DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | MEDICARE/MEDICAID CERTIFIC PART I - TO BE COMPLETED BY T | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| MEDICARE/MEDICAID PROVIDER N (L1) 245327 2.STATE VENDOR OR MEDICAID NO. (L2) 448415000 | О. | 3. NAME AND AD (L3) DIVINE PRO (L4) 312 EAST G (L5) IVANHOE, M | OVIDENCE H EORGE ST P | EALTH C | | 4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation | N: <u>2 (L8)</u> 2. Recertification 4. CHOW 6. Complaint | |
| 5. EFFECTIVE DATE CHANGE OF OWN (L9) 6. DATE OF SURVEY 11/15/2018 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): | | 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 10.THE FACILITY A. In Complian | 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP | 09 ESRD 10 NF 11 ICF/IID 12 RHC | 02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE And/Or Approved Waivers Of | 7. On-Site Visit 8. Full Survey After FISCAL YEAR ENDIT 09/30 The Following Requirem | NG DATE: (L35) | |
| To (b): 12.Total Facility Beds 13.Total Certified Beds | 25 (L18) 25 (L17) | Program Re Compliance1. Ac X B. Not in Com | equirements e Based On: cceptable POC | | 2. Technical Personnel 2. 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B * | 6. Scope of Se 7. Medical Di | ervices Limit rector m Size | |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 25 (L37) (L38) | 19 SNF (L39) | ICF (L42) | IID (L43) | | 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | (L15) | | |
| 16. STATE SURVEY AGENCY REMARK | S (IF APPLICA | BLE SHOW LTC CA | NCELLATION I | DATE): | | | | |
| 17. SURVEYOR SIGNATURE Date : Angela Hatch, HFE NE II 12/05/2018 (L19) | | | | (L19) | 18. STATE SURVEY AGENCY Kamala Fiske-Downing, E | | Date: 01/01/2019 (L20 | |
| PART 1 | II - TO BE | COMPLETED B | BY HCFA RE | . , | OFFICE OR SINGLE S | STATE AGENCY | (EEC | |
| DETERMINATION OF ELIGIBILITY | ipate (L21) | | PLIANCE WITH | I CIVIL | 1. Statement of Fina 2. Ownership/Contre 3. Both of the Above | ol Interest Disclosure Stmt | | |
| 22. ORIGINAL DATE 23 OF PARTICIPATION 07/01/1986 (L24) | . LTC AGREEN BEGINNING | | ENDING DAT | | 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs | 0 INVOLUM 05-Fail to | (L30) NTARY Meet Health/Safety Meet Agreement | |
| | ALTERNATI A. Suspension | VE SANCTIONS n of Admissions: uspension Date: | (L44) (L45) | | 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal | OTHER | er Status Change | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/ | CARRIER NO. | | 30. REMARKS | | | |
| | (I 28) | 03001 | | (131) | | | | |

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



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: 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

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 01/01/2019 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ` ' | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--|---|-----------|-------------------------------|--|
| | | 245327 | B. WING | | 11 | /15/2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | 10/2010 | |
| DIVINE P | ROVIDENCE HEALT | H CENTER | | 312 EAST GEORGE ST PO BOX 136 IVANHOE, MN 56142 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| E 000 | Initial Comments | | E 0 | 000 | | | |
| F 000 | Emergency Prepar conducted on 11/13 recertification surve | iance with CMS Appendix Z, edness Requirements, was 8/18 through 11/15/18, during a ey. The facility is in compliance mergency Preparedness | F 0 | 000 | | | |
| | was completed at y Department of Hea Center was found N requirements of 42 | gh 11/15/18, a standard survey your facility by the Minnesota lth. Divine Providence Health NOT in compliance with the CFR Part 483, Subpart B, ong Term Care Facilities. | | | | | |
| | as your allegation of Department's acce enrolled in ePOC, y at the bottom of the | f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. | | | | | |
| F 755 SS=D | on-site revisit of you validate that substate regulations has been your verification. | acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with rocedures/Pharmacist/Records b)(1)-(3) | F 7 | 755 | | 12/6/18 | |
| LADODATOD | drugs and biological them under an agre §483.70(g). The far personnel to admin | Services ovide routine and emergency als to its residents, or obtain eement described in cility may permit unlicensed ister drugs if State law | IATURE | 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

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 A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
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| | PROVIDER OR SUPPLIER PROVIDENCE HEALTH | I CENTER | ; | STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142 | , |
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| F 755 | permits, but only ur a licensed nurse. §483.45(a) Procedupharmaceutical ser that assure the acc dispensing, and adibiologicals) to meet §483.45(b) Service must employ or obtipharmacist who- §483.45(b)(1) Proviaspects of the provithe facility. §483.45(b)(2) Estal receipt and disposit sufficient detail to ereconciliation; and §483.45(b)(3) Deterorder and that an ais maintained and parties REQUIREMENT by: Based on observative review, the facility fainsulin pen was approximated and parties of the proview, the facility fainsulin pen was approximated and parties of the proview, the facility fainsulin pen was approximated and parties of the proview, the facility fainsulin pen was approximated and parties of the proview | der the general supervision of ares. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. Consultation. The facility ain the services of a licensed des consultation on all ision of pharmacy services in oblishes a system of records of ion of all controlled drugs in nable an accurate rmines that drug records are in account of all controlled drugs eriodically reconciled. AT is not met as evidenced ion, interview and document ailed to ensure a Novolog propriately primed prior to of 1 resident (R15). In failed to ensure parameters | F 755 | Corrective Action as it applies to or Subcutaneous Injection Policy was reviewed with all nurses at Nurses meeting on 12-6-18. Order clarifications or created and reviewed with all at nurses meeting on 12-6-18. Immediate corrective action: Insulin Pen Instructions were review with LPN-A immediately. Copies of instructions were placed in all nurse mailboxes and were reviewed at the | ation nurses wed the es |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | | SURVEY PLETED |
|--------------------------|--|--|--------------------|--|---|----------------------------|
| | | 245327 | B. WING | | 11/ | 15/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 312 EAST GEORGE ST PO BOX 1 IVANHOE, MN 56142 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 755 | During an observa administration on practical nurse (LF insulin to R15 via ablood glucose readwas to receive 6 uremoved the pen of the top of the pen and attached a nethen dialed the downly she had not performed insulin pen when opened for to fany other guida. During interview were (DON) on 11/13/18 confirmed staff were pens according to prior to administer. Review of the facil Subcutaneous, incompen for insulin injernedle with a minital the unit dosage arresident. Review of the mar Novolog Flexpen Fincluded: (1) Wipe the top of and attach the need inner caps. (2) Before each in may collect in the (3) To avoid injections. | attion of medication 11/13/18 at 6:33 p.m., licensed PN)-A prepared to administer a Novolog Flex Pen. R15's ding was 241, indicating R15 nits of Novolog. LPN-A from the medication cart, wiped with an alcohol pad, opened with alcohol pad, opened with alcohol pad, opened with alcohol pad, opened with alcohol pa | F 7 | nurses meeting on 12-6-18 Subcutaneous Injection Po All Residents medication re audited by DON on 11-24- clarification forms were se to clarify multiple dose ord were received for all reside 11-28-18 including R1 and was provided on clarifying orders that contain multiple new order clarification form meeting on 12-6-18. Continued monitoring to pr recurrence: DON will audit 3 insulin ad week for a month then 5 in administrations a month for Subcutaneous Injections p reviewed annually with nur hire with new nurses. Med audit will be completed on weekly for one month then months. Audit results will be tracked monthly at QAPI in next year. | olicy. ecords were 18 and nt to all doctors ers. New orders ents by R14. Education medication e doses and the n at the nurses revent ministrations a asulin or 3 months. colicy will be reses and upon ication order all new orders monthly for 3 be reviewed and | |

| | AND DI AN OF CORRECTION IN INDENTIFICATION NUMBER: | | ` , | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|----------------------|--|-------------------------------|----------------------------|
| DIVINE PROVIDENCE HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGES TP QBX 138 IVANHOE, MN 56142 | | | 245327 | B. WING _ | | 11 | /15/2018 |
| FREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 755 Continued From page 3 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 upards, 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 | | | | | 312 EAST GEORGE ST PO BOX 136 | | |
| 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 | PRÉFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF | HOULD BE | (X5) COMPLETION DATE |
| 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 | F 755 | dialing the ordered dose selector to set (4) Hold the Novole pointing up. (5) Tap the cartridg any air bubbles co (6) While keeping press the push-but selector returns to 0. (7) A drop of insulitip. If not, change the procedure no more than 6 tim (8) Administer the R1's admission recof 10/5/17, and individually administer the review of Fourther review o | I dose of insulin by turning the elect 2 units. og Flexpen with the needle ge gently a few times to make llect at the top of the cartridge. the needle pointing upwards, tton all the way in so the dose In should appear at the needle the needle and repeat the needle and repeat the needle and repeat the needle and repeat the licated R1 had been admitted luding:: cerebral palsy, es, dysphasia (difficulty estless leg syndrome. R1's medical record, indicated a corder for Nabumetone 500 2 to 1 tablet by mouth BID as needed) for pain related to ipheral neuropathy (nerve cluded no direction for when ster a half or a whole tablet. Indinistration record (MAR) eceived Nabumetone 5 times 11/13/18. There was no to whether R1 received a half | F 75 | 55 | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLE | | E SURVEY PLETED | | | | |
|--------------------------|---|---|--------------------|-------------|---|-----|----------------------------|
| | | 245327 | B. WING | | | 11/ | 15/2018 |
| | PROVIDER OR SUPPLIER | I CENTER | | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 12 EAST GEORGE ST PO BOX 136 VANHOE, MN 56142 | | |
| (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 APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 755 | feels she needs, eit and staff administer to her request. R14's admission rewas admitted on 8/2 including: multiple to the left upper limb, rehabilitation. Review of R14's me physician's order for HCL), 5 to 10 mg (1 times daily, as need order included no dadminister a half or R14's November 20 received the medical and 11/14/18. Therewhether R14 had rethe Flexeril. The medical record cognition. During in 11/14/18 at 11:05 a. only took a half table tell staff how much a half or whole table requested dose of F. The director of nursinterview on 11/14/2 expectation was stated. | cord indicated the resident 22/18, with diagnoses raumatic fractures, cellulitis of and pain for therapy and edical record indicated a r Flexeril (cyclobenzaprine 1/2 to 1 tablet) three (TID) ded for muscle spasms. The irection for when staff would a whole tablet. Review of 2/18 MAR, indicated she'd ation 18 times between 11/1 e was no documentation as to be exceived a half or whole dose of a indicated R14 had intact terview with LPN-A onm., LPN-A stated R14 usually et of Flexeril, but was able to medication she needed, either et, and staff administer the Flexeril. | F 7 | ' 55 | | | |

F5327028

PRINTED: 12/14/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245327 B. WING 11/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 EAST GEORGE ST PO BOX 136 **DIVINE PROVIDENCE HEALTH CENTER** IVANHOE, MN 56142 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. FP() 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

Electronically Signed

TITLE

12/07/2018

(X6) DATE

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 12/14/2018 FORM APPROVED OMB NO. 0938-0391

| | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|---|---|---|
| | 245327 | B. WING | _ | | 11/1 | 4/2018 |
| | | | 3 | 12 EAST GEORGE ST PO BOX 136 | * | |
| (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | | | (EACH CORRECTIVE ACTION SHOUL | D BE | (X5) COMPLETION DATE |
| By email to: Marian.Whitney@ <mailto:marian.w 1.="" a="" co="" correct="" defi<="" deficiency="" description="" following="" inf="" mu="" of="" plan="" td="" the="" to=""><td>estate.mn.us hitney@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE FORMATION: f what has been, or will be, done ciency.</td><td>K</td><td>0000</td><td></td><td></td><td></td></mailto:marian.w> | estate.mn.us hitney@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE FORMATION: f what has been, or will be, done ciency. | K | 0000 | | | |
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Event ID: L76H21

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 12/14/2018 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 245327 11/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 EAST GEORGE ST PO BOX 136 **DIVINE PROVIDENCE HEALTH CENTER** IVANHOE, MN 56142 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRFFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 | Continued From page 2 K 000 The requirement at 42 CFR, Subpart 483,70(a) is NOT MET as evidenced by: 11/14/18 K 753 Combustible Decorations K 753 SS=D CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. Decorations meet NFPA 701. Decorations exhibit heat release less than 0 100 kilowatts in accordance with NFPA 289. 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). 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: On 11/14/2018 the candle was removed Combustible Decorations and a battery light was set in place. The Combustible decorations shall be prohibited chapel volunteers and the Father of the unless one of the following is met: local church were communicated to Flame retardant or treated with approved regarding the change and the need to use fire-retardant coating that is listed and labeled for a battery light for all candles in the chapel. product. The Administrator also communicated the Decorations meet NFPA 701. 0 Decorations exhibit heat release less than change to the management and facility 100 kilowatts in accordance with NFPA 289. staff as well. The Operations Manager Decorations, such as photographs, paintings also has done daily checks to ensure that and other art are attached to the walls, ceilings the candle has not been replaced. and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).

(X2) MULTIPLE CONSTRUCTION

PRINTED: 12/14/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245327 11/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 312 EAST GEORGE ST PO BOX 136 DIVINE PROVIDENCE HEALTH CENTER IVANHOE, MN 56142 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 753 | Continued From page 3 K 753 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. 11/14/18 K 781 K 781 Portable Space Heaters SS=E 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 On 11/14/18 the heating unit was This deficient practice could affect 37 of 37 removed from the tub room in the facility. residents. We have communicated the reason to the residents, families and staff. The Portable Space Heaters Operations Manager is working with the Portable space heating devices shall be Fire Marshall for a replacement unit that prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee will meet all codes and safety features. 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.

Event ID: L76H21

PRINTED: 12/14/2018 FORM APPROVED OMB NO. 0938-0391

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Facility ID: 00339

PRINTED: 12/14/2018 FORM APPROVED OMB NO. 0938-0391

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| | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|--|-------------------|-----|---|------|----------------------------|
| | | 245327 | B, WING | | | 11/ | 14/2018 |
| | PROVIDER OR SUPPLIER | | | 312 | REET ADDRESS, CITY, STATE, ZIP CODE REAST GEORGE ST PO BOX 136 ANHOE, MN 56142 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| K 920 | Continued From p This deficient prac Maintenance Direct | tice was verified by the Facility | K | 920 | | | |
| | | | | | | | |
| | | | | | | | |



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 <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 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

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 01/01/2019 FORM APPROVED

(X6) DATE

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVAND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: A. BUILDING: | | | | | | |
|--|---|--|------------------------|--|-------|--------------------------|
| | | 00339 | B. WING | | 11/15 | 5/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | |
| DIVINE F | PROVIDENCE HEALTH | 1 CENTER | GEORGE S , MN 56142 | T PO BOX 136 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | ***** | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department. | Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. | | | | |
| | 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 | | | | | |
| | that may result from orders provided tha the Department witl | 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 | 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 | | | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/07/18 **Electronically Signed**

TITLE

Minnesota Department of Health

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---|---|---|------------------------|---|-------------------|--------------------------|
| | | 00339 | B. WING | | 11/1 | 5/2018 |
| NAME OF PROV | /IDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIVINE PRO | VIDENCE HEALTH | I CENTER | GEORGE S , MN 56142 | T PO BOX 136 | | |
| (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 APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| De you is rent text State con con Min On De the Ple con and Mir the fed assa Nu The col state con find after evi are Tin PL FO "PF AP | u electronically. Anecessary for Stater the word "correct. You must then ate licensure procompletion date, the rected prior to el nnesota Department's staff verection that you le following corrected indicate in your estate Licensing deral software. Tasigned to Minnes in the state Licensing Homes. Le assigned tag mediumn entitled "Information order. The dings which are interested by." Following which are interested for Corrected the Suggested Information order. The statement, idence by." Following the Suggested Information order. | oth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be rectronically submitting to the rent of Health. In 11/15/18, surveyors of this visited the above provider and tion orders are issued. Four electronic plan of have reviewed these orders, when they will be completed. The ent of Health is documenting and correction Orders using any numbers have been of the state statutes/rules for the orders. The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the state statute is rolled the surveyors findings wethod of Correction and | 2 000 | DETIGIENCI) | | |

Minnesota Department of Health

STATE FORM 6899 L76H11 If continuation sheet 2 of 10

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|----------------------|--|-------------------|--------------------------|
| | | 00339 | B. WING | | 11/1 | 5/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIVINE P | PROVIDENCE HEALTH | 1 CENTER | GEORGE S MN 56142 | T PO BOX 136 | | |
| (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 APPROL DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Continued From pa | ge 2 | 2 000 | | | |
| | | | | | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control | | 21426 | | | 12/20/18 |
| | maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volume Health shall provide regarding implements | e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines of States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines. | | | | |
| | by: Based on interview facility failed to ensitesting (TST) and s completed for 2 of | ent is not met as evidenced and document review, the ure tuberculosis (TB) skin ymptom screenings were 5 new employees (LPN-A and newly admitted residents (R7). | | Corrective Action as it applies to o TB Program Policy reviewed with a nurses at the nurses meeting on 1 and with all staff on 12-20-18 at th staff meeting. | all 2-6-18 | |

Minnesota Department of Health

STATE FORM 6899 L76H11 If continuation sheet 3 of 10

PRINTED: 01/01/2019 FORM APPROVED

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER DIVINE PROVIDENCE HEALTH CENTER DEFORMANCY STATE, ZIP CODE 112-64 DOR NO CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DON completed an audit on all employee TB records and notified employee 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 at program policy will be reviewed with nurses on 12-6-18 at nurses meeting and with all stand 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 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. 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 | | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE S | |
|---|----------|--|--|----------------|--|--|----------|
| CALL DIVINE PROVIDENCE HEALTH CENTER 312 EAST GEORGE ST PO BOX 136 (NANHOE, MN 56142) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DIVINE PROVIDER'S PLAN OF CORRECTION (EACH DOFNECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D | | | 00339 | B. WING | | 11/1 | 5/2018 |
| CALL CALL | NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PRÉFIX TAG CEACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 site proposed in the new service of the paperwork from DM-B's TST had been completed yet. Personnel record review indicated step-one of a TST was administered to DM-B, and no subsequent second step was documented as performed, nor was a symptom screen assessment performed to ensure 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 addition, 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 | DIVINE F | PROVIDENCE HEALTI | H CENTER | | T PO BOX 136 | | |
| 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 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 addition, 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 | PRÉFIX | (EACH DEFICIENC) | / MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | _D BE | COMPLETE |
| 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 | Personnel record remanager (DM)-B wof DM-B's employe TST was read on 1 There was no mentifirst-step TST was subsequent second performed, nor was performed to ensurand symptoms of a During interview wit (DON) on 11/15/18 the paperwork from The DON said wheread DM-B's test recould not find the opjust wrote DM-B's roon DON verified no secompleted yet. Personnel record rehired on 9/24/18. File indicated no TS 11/14/18. In addition screen assessmential was free from signs. The DON stated du 2:55 p.m., that she responsibility of inferon 10/30/18. The Don the completed at that time were staff who had screened for TB up she had not immedicated this issue at the correct this issue at the control of the correct this issue at the control of the correct this issue at the control of the correct this issue at the correct this | eview indicated dietary as hired on 7/25/18. Review e file indicated step-one of a 0/6/18 with a negative result. tion of the date or time the administered to DM-B, and no distep was documented as a symptom screening to DM-B was free from signs at 12:56 p.m., the DON stated in DM-B's TST had been lost. In the nursing staff went to esults 48-72 hours later, they riginal form documentation, so esults on a new form. The cond-step TST had been were with the director of nursing at 12:56 p.m., the DON stated in DM-B's TST had been lost. In the nursing staff went to esults 48-72 hours later, they riginal form documentation, so esults on a new form. The cond-step TST had been were with the performed to ensure LPN-A and symptoms of active TB. The performed to ensure LPN-A and symptoms of active TB. The performed to coordinator role in the performed to coordinator role in the performed to coordinator role in the performed to ensure the performed th | 21426 | DON completed an audit on all en TB records and notified employee need to redo their TB test. New be TB screening tool for HCW and refrom MDH will be implemented in December after the nurses meetin 12-6-18. TB program policy will be reviewed with nurses on 12-6-18 ameeting and with all staff on 12-20 the all staff meeting. New TB skin notification form was created and placed in the new employee folde Nurses will be educated on these on 12-6-18 at the nurses meeting. Continued monitoring to prevent recurrence: DON will audit all new employee a resident TB skin tests for the next months. All audit findings will be not the monthly QAPI meeting. DO continue to track new employee a resident TB compliance for the next meeting. | es that aseline esidents ng on e at nurses 0-18 at test will be rs. forms . and : 3 eviewed N will ind | |

Minnesota Department of Health

STATE FORM 6899 L76H11 If continuation sheet 4 of 10

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---|------------------------|--|---------|--------------------------|
| | | 00339 | | B. WING | | 11/1 | 5/2018 |
| NAME OF PROVIDER | OR SUPPLIER | • | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | |
| DIVINE PROVIDE | NCE HEALT | H CENTER | | GEORGE S , MN 56142 | T PO BOX 136 | | |
| PREFIX (EAC | CH DEFICIENC | ATEMENT OF DEF Y MUST BE PREC SC IDENTIFYING | EDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| on the ficare of R7 adm 1/3/18. record i adminis second- screenii The DO at 1:45 R7 had Review Program TB assed day of a screen. admitted within 7 prior to adminis confirm screenii sympton SUGGE DON ar procedu for tube Facility regulation TST pro audit refiles, to taken for Perform | ission reco Review of ndicated a tered until step admir- ng performe N confirme p.m., the Ta not been co- of the facili n, indicated essment an assigned du The policy d residents 2 hours of a admission, tered withir ed resident ng to ensur- ms of TB. ESTED MET ad/or designates reculosis for staff could ons, sympto- posess. The sident administration of the ensure con- orward to the pance Impro- | not gotten thi rd indicated a the resident's first-step TST 1/20/18 and th nistered, nor si ed. d during interes ST and sympto completed in a ty's August 20 I all employee d negative TS ties including furhter indicat were to have admission, or with a second 14 days. The s were also to be they were fro THOD OF CO nee, could revi to the screen residents and be educated of m screening, DON and/or d issions, and n npliance. Resi e Quality Assi ovement (QAF | n admit date of TB screening had not been here had been no ymptom view on 11/15/18 om screening for timely manner. 16 policy, TB s were to have a streen before the first a symptom ted newly the first TST within 90 days distep TST expolicy also have a symptom have of signs and service policies and hing and testing distemployees. On the TB and the two-step designee could ew employee ults could be | 21426 | | | |

Minnesota Department of Health

STATE FORM 6899 L76H11 If continuation sheet 5 of 10

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|------------------------|--|-----------------------------------|--------------------------|
| | | 00339 | | B. WING | | 11/1 | 5/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| DIVINE F | PROVIDENCE HEALTH | I CENTER | | GEORGE S , MN 56142 | T PO BOX 136 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21426 | Continued From pa | ge 5 | | 21426 | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: T | wenty one- | | | | |
| 21525 | MN Rule 4658.1305 Consultation | 5 A.B.C Pharmacist | Service | 21525 | | | 12/6/18 |
| | provision of pharma home; B. establishes and disposition of a detail to enable an a | nacist currently licer who: Isultation on all aspacy services in the rasystem of records all controlled drugs in accurate reconciliated and that an accorded and that an accorded whose second in the cords and that an accorded whose second in the cords and that an accorded whose second in the cords are the cords and that an accorded whose second in the cords are the | ects of the nursing s of receipt n sufficient ion; and | | | | |
| | This MN Requirements: Based on observation review, the facility fainsulin pen was approximated administration for 1 addition, the facility were developed for Nabumetone (non-Flexeril (muscle related R14). Findings include: During an observation administration on 1 practical nurse (LPI insulin to R15 via a blood glucose reading review. | on, interview and dealled to ensure a Noropriately primed pof 1 resident (R15) failed to ensure pass needed (PRN) narcotic pain relieve exer), for 2 of 5 resident (N13/18 at 6:33 p.m. N)-A prepared to ac Novolog Flex Pen. | ocument ovolog rior to . In arameters er) and idents (R1 ., licensed dminister R15's | | Corrective Action as it applies to a Subcutaneous Injection Policy was reviewed with all nurses at Nurses meeting on 12-6-18. Order clarification created and reviewed with all at nurses meeting on 12-6-18. Immediate corrective action: Insulin Pen Instructions were reviewith LPN-A immediately. Copies of instructions were placed in all nurmailboxes and were reviewed at the nurses meeting on 12-6-18 along Subcutaneous Injection Policy. All Residents medication records audited by DON on 11-24-18 and clarification forms were sent to all | ewed of the ses the with the were | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|------------------------|--|--|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00339 | B. WING | | 11/15/2 | 2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIVINE PROVIDENCE HEALTH CENTER | | | GEORGE S , MN 56142 | T PO BOX 136 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 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) COMPLETE DATE |
| 21525 | was to receive 6 un removed the pen from the top of the pen wand attached a new then dialed the dos why she had not provide to manufacturer's in though insulin pensions when opened for the of any other guidant. During interview with (DON) on 11/13/18 confirmed staff were pensions according to the prior to administering. Review of the facility Subcutaneous, indipen for insulin injection needle with a mining the unit dosage am resident. Review of the manufold Novolog Flexpen Princluded: (1) Wipe the top of and attach the need inner caps. (2) Before each injection and injection dosing, prime the proposition of the pointing up. (3) To avoid injection dose selector to see (4) Hold the Novolog pointing up. (5) Tap the cartridgent in the cartri | om the medication cart, wiped with an alcohol pad, opened or needle onto the pen. She age to 6 units. When asked imed the pen first, according instructions, LPN-A stated she is only needed to be primed e first time and was unaware ce. In the director of nursing at 6:43 p.m., the DON e supposed to prime insuling the manufacturer's instructions in ginsulin. It's current policy, Injections, cated if staff used an insuling the manufacturer's prime the num of 2 units prior to setting ount and administering to the suffacturer's March 2017, rescribing Information the pen with an alcohol paddle, removing both outer and ection small amounts of air artridge during normal use. In gair and to ensure proper en with 2 units of air prior to dose of insulin by turning the | 21525 | to clarify multiple dose orders. Newere received for all residents by including R1 and R14. Education provided on clarifying medication that contain multiple doses and thorder clarification form at the nursemeeting on 12-6-18. Continued monitoring to prevent recurrence: DON will audit 3 insulin administrations a month for 3 more Subcutaneous Injections policy wireviewed annually with nurses and hire with new nurses. Medication audit will be completed on all new weekly for one month then month months. Audit results will be reviet tracked monthly at QAPI meetings next year. | 11-28-18 was orders e new es ations a oths. Il be d upon order orders y for 3 wed and | |

Minnesota Department of Health

STATE FORM 6899 L76H11 If continuation sheet 7 of 10

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Minnesota Department of Health

| AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|------------------------|--|-------------|--------------------------|
| | | 00339 | | B. WING | | 11/ | 15/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIVINE F | PROVIDENCE HEALTH | H CENTER | | GEORGE S , MN 56142 | T PO BOX 136 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETE DATE |
| 21525 | (6) While keeping the press the push-butted selector returns to 0. (7) A drop of insulination in the procedure of the procedure of the procedure of the procedure of 10/5/17, and individe with diagnoses include pressive episodes swallowing), and resulting the procedure of 10/5/17, and individe pressive episodes swallowing), and resulting the procedure of the pro | he needle pointing on all the way in some all the way in some all the way in some all the needle and representations as ordered and representation as ordered and the needle and representation as ordered and the needle and indicated R1 had been all the needle and indicated R1 had bee | the needle eat the admision date an admitted alsy, iculty me. d, indicated a stone 500 uth BID in related to y (nerve in for when ble tablet. In the sea of the sea | 21525 | | | |
| | was admitted on 8/2 | | | | | | |

Minnesota Department of Health

STATE FORM 6899 L76H11 If continuation sheet 8 of 10

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|----------------------|--|-------|--------------------------|
| | | 00339 | B. WING | | 11/1 | 5/2018 |
| NAME OF F | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIVINE P | ROVIDENCE HEALTH | 1 CENTER | GEORGE S MN 56142 | T PO BOX 136 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 21525 | rehabilitation. Review of R14's me physician's order for HCL), 5 to 10 mg (10 times daily, as need order included no dadminister a half or R14's November 20 received the medica and 11/14/18. There whether R14 had retained the Flexeril. The medical record cognition. During in 11/14/18 at 11:05 at only took a half table tell staff how much a half or whole table requested dose of Figure 11/14/19. The director of nursinterview on 11/14/19 expectation was stated or stated to indicate periodication should be SUGGESTED MET administrator, DON could review and refor appropriate medication administrator, to the Qualit Improvement (QAP) | and pain for therapy and edical record indicated a r Flexeril (cyclobenzaprine 1/2 to 1 tablet) three (TID) ded for muscle spasms. The irection for when staff would a whole tablet. Review of 018 MAR, indicated she'd ation 18 times between 11/1 e was no documentation as to eccived a half or whole dose of indicated R14 had intact terview with LPN-A on .m., LPN-A stated R14 usually et of Flexeril, but was able to medication she needed, either et, and staff administer the elexeril. sing (DON) stated during 18, at 4:32 p.m. her aff would clarify medication arameters for what dose of | 21525 | | | |

Minnesota Department of Health

STATE FORM 6899 L76H11 If continuation sheet 9 of 10

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER DIVINE PROVIDENCE HEALTH CENTER DIVINE PROVIDENCE HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST GEORGE ST PO BOX 136 INAMHOE, MN 56142. (204) D (EACH DEPICINENCY MUST BE PREPICIENCES TAG CROSS-REFERENCED TO THE APPROPRIATE DIVINE PROPINE (EACH CORRECTION SHOULD BE COMPLETE | | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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