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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L76H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00339

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245327**
2.STATE VENDOR OR MEDICAID NO.
(L2) **448415000**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE HEALTH CENTER**
(L4) **312 EAST GEORGE ST PO BOX 136**
(L5) **IVANHOE, MN** (L6) **56142**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/15/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **25** (L18)
13.Total Certified Beds **25** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	25			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Angela Hatch, HFE NE II 12/05/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/01/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

December 3, 2018

Administrator
Divine Providence Health Center
312 East George St. PO Box 136
Ivanhoe, MN 56142

RE: Project Number S5327030

Dear Administrator:

On November 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. .

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 25, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (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 (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 February 15, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by May 15, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was conducted on 11/13/18 through 11/15/18, during a recertification survey. The facility is in compliance with Appendix Z, Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/13/18 through 11/15/18, a standard survey was completed at your facility by the Minnesota Department of Health. Divine Providence Health Center was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		12/6/18

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

Electronically Signed | 12/07/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142

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F 755	Continued From page 1 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Novolog insulin pen was appropriately primed prior to administration for 1 of 1 resident (R15). In addition, the facility failed to ensure parameters were developed for as needed (PRN) Nabumetone (non-narcotic pain reliever) and Flexeril (muscle relaxer), for 2 of 5 residents (R1 and R14). Findings include:	F 755	Corrective Action as it applies to others: Subcutaneous Injection Policy was reviewed with all nurses at Nurses meeting on 12-6-18. Order clarification form created and reviewed with all nurses at nurses meeting on 12-6-18. Immediate corrective action: Insulin Pen Instructions were reviewed with LPN-A immediately. Copies of the instructions were placed in all nurses mailboxes and were reviewed at the	

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	245327	A. BUILDING _____ B. WING _____	11/15/2018

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F 755	Continued From page 2 During an observation of medication administration on 11/13/18 at 6:33 p.m., licensed practical nurse (LPN)-A prepared to administer insulin to R15 via a Novolog Flex Pen. R15's blood glucose reading was 241, indicating R15 was to receive 6 units of Novolog. LPN-A removed the pen from the medication cart, wiped the top of the pen with an alcohol pad, opened and attached a new needle onto the pen. She then dialed the dosage to 6 units. When asked why she had not primed the pen first, according to manufacturer's instructions, LPN-A stated she though insulin pens only needed to be primed when opened for the first time and was unaware of any other guidance. During interview with the director of nursing (DON) on 11/13/18 at 6:43 p.m., the DON confirmed staff were supposed to prime insulin pens according to the manufacturer's instructions prior to administering insulin. Review of the facility's current policy, Injections, Subcutaneous, indicated if staff used an insulin pen for insulin injection, they were to prime the needle with a minimum of 2 units prior to setting the unit dosage amount and administering to the resident. Review of the manufacturer's March 2017, Novolog Flexpen Prescribing Information included: (1) Wipe the top of the pen with an alcohol pad and attach the needle, removing both outer and inner caps. (2) Before each injection small amounts of air may collect in the cartridge during normal use. (3) To avoid injecting air and to ensure proper dosing, prime the pen with 2 units of air prior to	F 755	nurses meeting on 12-6-18 along with the Subcutaneous Injection Policy. All Residents medication records were audited by DON on 11-24-18 and clarification forms were sent to all doctors to clarify multiple dose orders. New orders were received for all residents by 11-28-18 including R1 and R14. Education was provided on clarifying medication orders that contain multiple doses and the new order clarification form at the nurses meeting on 12-6-18. Continued monitoring to prevent recurrence: DON will audit 3 insulin administrations a week for a month then 5 insulin administrations a month for 3 months. Subcutaneous Injections policy will be reviewed annually with nurses and upon hire with new nurses. Medication order audit will be completed on all new orders weekly for one month then monthly for 3 months. Audit results will be reviewed and tracked monthly at QAPI meetings for the next year.	

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	245327	A. BUILDING _____ B. WING _____	11/15/2018

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F 755	Continued From page 3	F 755		

dialing the ordered dose of insulin by turning the dose selector to select 2 units.
(4) Hold the Novolog Flexpen with the needle pointing up.
(5) Tap the cartridge gently a few times to make any air bubbles collect at the top of the cartridge.
(6) While keeping the needle pointing upwards, press the push-button all the way in so the dose selector
returns to 0.
(7) A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure
no more than 6 times.
(8) Administer the insulin as ordered.

R1's admission record identified an admision date of 10/5/17, and indicated R1 had been admitted with diagnoses including:: cerebral palsy, depressive episodes, dysphasia (difficulty swallowing), and restless leg syndrome.

Further review of R1's medical record, indicated a current physician's order for Nabumetone 500 milligrams (mg) 1/2 to 1 tablet by mouth BID (twice daily) PRN (as needed) for pain related to a diagnoses of peripheral neuropathy (nerve pain). The order included no direction for when staff would administer a half or a whole tablet. R1's medication administration record (MAR) indicated he had received Nabumetone 5 times between 11/7 and 11/13/18. There was no documentation as to whether R1 received a half or a whole tablet.

The medical record indicated R1 had intact cognition. During interview with licensed practical nurse (LPN)-A on 11/14/18 at 11:00 a.m., LPN-A stated R1 decides how much medication she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING _____ B. WING _____	11/15/2018

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F 755	Continued From page 4	F 755		

feels she needs, either a half or a whole tablet, and staff administer the Nabumetone according to her request.

R14's admission record indicated the resident was admitted on 8/22/18, with diagnoses including: multiple traumatic fractures, cellulitis of the left upper limb, and pain for therapy and rehabilitation.

Review of R14's medical record indicated a physician's order for Flexeril (cyclobenzaprine HCL), 5 to 10 mg (1/2 to 1 tablet) three (TID) times daily, as needed for muscle spasms. The order included no direction for when staff would administer a half or a whole tablet. Review of R14's November 2018 MAR, indicated she'd received the medication 18 times between 11/1 and 11/14/18. There was no documentation as to whether R14 had received a half or whole dose of the Flexeril.

The medical record indicated R14 had intact cognition. During interview with LPN-A on 11/14/18 at 11:05 a.m., LPN-A stated R14 usually only took a half tablet of Flexeril, but was able to tell staff how much medication she needed, either a half or whole tablet, and staff administer the requested dose of Flexeril.

The director of nursing (DON) stated during interview on 11/14/18, at 4:32 p.m. her expectation was staff would clarify medication orders to indicate parameters for what dose of medication should be administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE HEALTH CENTER	**312 EAST GEORGE ST PO BOX 136** **IVANHOE, MN 56142**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Divine Providence Health Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Divine Providence Health Center is a one-story building, constructed in 1967. It has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an outpatient medical clinic and an assisted living facility by 2-hour fire wall assemblies, with opening protective's consisting of labeled, self-closing, positive latching 90-minute fire-rated door assemblies.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with battery-operated smoke alarms.

The facility has a capacity of 25 beds and had a census of 23 at time of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245327	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2018**

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DIVINE PROVIDENCE HEALTH CENTER	**312 EAST GEORGE ST PO BOX 136** **IVANHOE, MN 56142**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).	K 753	On 11/14/2018 the candle was removed and a battery light was set in place. The chapel volunteers and the Father of the local church were communicated to regarding the change and the need to use a battery light for all candles in the chapel. The Administrator also communicated the change to the management and facility staff as well. The Operations Manager also has done daily checks to ensure that the candle has not been replaced.	11/14/18

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	245327	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2018**

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K 753	Continued From page 3 o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6. This deficient practive could affect 23 out of the 23 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/14/2018, during the inspection, a lit candle was observed in the Chapel. There were no staff in the area. This deficient practice was verified by the Facility Maintenance Director.	K 753		
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: This deficient practice could affect 37 of 37 residents. Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This deficient practice could affect 23 of 23 residents.	K 781	On 11/14/18 the heating unit was removed from the tub room in the facility. We have communicated the reason to the residents, families and staff. The Operations Manager is working with the Fire Marshall for a replacement unit that will meet all codes and safety features.	11/14/18

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K 781	Continued From page 4 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/14/2018, a portable heating device was observed in a Tub Room. This deficient practice was verified by the Facility Maintenance Director.	K 781		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced	K 920		11/14/18

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K 920	Continued From page 5 by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 23 of the 23 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/14/2018, during the inspection, a power strip was observed in the staff break room with a microwave and toaster plugged into it.	K 920	On 11/14/18 the Operation Manager removed the power strip from the staff break room. He then plugged both the microwave and toaster directly into the wall. The Administrator communicated the change to all staff. The Operations Manager will audit weekly to ensure that the equipment remains plugged directly into the wall.	

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K 920	Continued From page 6 This deficient practice was verified by the Facility Maintenance Director.	K 920		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 3, 2018

Administrator
Divine Providence Health Center
312 East George St. PO Box 136
Ivanhoe, MN 56142

Re: State Nursing Home Licensing Orders - Project Number S5327030

Dear Administrator:

The above facility was surveyed on November 13, 2018 through November 15, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	00339	A. BUILDING: _____ B. WING _____	11/15/2018

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 11/13/18 through 11/15/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) skin testing (TST) and symptom screenings were completed for 2 of 5 new employees (LPN-A and DM-B); and 1 of 5 newly admitted residents (R7).	21426	Corrective Action as it applies to others: TB Program Policy reviewed with all nurses at the nurses meeting on 12-6-18 and with all staff on 12-20-18 at the all staff meeting.	12/20/18

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21426	Continued From page 3 Findings include: Personnel record review indicated dietary manager (DM)-B was hired on 7/25/18. Review of DM-B's employee file indicated step-one of a TST was read on 10/6/18 with a negative result. There was no mention of the date or time the first-step TST was administered to DM-B, and no subsequent second step was documented as performed, nor was a symptom screening performed to ensure DM-B was free from signs and symptoms of active TB. During interview with the director of nursing (DON) on 11/15/18 at 12:56 p.m.,the DON stated the paperwork from DM-B's TST had been lost. The DON said when the nursing staff went to read DM-B's test results 48-72 hours later, they could not find the original form documentation, so just wrote DM-B's results on a new form. The DON verified no second-step TST had been completed yet. Personnel record review indicated LPN-A was hired on 9/24/18. Review of LPN-A's employee file indicated no TST was administered until 11/14/18. In addtion, there had been no symptom screen assessment performed to ensure LPN-A was free from signs and symptoms of active TB. The DON stated during interview on 11/14/18 at 2:55 p.m., that she'd first taken over the responsibility of infection control coordinator role on 10/30/18. The DON said during an audit completed at that time, she'd discovered there were staff who had not been appropriately screened for TB upon hire. However, she verified she had not immediately taken measures to correct this issue at that time she'd identified it. The DON said she'd been working many hours	21426	Immediate Corrective action: DON completed an audit on all employee TB records and notified employees that need to redo their TB test. New baseline TB screening tool for HCW and residents from MDH will be implemented in December after the nurses meeting on 12-6-18. TB program policy will be reviewed with nurses on 12-6-18 at nurses meeting and with all staff on 12-20-18 at the all staff meeting. New TB skin test notification form was created and will be placed in the new employee folders. Nurses will be educated on these forms on 12-6-18 at the nurses meeting. Continued monitoring to prevent recurrence: DON will audit all new employee and resident TB skin tests for the next 3 months. All audit findings will be reviewed at the monthly QAPI meeting. DON will continue to track new employee and resident TB compliance for the next year and review monthly at QAPI.	

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21426	Continued From page 4 on the floor so had not gotten this issue taken care of yet.. R7 admission record indicated an admit date of 1/3/18. Review of the resident's TB screening record indicated a first-step TST had not been administered until 1/20/18 and there had been no second-step administered, nor symptom screening performed. The DON confirmed during interview on 11/15/18 at 1:45 p.m., the TST and symptom screening for R7 had not been completed in a timely manner. Review of the facility's August 2016 policy, TB Program, indicated all employees were to have a TB assessment and negative TST before the first day of assigned duties including a symptom screen. The policy furhter indicated newly admitted residents were to have the first TST within 72 hours of admission, or within 90 days prior to admission, with a second step TST administered within 14 days. The policy also confirmed residents were also to have a symptom screening to ensure they were free of signs and symptoms of TB. SUGGESTED METHOD OF CORRECTION: The DON and/or designee, could review policies and procedures related to the screening and testing for tuberculosis for residents and employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step TST process. The DON and/or designee could audit resident admissions, and new employee files, to ensure compliance. Results could be taken forward to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for any ongoing monitoring.	21426		

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21426	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Novolog insulin pen was appropriately primed prior to administration for 1 of 1 resident (R15). In addition, the facility failed to ensure parameters were developed for as needed (PRN) Nabumetone (non-narcotic pain reliever) and Flexeril (muscle relaxer), for 2 of 5 residents (R1 and R14). Findings include: During an observation of medication administration on 11/13/18 at 6:33 p.m., licensed practical nurse (LPN)-A prepared to administer insulin to R15 via a Novolog Flex Pen. R15's blood glucose reading was 241, indicating R15	21525	Corrective Action as it applies to others: Subcutaneous Injection Policy was reviewed with all nurses at Nurses meeting on 12-6-18. Order clarification form created and reviewed with all nurses at nurses meeting on 12-6-18. Immediate corrective action: Insulin Pen Instructions were reviewed with LPN-A immediately. Copies of the instructions were placed in all nurses mailboxes and were reviewed at the nurses meeting on 12-6-18 along with the Subcutaneous Injection Policy. All Residents medication records were audited by DON on 11-24-18 and clarification forms were sent to all doctors	12/6/18

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21525	Continued From page 6 was to receive 6 units of Novolog. LPN-A removed the pen from the medication cart, wiped the top of the pen with an alcohol pad, opened and attached a new needle onto the pen. She then dialed the dosage to 6 units. When asked why she had not primed the pen first, according to manufacturer's instructions, LPN-A stated she though insulin pens only needed to be primed when opened for the first time and was unaware of any other guidance. During interview with the director of nursing (DON) on 11/13/18 at 6:43 p.m., the DON confirmed staff were supposed to prime insulin pens according to the manufacturer's instructions prior to administering insulin. Review of the facility's current policy, Injections, Subcutaneous, indicated if staff used an insulin pen for insulin injection, they were to prime the needle with a minimum of 2 units prior to setting the unit dosage amount and administering to the resident. Review of the manufacturer's March 2017, Novolog Flexpen Prescribing Information included: (1) Wipe the top of the pen with an alcohol pad and attach the needle, removing both outer and inner caps. (2) Before each injection small amounts of air may collect in the cartridge during normal use. (3) To avoid injecting air and to ensure proper dosing, prime the pen with 2 units of air prior to dialing the ordered dose of insulin by turning the dose selector to select 2 units. (4) Hold the Novolog Flexpen with the needle pointing up. (5) Tap the cartridge gently a few times to make any air bubbles collect at the top of the cartridge.	21525	to clarify multiple dose orders. New orders were received for all residents by 11-28-18 including R1 and R14. Education was provided on clarifying medication orders that contain multiple doses and the new order clarification form at the nurses meeting on 12-6-18. Continued monitoring to prevent recurrence: DON will audit 3 insulin administrations a week for a month then 5 insulin administrations a month for 3 months. Subcutaneous Injections policy will be reviewed annually with nurses and upon hire with new nurses. Medication order audit will be completed on all new orders weekly for one month then monthly for 3 months. Audit results will be reviewed and tracked monthly at QAPI meetings for the next year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00339	A. BUILDING: _____ B. WING _____	11/15/2018

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21525	Continued From page 7 (6) While keeping the needle pointing upwards, press the push-button all the way in so the dose selector returns to 0. (7) A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. (8) Administer the insulin as ordered. R1's admission record identified an admision date of 10/5/17, and indicated R1 had been admitted with diagnoses including:: cerebral palsy, depressive episodes, dysphasia (difficulty swallowing), and restless leg syndrome. Further review of R1's medical record, indicated a current physician's order for Nabumetone 500 milligrams (mg) 1/2 to 1 tablet by mouth BID (twice daily) PRN (as needed) for pain related to a diagnoses of peripheral neuropathy (nerve pain). The order included no direction for when staff would administer a half or a whole tablet. R1's medication administration record (MAR) indicated he had received Nabumetone 5 times between 11/7 and 11/13/18. There was no documentation as to whether R1 received a half or a whole tablet. The medical record indicated R1 had intact cognition. During interview with licensed practical nurse (LPN)-A on 11/14/18 at 11:00 a.m., LPN-A stated R1 decides how much medication she feels she needs, either a half or a whole tablet, and staff administer the Nabumetone according to her request. R14's admission record indicated the resident was admitted on 8/22/18, with diagnoses including: multiple traumatic fractures, cellulitis of	21525		

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21525	Continued From page 8 the left upper limb, and pain for therapy and rehabilitation. Review of R14's medical record indicated a physician's order for Flexeril (cyclobenzaprine HCL), 5 to 10 mg (1/2 to 1 tablet) three (TID) times daily, as needed for muscle spasms. The order included no direction for when staff would administer a half or a whole tablet. Review of R14's November 2018 MAR, indicated she'd received the medication 18 times between 11/1 and 11/14/18. There was no documentation as to whether R14 had received a half or whole dose of the Flexeril. The medical record indicated R14 had intact cognition. During interview with LPN-A on 11/14/18 at 11:05 a.m., LPN-A stated R14 usually only took a half tablet of Flexeril, but was able to tell staff how much medication she needed, either a half or whole tablet, and staff administer the requested dose of Flexeril. The director of nursing (DON) stated during interview on 11/14/18, at 4:32 p.m. her expectation was staff would clarify medication orders to indicate parameters for what dose of medication should be administered. SUGGESTED METHOD OF CORRECTION: The administrator, DON, and consulting pharmacist could review and revise policies and procedures for appropriate medication administration and educate staff. The DON or designee, could audit medication administration records and take those results to the Quality Assurance Performance Improvement (QAPI) committee for a set amount of time to determine compliance and the need for further monitoring.	21525		

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21525	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21525		