the pamphiet identified possible access site problems and infiltration, swelling and pain, bleeding, infection and clotting.       00 8/20/15, at 9:35 a.m. during interview clinical manager (CM). B reported licensed nursing staff monitoring for bleeding or emergency procedures if just like anyone else." CM-B had been unaware an Memorandum of Understanding that had included specific instructions for monitoring had been in R67's chart, and had b

	T OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/	20/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
T ELIZA	BETH MEDICAL CEI	NIFR	TH GRANT BC IA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
		complications to include , pain, bleeding, infection and				
	Mayo Clinic Dialysis the dialysis center I to the facility after e stated monitoring s swelling for infectio	view on 8/20/15, at 10:52 a.m. s Nurse Supervisor reported had sent an information sheet each dialysis session and hould have included pain and n, and further stated the have been monitored ding.				
	of nursing verified of	8/20/15, at 1:03 p.m. director dialysis care had not been the facility lacked an I plan.				
	interventions for rea	cedure on emergency medical sidents receiving dialysis en requested and none				
	facility could review procedures. The fa education on emerge monitoring of a dial review the care pla ensure completene committee could de	THOD OF CORRECTION: The //revise dialysis policies and cility could provide staff gency services and the lysis resident. The facility could ns of dialysis residents to ess. The quality assurance evelop and implement an at would help maintain				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			9/26/15

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
9T EI 17/	ABETH MEDICAL CEI	1200 FIF	TH GRANT E	OULEVARD WEST		
		WABASH	IA, MN 5598	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	age 15	2 965			
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document ailed to provide the physician c diet for 1 of 1 resident (R76) beutic diets.		Corrected		
	Findings included:					
	on 8/19/15, at 5:38 episode that lasted assistant (NA)-F ha the coughing episo protruding and eyes served regular con- chunks of tomatoes assistant (DA)-C ve soup was wrong ar pudding thick. At 5: had prepared the s was not supposed [referencing the tor pieces]" and explai pureed and then th	erved during an evening meal p.m. R76 had two coughing 45 seconds each after nursing ad given bites of food. During de R76's tongue had been s were moist. R76 had been sistency tomato soup with s. At 5:57 p.m. dietary erified the consistency of the d stated it should have been 59 p.m. DA-D indicated she oup incorrectly and stated, "It to have the chunks nato soup with solid tomato ned it should have been ickened. At 6:29 p.m. NA-F given R76 a bite of soup that	3			
	had a piece of tom coughed the soup	ato, then realized after R76 was supposed to be pureed, '6 a bite of only the liquid soup				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		1200 FIF		OULEVARD WEST		
SI ELIZA	ABETH MEDICAL CE	WABASH	IA, MN 55981			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 16	2 965			
	NA-F further stated soup with the correct thought it had been get a new bowl of s notified the nurse of 6:48 p.m. registere been made aware	been the wrong consistency. I she had not replaced the act consistency because in too late in the meal service to soup. NA-F stated she had not of the coughing episode. At d (RN)-G stated she had not of the coughing episode during wed up with a respiratory				
	at 7:57 a.m. R76's and diet butterscott consistency of app butterscotch puddin times and given a b gave another bite of again coughed. Wh consistency of the picked up the spoo pudding dripped of pudding thick, it co tested the hot cere NA-I stated the corr supposed to be cho residents. During a the certified dietary pudding consistent on the spoon when	meal observation on 8/20/15, meal tray included hot cereal ch pudding both with a lesauce. NA-I gave bite of ng, R76 coughed a couple of bite of thickened water. NA-I of butterscotch pudding, R76 nen NA-I was asked the butterscotch pudding, NA-I n and tipped it, butterscotch f the spoon and stated, "It's uld be a little thicker." NA-I al and made the same remark. isistency of the food is ecked prior to giving to n interview at 8:33 a.m. with manager (CDM)-E stated by is correct when food stays i tipped and beverages in a glass when tipped upside				
	6/26/15 indicated s was dependent on that included but w Syndrome, and rec diet. In addition the	nimum Data Set (MDS) dated evere cognitive impairment, staff for eating, had diagnoses as not limited to Downs juired a mechanically altered MDS indicated R76 held food r had residual food in mouth				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00675	B. WING		08/20/2015		
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
T FI 17/	ABETH MEDICAL CE	NTER 1200 FIF	TH GRANT BC	ULEVARD WEST			
		WABASH	HA, MN 55981			1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 965	Continued From pa	age 17	2 965				
	after meals and co or when swallowing	ughed or choked during meals g medications.					
	completed 1/12/15 resident was totally and required puddi pureed diet. The C	ssessment (CAA) last with annual MDS indicated dependent on staff for feeding ng thick liquids and had a AA did not identify R76 had a agia (difficulty swallowing).	9				
	8/20/15. The copy 3/21/13, the "feedir written changes in to follow because of chronological order to read. It was deter informed staff R76 eating, required pu a pureed diet. The dysphagia and hist accident (stroke). T risk for aspiration/of evaluation from the held food in mouth	by ided by the facility on provided had a print date of ng" plan of care had hand the margins that were difficult changes since 2013 were not in r and hand writing was difficult ermined the current care plan was dependent on staff for dding thick liquids, and was on care plan identified R76 had ory of cerebral vascular The care plan did not identify choking and did not include the e quarterly MDS indicating R76 and coughed/choked during n swallowing medications.					
	the facility on 8/20/ pureed diet with pur nursing assist care information from th food in mouth or co times or when swa Furthermore, the co	stant care sheet provided by 15 informed staff R76 required adding thick liquids. The e sheet did not include the be MDS that indicated R76 held bughed/choked during meal llowing medications. are sheet did not include ther identified swallowing					
		ders provided by the facility on 1500 calorie, pureed with					

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00675	B. WING		08/20/2015	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• • • • •	
ST ELIZ	ABETH MEDICAL CE	NIFR	TH GRANT BC IA, MN 55981	DULEVARD WEST		
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	age 18	2 965			
	Nutritional assess R76 had a pureed and required assist assessment also re- with meals". During an interview RN-B stated R76's thick after a dieticial because of increase times. RN-B verified been in the care pl episodes of chokin further explained, " aspiration risk if the consistency." RN- involved related to of attorney. During an interview director of nursing consistency should stated, ideally the of aspiration/coughing interventions.	pudding thick liquids." nent dated 6/23/15 indicated diet with pudding thick liquids tance from staff. The ead, "does do some coughing v on 8/20/15, at 10:48 a.m. diet was changed to pudding an's recommendation on 8/6/14 sed coughing during meal ed diagnoses of dysphagia had an without any interventions fo g/coughing/aspiration. RN-B 'We assume people are ey are on a therapeutic liquid B stated speech had not been preference of medical power v on 8/20/15, at 12:13 p.m. (DON) stated the correct diet d have been served. DON care plan would identify g and include the appropriate	r			
	Term Care last rev R.D. [registered die nutritional status and prescribed diet ord plan is individualized of the consistency and aspiration, to r statusDysphagi with diagnosed, do	ralized Diet Guidelines for Long iewed 6/2014 read, "A qualified etician] will assess residents' nd appropriateness of the ler so that each nutrition care ed for each residentthe goal alteration is to prevent choking maintain normal nutritional a-primarily used for residents ocumented swallowing msall thickened liquids and				
	texture that the res	s are provided at the degree to sident can safely tolerate as fessional monitoring the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00675	B. WING		08/	20/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ST ELIZ	ABETH MEDICAL CEI	NTER	TH GRANT BC HA, MN 55981	OULEVARD WEST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	lge 19	2 965			
	The facility could de mechanically altere nursing staff. The c develop and perfor	THOD OF CORRECTION: evelop and present ed diet education to dietary and certified dietary manager could m period audits of staff to being served with the (s).				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			9/26/15
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service e	and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in r detection, investigation, and s of infectious diseases; d precautions systems to smission of infectious agents; ducation in infection				
	immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 465 G. a system fo H. a system fo	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as	5			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEI	NIER	TH GRANT E HA, MN 5598	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 20	21390			
	incontinence produ I. methods for	-				
	by: Based on observat review, facility faile hygiene practice wa	ent is not met as evidenced ions interview and record ed to ensure proper hand as used to prevent the spread 1 resident (R72) observed for cares.		Corrected		
	Findings include:					
	during continuous of ready for bed. Nurse the wet incontinent gloves, brief fell to up and threw it in w hands NA-A continu- then removed R72' towels from bedsid towel, removed R72 R72. NA-A continue removed R72's par area than removed washed her hands.		f			
	stated the correct w "get hands wet, ap	n 8/19/15, at 7:25 p.m. NA-A, way to do hand washing was ply soap, scrub for 20 seconds ry hands, get new towel and	,			
	stated, "I expect sta clean dry towel afte	n 8/20/15, at 8:10 a.m. DON aff to turn off the water with a er washing their hands. I would nge their gloves and wash their				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00675	B. WING	B. WING		08/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ST ELIZ	ABETH MEDICAL CE	NIER	TH GRANT BO	OULEVARD WEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	age 21	21390				
	hands after picking from the floor."	a soiled incontinence pad					
	Registered Nurse ( nurse, when asked change and hand h stated NA-A should before touching the	n 8/20/15, at 10:04 a.m. (RN)-D the Infection control I her expectation for glove hygiene during R72's cares she I have taken off her gloves e glasses and wash her hands going from dirty to clean.	9				
	The director of nurs	THOD OF CORRECTION: sing could in-service all staff hygiene practice to prevent the when caring for residents.	,				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			9/26/15	
	maintain a compre infection control pro- current tuberculosi issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provide	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines.					
	(b) Written compli- be maintained by th	ance with this subdivision mus ne nursing home.	t				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ABETH MEDICAL CEI	NTER		DULEVARD WEST		
040 15			IA, MN 55981			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ige 22	21426			
	by: READY FOR REVI Based on interview facility failed to ens testing (TST) was a residents (R45, R9) residents (R57, R9) two-step TST with b interpretation readin 1 of 6 residents (R4 baseline tuberculos facility failed to ens E-B, E-C, E-D) rece testing with both ind reading results; and employees (E-E) recently the second testing results; and	and document review the ure a two step tuberculin skin administered for 2 of 6 0); failed to ensure 4 of 6 0, R115, R117) ) received both induration and ng results; and failed to ensure 45) had a completed a sis screen; in addition the ure 4 of 6 employees (E-A, eived two-step tuberculin skin duration and interpretation d failed to ensure 1 of 6 eccived a two-step TST. This effect all 73 residents in the		Corrected		
	R45 was admitted t received her first T this TST were not r	to the facility on 2/23/15. R45 ST on 2/23/15, the results of ecorded. A baseline om screen was requested but				
	medication adminis 2015 indicated a "s administered on 7/2 a 0 mm reading, lac	to the facility on 7/22/15. R90's stration record (MAR) for July tep 2 Tubersol PPD" was 25/15 and read on 7/27/15 with cking interpretation. The date ep one TST was not found.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00675	B. WING		08/20/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ELIZA	BETH MEDICAL CE	NIER	TH GRANT BC IA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 23	21426			
	Record review india TST was administer note in the chart with (CM)-A, dated 7/27 protein derivative, re- latent TB] both step facility and were nee [millimeter reading] [positive/negative] T R115 was admitted R115's MAR revea was administered of with a negative rea R117 was admitted R117's MAR revea was administered of with a negative rea E-A started at the f a TST on 3/19/15 v E-B started at the f a first step TST on interpretation. A se which lacked interp E-C started at the f a first step TST on TST on 7/10/15. Both E-D started at the f	to the facility on 7/27/15. cated a first and second step pred on 4/27/15 and 5/11/15. A ritten by clinical manager 7/15, indicated; "PPD [purified method used to diagnosis of 1 and 2 given at previous egative." No induration and interpretation reading results were provided. It to the facility on 7/1/15. led "Tubersol PPD step two" on 7/15/15 and read on 7/17/15 ding, lacking induration. It to the facility on 8/10/15. led "Tubersol PPD step one" on 8/10/15 and read on 8/12/15 ding, lacking induration. acility on 3/23/15. E-A received 4/29/15 which lacked cond TST was given 6/5/15 oretation and induration. facility on 7/1/15. E-C received 6/27/15 and a second step oth TST's lacked interpretation facility on 3/23/15. E-D o TST on 3/13/15 and a on 4/15/15. Both TST's lacked	5			
	E-E started at the f	acility on 7/20/15. E-E received	4			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00675	B. WING		- 08/20/2015		
JAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		1200 FIF		OULEVARD WEST			
	ABETH MEDICAL CE	WABAS	HA, MN 55981				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	age 24	21426				
	the time frame prio first step TST also	2/23/15, which was outside of r to starting at the facility. The lacked any reading results. A vas administered and read on					
		p.m. the director of nursing ne reading is negative there surement."					
	about R57's TST re "I would have to ca	p.m. the DON was asked esults from a previous facility; Il to know what their note tation would be that they would a problem."	t				
	she did not know th and the second TS documented/admir also verified R45 d "I thought we were Department of Hea	nistered incorrectly. The DON id not have her first TST read. following MDH [Minnesota alth] guidelines." The DON aware the results required both					
	Control Plan dated Page 11, "Baseline associates except required to begin to at the time of the p test must be read 4 physicianIf associ	TB Screening: All new known positive reactors are wo-step tuberculin skin testing replacement evaluationThe 48-72 hours later by a nurse or ciate provides written evidence re TST within the past year, thi	e				
	Test dated 7/20/11	cy, Resident Tuberculin Skin ion only is considered in					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00675	B. WING	B. WING		20/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CE	NIFR	TH GRANT BC HA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From pa interpreting the tes	t.	21426			
	be measured and r	e diameter of induration should recorded in millimeters."				
	Tuberculosis Contr Settings, A guide for	nent of Health, Regulations for rol in Minnesota Health Care or implementing tuberculosis gulation in your facility, dated				
	Page 10, Screenin General principles, include the date of the number of milli	g Health Care Workers, "TST documentation should the test (i.e.month, day, year), meters of induration (if no				
	(i.e., positive or neg "An employee may after a negative TE negative IGRA or T	ent "0" mm) and interpretation gative). Baseline TB screening begin working with patients symptom screen and a FST (i.e., first step) dated withir				
	principles, "Screen 72 hours of admiss admissionTST de	g Residents, General ing should be initiated within sion or 90 days prior to ocumentation for residents				
	the number of milli	date (i.e., month, date, year), meters of induration (if no ent "0" mm), and interpretation gative).				
	The director of nur policies and procee The director of nur	THOD OF CORRECTION: sing could review tuberculosis dures to ensure compliance. sing could educate nursing as and procedures for				
	employee and resident and tuberculosis second ongoing tuberculosis	dent tuberculosis skin tests creens and provide all staff sis training. The director of itor staff compliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVE COMPLETED	
		00675			08/	20/2015
IAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEN	NTER	H GRANT BO A, MN 55981	ULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21530	A. The drug regim reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ad report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician. If the med the attending physic justification for the o physician does not must be referred fo assessment and as by part 4658.0070.	D A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. director of nursing services hysician, and these reports n by the time of the next boner, if indicated by the urposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur t's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must he medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist	21530			9/26/15

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/20/2015	
		00675	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
T ELIZA	ABETH MEDICAL CEI	NTER	TH GRANT E HA, MN 5598	OULEVARD WEST		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLET DATE
21530	Continued From pa	ge 27	21530			
	by:	ent is not met as evidenced and document review the		Corrected		
	identified irregularit medication docume	ure the consulting pharmacist ies for as needed (PRN) entation for 1 of 3 residents unnecessary medication use.				
	according to the fac the following diagno electronic medical	to the facility on 2/28/2014 cility admission record and had oses according to the facilities record: mononeuritis, varicose gedema, arthropathy, and				
	osteoarthrosis. R21's electronic ph the facility on 8/19/ (narcotic-like pain r mouth as needed to	ysician's orders provided by				
	informed staff R21 ankle, and shoulde to offer warm/cold	ovided by the facility on 8/19/19 had chronic pain in right foot, r. The care plan directed staff backs for break through pain. dministration record was	5			
	reviewed from 6/7/ <sup>-</sup> indicated a total of had been administered were administered	15 through 8/20/15; the record twelve doses of PRN Ultram ered. Of the twelve doses that it was not evident in the				
	had been attempted of the doses. It was not evident in	-pharmacological intervention d and/or documented for eight n the medical record the cist had identified the lack of				
	documentation of a non-pharmacologic					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00675	B. WING		08/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ELIZA	ABETH MEDICAL CE	NTER	TH GRANT BO HA, MN 55981	DULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 28	21530			
	registered nurse (F medications should non-pharmacologic effectiveness was. During an interview director of nursing had been to attemp of non-pharmacolo administration of a Multiple and unsuc contact the consult Facility policy that current standards of	v on 8/19/15, at 3:31 p.m. the (DON) stated her expectation of and document effectiveness ogical interventions prior to the II PRN medications. ccessful attempts were made to ting pharmacist for interview. was obtained did not reflect of the utilization of cal interventions prior to the				
	The administrator, consulting pharma policies and procee medication usage. educated as neces pharmacist's review with the pharmacis reviews on a regula	THOD OF CORRECTION: director of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the w. The DON or designee, along t, could audit medication ar basis to ensure compliance. R CORRECTION: Twenty-one				
21535	MN Rule4658.131 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535			9/26/15
	must be free from unnecessary drug	al. A resident's drug regimen unnecessary drugs. An is any drug when used: e dose, including duplicate drug ve duration;	)			

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STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00675	B. WING		08/	20/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CE	NIER	TH GRANT E IA, MN 5598	BOULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 29	21535			
	which indicate the discontinued. In addition to the of part 4658.1310, th with provisions in t Code of Federal R 483.25 (1) found in Operations Manua Long-Term Care F Department of Hea Health Care Finand This standard is in available through t	ence of adverse consequences dose should be reduced or drug regimen review required in he nursing home must comply he Interpretive Guidelines for egulations, title 42, section a Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on observative facility for the facility of the facility of the facility for the fact the following diagon electronic medical veins with lower less osteoarthrosis. R21's electronic physical statements of the fact the following for the fact the fact the following diagon electronic medical veins with lower less osteoarthrosis. R21's electronic physical statements of the fact the following for the fact the	tion, interview, and document ailed to ensure 1 of 5 residents titration or a physician's a dose reduction was this time and failed to ensure non-pharmacological measures the administration of PRN (as n for 1 of 3 residents (R21) to the facility on 2/28/2014 cility admission record and had oses according to the facilities record: mononeuritis, varicose g edema, arthropathy, and hysician's orders provided by '15 included Ultram		Corrected		

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00675	B. WING		08/20/2015	
	PROVIDER OR SUPPLIER		DBESS CITY S	TATE, ZIP CODE	00//	20/2013
	ABETH MEDICAL CEI	NTER 1200 FIFT	TH GRANT BO	DULEVARD WEST		
	SUMMARY ST		IA, MN 55981	PROVIDER'S PLAN OF CC		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLET DATE
21535	Continued From pa	age 30	21535			
nnesota D	(PRN) for pain. R21's care plan pro- informed staff R21 ankle, and shoulde to offer warm/cold p R21's medication a reviewed from 6/7// indicated a total of had been administered medical record if no intervention had be the medication for of During an interview registered nurse (F medications should non-pharmacologic effectiveness was.' During an interview director of nursing had been to attemp of non-pharmacologic administration of al Facility policy that we current standards of non-pharmacologic administration of P SUGGESTED MET The director of nurs responsible for met dose reduction and compliance.	d be documented with cal interventions and what the v on 8/19/15, at 3:31 p.m. the (DON) stated her expectation of and document effectiveness gical interventions prior to the II PRN medications. was obtained did not reflect of the utilization of cal interventions prior to the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (*	(X3) DATE SURVEY COMPLETED	
		00675	B. WING		08/20/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
T ELIZA	ABETH MEDICAL CEI	NIFR	TH GRANT E A, MN 5598	OULEVARD WEST 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
21610	Continued From pa	age 31	21610			
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610		9/26/15	
	must store all drugs under proper tempe	e of drugs. A nursing home s in locked compartments erature controls, and permit rsing personnel to have				
	by: Based on observat review facility failed	ent is not met as evidenced ion, interview, and record to ensure non-licensed staff ervised access to 1 of 3		Corrected		
	Findings include:					
	observation a hous mopping the floor of behind the nurses of facility nurse or train nurses station or in Licensed practical	B a.m. During a random sekeeper was observed of the Medication room located station. There was not a ned medication aide at the the medication room. nurse (LPN)-B was observed layroom talking with residents				
	stated, "It is my nor housekeeper be in or TMA [trained me LPN-B verified the medication room, w housekeeper was i stated that the med Coumadin, antibiot	n 8/20/15, at 9:30 a.m. LPN-B rmal practice to let the the drug room without a nurse edication assistant] present." medication cart, located in the vas unlocked while the n the medication room. LPN-B dication cart contained ics, antipsychotics, antianxiety, d insulin along with other ns.				
	During an interview	<i>i</i> on 08/20/2015, at 12:19 the				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00675	B. WING	B. WING		20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CEI	NIFR	TH GRANT BO HA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE
21610	Continued From pa	age 32	21610			
	need to be secured the expectation the	(DON) stated medications I. In addition, The stated it is nurse would be in the vicinity nsed staff while in the				
	Storing of Medication staff: "POLICIES: locked in a designate able to be distributed medication. Medic	facility staff, Receiving and ons dated 7/16/13, instructs All medications are to be kept ated area when received until ed to the appropriate ations are not to be left ounter or nurses desk."				
	The facility could re procedures. The fa present staff educa committee could de	THOD OF CORRECTION: eview/revise policies and cility could develop and tion. The quality assurance evelop and implement audits to dically to ensure on-going	D			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			9/26/15
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				
	by: Based on observat	ent is not met as evidenced ion, interview, and record ailed to ensure 4 of 6 resident	s	Corrected		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00675	B. WING			08/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	ABETH MEDICAL CE	NIFR	TH GRANT BO HA, MN 55981	OULEVARD WEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pr	200.00	21805	DEFICIENC	Y)		
21005		R55) were assisted with eating	21003				
	Findings include:						
	p.m. nursing assist sitting between R4 barrier gloves while Neither R42 or R70 food. Both resident R76 was admitted according to the fa quarterly Minimum	e observed on 8/19/15, at 5:22 tant (NA)-F was observed 2 and R72 wearing rubber e assisting R42 and R76 to eat 6 had a sandwich or finger ts had a puree diet. to the facility on 2/27/2013, cility admission record. R76's Data Set (MDS) dated 6/26/15					
	dependent on staff included but was n and required a mer addition the MDS i mouth/cheeks or h meals and coughe when swallowing n R76's care plan wa 8/20/15. The copy	as provided by the facility on provided had a print date of	,				
	staff, R76 was dep required pudding the pureed diet. The ca	ng" plan of care plan informed endent on staff for eating, hick liquids, and was on a are plan identified R76 had cory of cerebral vascular					
	according to the fa annual MDS dated cognitive impairme eating, had diagno	to the facility on 3/13/2009, cility admission record. R42's 5/24/15, indicated severe ent, was dependent on staff for ses that included but was not er disease, and required a					

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00675	B. WING		08/	20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST ELIZ	ABETH MEDICAL CE	NIER	TH GRANT BC IA, MN 55981	OULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 34	21805			
	5/26/15, the nutritic staff, R42 was fed thick liquids, and w plan identified R42 During an Interview stated she had wor thought we had to. wearing gloves to a entire meal could b During an interview director of nurses s have a barrier of so touch food, if the re drool or coughing.	y on 8/20/15 at 7:27 a.m. the stated she would expect staff to ome sort if they were going to esident was having a lot of However, the wearing gloves s not the norm and I would not				
	located on the 200 assisted with eating offering fluids and while wearing barri	erved 8/19/15, at 5:43 p.m. Wing dining hall being g. NA-C was seen to be assisting with eating, all the er gloves. NA-C did not during the entire dining ).				
	eat on 8/19/15 at 5 assisted with eating stopped assisting a returned to assistin The other two NA's	erved while being assisted to :25 p.m. R55 was being g by a NA. The NA then and got up, applied gloves, and ig R55 with the rest of meal. assisting residents with eating ting and applied gloves.				
	Registered Nurse ( stated that the exp	v on 8/20/15, at 10:04 a.m. (RN)-D Infection control nurse, ectation for use of gloves wher to eat was if there were a lot				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00675	B. WING		08/20/2015	
AME OF F	PROVIDER OR SUPPLIER	4	DDRESS, CITY, ST	TATE ZIP CODE		
	ABETH MEDICAL CE	NTER 1200 FIF		DULEVARD WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 35	21805	DEHOIENOI	)	
	when they want to, why. RN-D then sa wear gloves." RN-I to wearing gloves Policy was request assisting resident t SUGGESTED ME <sup>-</sup> The director of nur employees on the settings.	f are told they can wear gloves just let the residents know uid, "If it is wet and not yours D questioned why they chose during the entire meal time. ted for use of gloves when to eat and none was provided. THOD OF CORRECTION: sing could in-service all need to promote dignity in all R CORRECTION: Twenty-one				