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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0UGV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 28617

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245621**
2.STATE VENDOR OR MEDICAID NO.
(L2) **154115000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLKESTONE**
(L4) **100 PROMENADE AVENUE**
(L5) **WAYZATA, MN** (L6) **55391**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/20/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (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 **30** (L18)
13.Total Certified Beds **30** (L17)

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

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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
30				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NEII 09/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/06/2014
(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.
00325
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5621

On June 20, 2017 a health PCR was completed to verify compliance with the deficiencies issued pursuant to the standard survey completed on April 19, 2017 and the FMS completed on May 12, 2017. Based on our revisit we have determined the facility has corrected all deficiencies issued pursuant to the standard survey completed on April 19, 2017 and the FMS completed on May 12, 2017, effective June 16, 2017.

As a result of finding the facility has achieved compliance, we are recommending the following action as it relates to the imposed remedies in the CMS letter of May 19, 2017:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 19, 2017, be rescinded.

Since DPNA did not go into effect, the facility would not be subject to a two year loss of NATCEP, which was to begin July 19, 2017.

Effective June 16, 2017, the facility is certified for 30 skilled nursing facility beds.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245621

September 22, 2017

Ms. Janae Beaudot, Administrator
Folkestone
100 Promenade Avenue
Wayzata, MN 55391

Dear Ms. Beaudot:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 16, 2017 the above facility is certified for:

30 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered
September 21, 2017

Ms. Janae Beaudot, Administrator
Folkestone
100 Promenade Avenue
Wayzata, MN 55391

RE: Project Number S5621003, S5621004

Dear Ms. Beaudot:

On May 5, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 19, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 12, 2017, a surveyor representing the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On May 19, 2017, CMS forwarded the results of the FMS to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 19, 2017. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of May 19, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 19, 2017.

On June 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 19, 2017 and an FMS completed on May 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 19, 2017 and FMS completed on May 12, 2017, effective June 16, 2017

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of May 19, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 19, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 19, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 19, 2017, is to be rescinded.

In their letter of May 19, 2017, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 19, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 16, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0UGV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 28617

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245621**

2. STATE VENDOR OR MEDICAID NO. (L2) **154115000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLKESTONE**
(L4) **100 PROMENADE AVENUE**
(L5) **WAYZATA, MN** (L6) **55391**

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 **04/19/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (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 **30** (L18)

13.Total Certified Beds **30** (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
30				
(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 :
Sandra Tatro, HFE NF II 05/16/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/06/2014
(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.
00325 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2017 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 5, 2017

Ms. Janae Beaudot, Administrator
Folkestone
100 Promenade Avenue
Wayzata, MN 55391

RE: Project Number S5621003

Dear Ms. Beaudot:

On April 20, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716 Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 30, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 30, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 20, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 20, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. BUILDING _____ B. WING _____	Exit date 4/19/2017 04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	**100 PROMENADE AVENUE WAYZATA, MN 55391**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		5/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/15/2017

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
	245621	A. BUILDING _____ B. WING _____	4/19/2017 04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	**100 PROMENADE AVENUE WAYZATA, MN 55391**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 280		

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	245621	A. BUILDING _____ B. WING _____	4/19/2017 04/20/2017

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F 280	Continued From page 2 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 3 residents (R33) reviewed for activities of daily living (ADLs). Findings include: R33's quarterly Minimum Data Set (MDS) dated 2/27/17, indicated she was cognitively impaired and required physical assistance with personal hygiene and bathing. R33's care plan dated April 2017, indicated a self care deficit related to dementia, limited mobility and confusion. The MDS further indicated the resident required staff assist with bathing and grooming. R33's careplan dated 3/9/17, indicated: "I [R33] want to be clean and well dressed daily." R33's current care plan did not include any additional interventions to address the issue with her hair being oily. On 4/18/17, at 9:23 a.m., family member (FM)-A stated, "I feel her [R33] hair could be cleaner."	F 280	R 33 was provided bathing assistance upon request by the family. R 33□s care plan, My Best Day and NAR assignment sheet was updated to reflect the change in schedule for 2 baths a week. Resident continued to be scheduled for regular beauty shop appointments per family preference. The resident has since passed away. All residents were reviewed to ensure their bathing and hygiene needs were being met as per their preferences and correctly identified on the care plan and my Best Day/ assignment sheet. Preferences and care needs are reviewed with the resident and family upon admission, at each care conference and as part of the RAI process to ensure residents ADL needs are being met and add preferences to care plan with resident and family input.	

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F 280	Continued From page 3 On 4/17/17, at 5:04 p.m., R33 sat in her wheelchair at the table in the dining room . R33's hair was slicked down and appeared oily. On 4/18/17, at 12:14 p.m., R33 was seated at the table in the dining room. Her hair was hanging straight and cut off blunt at the ends. Her hair still looked oily. On 4/18/17, at 12:27 p.m., NA-A stated R33 received one shower a week on Thursday mornings. NA-A further stated the stylist had given the NAs a particular shampoo to use on R33's hair because her hair gets extremely oily fast. NA-A stated R33's hair looked nice after the shower, but it only helped for a few days. On 4/18/17, at 1:36 p.m., the beautician stated she tried to wash R33's hair once but it did not work. She stated R33 is too stiff to wash her hair in the chair. She stated R33's hair needed to be washed in the shower and that she needed two showers a week. On 4/18/17, at 2:41 p.m., the assistant director of nursing (ADON) stated R33 had naturally greasy looking hair even after her shower. The ADON stated the facility had tried some shampoo shower caps to clean the hair, but stated the caps did not work. On 4/19/17, at 1:05 p.m., NA-C stated R33's hair was washed every Thursday morning in the shower with shampoo from the salon. NA-C stated R33 was very "stiff" but did not have any behaviors or anxiety in the shower. On 4/19/17, a facility policy regarding care planning was requested, but not made available.	F 280	The care planning policy was reviewed and is current. An in-service will be held for all staff the week of 5/15/17 regarding resident preferences and resident needs. Audits will be completed weekly for 4 weeks then monthly thereafter to make sure baths and resident preferences are being completed according to resident plan of care. QA team will review and ensure ongoing compliance and further frequency of audits. The Clinical Administrator is responsible for ongoing performance.	

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F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care plan interventions for grooming assistance for 1 of 3 residents (R30) reviewed for activities of daily living who required assistance with shaving. Findings include: R30's Quarterly Minimum Data Set (MDS) dated 4/3/17, indicated he had intact cognition and required extensive staff assistance to complete personal hygiene. A Care Area Assessment (CAA) summary dated 10/6/16, indicated R30 had "modified independence" with decision making and needed staff assistance with ADLs. The CAA indicated "Patient [R30] can communicate his needs at times, though due to episodes of confusion staff must also anticipate needs." R30's careplan dated 9/30/16, identified an ADL (Activities of Daily Living) self care performance deficit related to fatigue, limited mobility, Parkinson's disease and dementia. The care plan directed staff to provide R30 assistance with personal hygiene.	F 282	R30□s -razor has been serviced to enable a clean shave. The resident was provided shaving assistance upon identification of missed shaving. Resident #30□s care plan was reviewed for preferences and was updated to ensure staff are offering to shave resident according to preference and needs. All residents were reviewed to ensure their grooming and hygiene needs were being met as per their preferences and correctly identified on the care plan and my Best Day/ assignment sheet. Preferences and care needs are reviewed with the resident and family upon admission, at each care conference and as part of the RAI process to ensure residents ADL needs are being met and care planned with resident and family input. An in-service will be held for all staff the week of 5/15/17 regarding following policy and updating the care plan and hygiene needs. The care plan policy was reviewed and is current.	5/26/17

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F 282	Continued From page 5 During an observation on 4/17/17, at 5:04 p.m., R30 was seated in a wheelchair at the table in the dining room and was observed to have long hairs on his face and neck. R30 also had hairs sticking out of each ear and his eyelashes were encrusted with matter. During an initial interview on 4/17/17, at 6:57 p.m., R30 stated he felt he could use a little more help from staff with cares. During observation on 4/18/17 at 12:14 p.m., R30 sat at a table in the dining room. He was unshaven and had visible hair protruding from his ears. At 1:26 p.m., while waiting for staff to help him to lay down on his bed, R30 was interviewed about his care. In reference to his facial hair, R30 stated, "especially around the chin and neck, that is as good as we could get it." On 4/18/17, at 12:15 p.m., NA-A was interviewed and stated he shaved R30 daily when she worked with him. NA-A stated he had helped R30 shave that morning, but added that how well R30 could be shaved depended on how long it had been since it had previously been shaved. NA-A further stated R30 needed to be reminded to shave, and stated this morning it had looked like R30 had not shaved yesterday or the day before that. During an interview on 4/18/17 at 2:23 p.m., NA-C also stated staff had to remind R30 to shave and needed to supervise him. NA-C stated sometimes R30 needed more help, and that the assistance R30 needed varied dependent on his mood. NA-C verified R30 had not been shaved yesterday for sure and possibly the day before too.	F 282	Audits regarding resident grooming and preferences will be conducted weekly for 4 weeks with results reported to QA to ensure ongoing compliance and ongoing frequency of audits. The Clinical Administrator will be responsible for ongoing compliance.	

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F 282	Continued From page 6 On 4/18/17, at 2:26 p.m. the assistant director of nursing (ADON) stated R30 needed staff assistance with shaving and stated he should be shaved per preference, particularly if noted on the careplan. On 4/19/17, at 7:15 a.m., R30 was lying on top of his bed fully dressed. He was unshaven around his chin, slightly unshaven on the side of his face, and was observed to have hair in his ears and on his neck. At 8:03 a.m. NA-D and registered nurse (RN)-B assisted R30 to get up for breakfast. After assisting R30 into his wheel chair, NA-D gave him his eyeglasses but did not offer to shave him. At 9:17 a.m., the hospice nurse wheeled R30 from the dining room to his room. At 9:41 a.m. the hospice nurse stated to NA-F, "[R30] has to go to the toilet, his stomach is rumbling and I just want to let you know I finished his shaving."	F 282		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming assistance for 1 of 3 residents (R30) reviewed for activities of daily living (ADL's) who could participate with his ADL cares. Findings include:	F 311	R30□s -razor has been serviced to enable a clean shave. The resident was provided shaving assistance upon identification of missed shaving. Resident #30□s care plan was reviewed for preferences and was updated to ensure staff are offering to shave resident according to preference and needs.	5/26/17

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F 311	Continued From page 7 R30's Quarterly Minimum Data Set (MDS) dated 4/3/17, indicated he had intact cognition and required extensive staff assistance to complete personal hygiene. A Care Area Assessment (CAA) summary dated 10/6/16, indicated R30 had "modified independence" with decision making and needed staff assistance with ADLs. The CAA indicated "Patient [R30] can communicate his needs at times, though due to episodes of confusion staff must also anticipate needs." R30's careplan dated 9/30/16, identified an ADL self care performance deficit related to fatigue, limited mobility, Parkinson's disease and dementia. The care plan directed staff to assist with personal hygiene. On 4/17/17, at 5:04 p.m., R30 was seated in a wheelchair at the table in the dining room and was observed to have long hairs on his face and neck. R30 also had hairs sticking out of each ear and his eyelashes were encrusted with matter. During an initial interview on 4/17/17, at 6:57 p.m., R30 stated he felt he could use a little more help from staff with cares. On 4/18/17, at 12:14 p.m., R30 sat at a table in the dining room. He was unshaven and had visible hair protruding from his ears. At 1:26 p.m., while waiting for staff to help him to lay down on his bed, R30 was interviewed about his care. In reference to his facial hair, R30 stated, "especially around the chin and neck, that is as good as we could get it." On 4/18/17, at 12:15 p.m., NA-A stated he shaved R30 daily when he worked with him. NA-A	F 311	All residents were reviewed to ensure their grooming and hygiene needs were being met as per their preferences and correctly identified on the care plan and my Best Day/ assignment sheet. Preferences and care needs are reviewed with the resident and family upon admission, at each care conference and as part of the RAI process to ensure residents ADL needs are being met and care planned with resident and family input. An in-service will be held for all staff the week of 5/15/17 regarding following policy and updating the care plan and hygiene needs . The care plan policy was reviewed and is current. Audits regarding resident grooming and preferences will be conducted weekly for 4 weeks with results reported to QA to ensure ongoing compliance and ongoing frequency of audits. The Clinical Administrator will be responsible for ongoing compliance.	

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F 311	Continued From page 8	F 311		

stated he had helped R30 shave that morning, but added that how well R30 could be shaved depended on how long it had been had been since his last shave. NA-A further stated R30 needed to be reminded to shave, and stated this morning it had looked like R30 had not shaved yesterday or the day before that.

On 4/18/17, at 2:23 p.m., NA-C also stated staff had to remind R30 to shave and needed to supervise him. NA-C stated sometimes R30 needed more help, and that the assistance R30 needed varied dependent on his mood. NA-C verified R30 had not been shaved yesterday for sure and possibly the day before too.

On 4/18/17, at 2:26 p.m. the assistant director of nursing (ADON) stated R30 needed staff assistance with shaving and stated he should be shaved per preference, particularly if noted on the careplan.

On 4/19/17, at 7:15 a.m., R30 was lying on top of his bed fully dressed. He was unshaven around his chin, slightly unshaven on the side of his face, and was observed to have hair in his ears and on his neck. At 8:03 a.m. NA-D and registered nurse (RN)-B assisted R30 to get up for breakfast. After assisting R30 into his wheel chair, NA-D gave him his eyeglasses but did not offer to shave him. At 9:17 a.m., the hospice nurse wheeled R30 from the dining room to his room. At 9:41 a.m. the hospice nurse stated to NA-F, "[R30] has to go to the toilet, his stomach is rumbling and I just want to let you know I finished his shaving."

On 4/19/17, a facility policy regarding ADL assistance was requested but was not provided.

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F 312	Continued From page 9	F 312		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene assistance for 1 of 3 dependent residents (R33) reviewed for ADLs. Findings include: R33's quarterly Minimum Data Set (MDS) dated 2/27/17, indicated she was cognitively impaired and required physical assistance with personal hygiene and bathing. R33's care plan dated April 2017, indicated a self care deficit related to dementia, limited mobility and confusion. The MDS further indicated the resident required staff assist with bathing and grooming. R31's careplan dated 3/9/17, indicated: "I [R33] want to be clean and well dressed daily." On 4/18/17, at 9:23 a.m., family member (FM)-A stated, "I feel her [R33] hair could be cleaner." On 4/17/17, at 5:04 p.m., R33 sat in her wheelchair at the table in the dining room . R33's hair was slicked down and appeared oily. On 4/18/17, at 12:14 p.m., R33 was seated at the table in the dining room. Her hair was hanging straight and cut off blunt at the ends. Her hair still looked oily.	F 312	Plan of correction as it applies to resident #R 33- Resident was provided bathing assistance upon request by the family. R 33□s care plan, My Best Day and NAR assignment sheet was updated to reflect the change in is now scheduled for 2 baths a week to avoid greasy hair. Resident also continued to be scheduled for regular beauty shop appointments per family preference. This has been added to resident□s care plan. The resident has since passed away. Corrective action as it applies to other residents- All residents were reviewed to ensure their bathing and hygiene needs were being met as per their preferences and correctly identified on the care plan and my Best Day/ assignment sheet. Review hygiene/ADL preferences and care needs are reviewed with the resident and family upon admission, at each care conference and as part of the RAI process to ensure residents ADL needs are being met and add preferences to care plan with resident and family input. The care planning policy was reviewed and is current. An in-service will be held for all staff the week of 5/15/17 to review	5/26/17

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F 312	Continued From page 10 On 4/18/17, at 12:27 p.m., NA-A stated R33 received one shower a week on Thursday mornings. NA-A further stated the stylist had given the NAs a particular shampoo to use on R33's hair because she has extremely dry skin and her hair gets extremely oily fast. NA-A stated R33's hair looked nice after the shower, but it only helped for a few days. On 4/18/17, at 1:36 p.m., the beautician stated R33's family gave permission for her to go ahead and pick up R33 whenever she needed a hair cut. The beautician stated she tried to wash R33's hair once but it did not work. She stated R33 is too stiff to wash her hair in the chair. She stated R33's hair needed to be washed in the shower and that she needed two showers a week so staff could wash her hair. The beautician stated R33's hair gets oily fast and only looked clean for a couple of days after washing. On 4/18/17, at 2:41 p.m., the assistant director of nursing (ADON) stated R33 had naturally greasy looking hair even after her shower. The ADON stated R33's greasy hair had not been brought up over the past year, and the facility had tried some shampoo shower caps to clean the hair, but stated the caps did not work. The ADON stated showers were difficult for R33 and stated she gets anxious and all tightened up. On 4/19/17, at 1:05 p.m., NA-C stated she'd given R33 a shower that morning. NA-C stated R33's hair was washed every Thursday morning in the shower with shampoo from the salon. NA-C stated R33 was very "stiff" but did not have any behaviors or anxiety in the shower. On 4/19/17, a facility policy regarding ADL	F 312	plan of correction for resident #33 along with the other residents at Folkestone regarding resident preferences and resident needs. Reoccurrence will be prevented by completing audits to ensure residents hair looks clean according to their ADL preferences weekly for 4 weeks then monthly thereafter to make sure baths and resident preferences are being completed according to resident preference plan of care. QA team will determine review and ensure ongoing compliance and further frequency of audits. The Clinical Administrator is responsible for ongoing performance.	

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F 312	Continued From page 11 assistance was requested but was not provided.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine if side rails were safe and appropriate for use for 1 of 1 residents (R30) reviewed for accidents. Findings include:	F 323	R # 30 was assessed for side rails upon identification of the lack of assessment. Half side rails were taken off of the bed and replaced with grab bars by hospice team on 4/19/17. A new physical device assessment was completed and care plan updated to reflect changes.	5/26/17

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F 323	Continued From page 12 R30's quarterly Minimum Data Set (MDS) dated 4/3/17, indicated he had intact cognition and required extensive assist with transfers and bed mobility. Care Area Assessment (CAA) summary dated 10/6/16, indicated R30 had impaired mobility and was dependent on staff to meet mobility needs. R30's care plan dated 4/10/17, indicated half side rails to assist with bed mobility on long bed. Review of the physical device consent obtained by the assistant director of nursing (ADON) on 4/18/17, at 6:27 p.m., indicated: Okay for use of 1/2 side rails for bed mobility and positioning. Risks and benefits; with son completed 4/18/17, verbal consent given 4/10/17, description Change in device The Physical Device assessment indicated "Resident [R30] recently received an XL bed that's longer to accommodate his height and limit the occurrences of his feet touching the foot board. New bed delivered by hospice is equipped with 1/2 side rails as standard that are used like previous grab bars. Half side rails verbally discussed with resident and family upon arrival of new bed and all parties agreed that longer bed is better and the rails will be used the same as grab bars. No concerns and no desire at that time for change." On 4/17/17, at 2:14 p.m., R30's bed was observed to have bilateral half rails. The siderails which were both observed in the raised position, had movement of 2-3 inches back and forth. NA (nursing assistant)-A stated the resident required two staff to transfer with the use of a Hoyer (mechanical lifting device). On 4/18/17, at 12:15 p.m., NA-A stated R30 had received the new bed two weeks ago. NA-A	F 323	Corrective action as it applies to other residents- All beds were checked for side rails. Currently there are no beds at Folkestone with side rails. Each replacement bed that comes into Folkestone will be assessed to ensure that side rails are not in place without assessment for appropriate use and safety, consent, and care plan updated per policy. All residents are assessed for the use of physical devices upon admission, minimally quarterly and with significant change of conditioning in conjunction with the RAI process. The policy for physical devices was reviewed and is current. An in-service will be held for all staff the week of 5/15/17 to review the physical device policy and procedure. Audits for appropriate assessment and use of physical devices will be conducted weekly for 4 weeks and ongoing as needed. The facility QA committee will review the audits and corrections for ongoing compliance. The Administrator will be responsible for compliance.	

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	245621	A. BUILDING _____ B. WING _____	4/19/2017 04/20/2017

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F 323	Continued From page 13 confirmed R30 previously had grab bars in place on the other bed. On 4/19/17, at 7:57 a.m., registered nurse (RN)-B stated R30 needed staff assistance to turn from side to side. RN-B further stated R30 is afraid of falling and wants the side rails in the raised position. On 4/18/17, at 2:26 p.m., the assistant director of nursing (ADON) stated the facility had discussed whether R30's side rails were actually side rails or grab bars. She stated the family had seen the new bed and agreed to it and R30 had been care planned for side rails. The ADON stated a new assessment should have been completed for the side rails and stated she had not had the family sign a consent or explained risk/benefits of the side rails. The ADON stated R30 used the siderails for repositioning. The ADON explained the siderails could not go down and that R30 needed them for bed mobility and positioning and with cares. On 4/19/17, at 1:55 p.m. the director of nursing (DON) stated they had taken side rails off R30's bed and put on new circular grab bars. The DON stated a new assessment for the grab bars would be completed and the careplan updated. On 4/19/17, a policy related to side rail assessment was requested from the facility but was not provided.	F 323		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local	F 371		5/26/17

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F 371	Continued From page 14 authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a sanitary food storage environment and failed to serve food in a sanitary manner. This had the potential to affect all 29 residents residing in the facility. Findings include: During an initial kitchen tour with the executive cook (EC) on 4/17/17, at 12:24 p.m., the following observations were made: - A scoop was noted in a bin filled with bread crumbs. The EC stated scoops should not be stored in the bin, but should be hung up. He	F 371	All identified scoops and items not appropriately labeled or stored were removed and corrected upon identification. Staff involved in infection control practices were re-educated on appropriate procedure.The ice scoop rack was repaired. All culinary staff were educated on infection control and sanitation practices including properly storing scoops on provided hooks, glove use and dating and storage of food items.The related policies were reviewed and are current. In-service will take place with all culinary staff to	

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F 371	Continued From page 15 picked the scoop out of the bin and placed it on a designated hook. A bin filled with granola had a disposable plastic cup stored in it. The EC removed the cup from the bin and threw it away. Another bin containing flour also had a scoop stored in it which the EC removed. - The freezer contained two open boxes of fish in open plastic bags. The open container was not dated. A bag of chicken fingers and a bag of hash browns were also open and undated. The EC stated the bags may have been opened recently since it was the beginning of the week, but confirmed they should be dated when opened. - The ice machine had an ice scoop laying directly on top of the machine. Two screws were sticking out of the wall on the left side of the ice machine. The EC stated the ice scoop should be hanging next to the machine, but the hanger had broken and had not yet been repaired. The EC removed the ice scoop from the top of the machine and placed it in a plastic container and set it on top of the machine. During a meal service observation on 4/17/17 at 5:14 p.m., the following was observed: Dietary aide (DA)-A was noted wearing gloves. DA-A picked up a tray and set it on a lower counter. DA-A then took out a bin of condiments and placed them on the counter, began opening and closing cabinets and placing her gloved hands on the counter tops. DA-A then peeled off the plastic from the pans on the steam table, picked up parmesan cheese with her fingers and sprinkled it on the spaghetti. DA-A picked up garlic bread, with the same gloved hands and was noted to touch the spaghetti, wearing the	F 371	review policies on proper glove use, hand washing, and food storage. Audits will be completed weekly for 4 weeks and monthly thereafter and brought to QA team to ensure ongoing compliance. Culinary Director will be responsible for ongoing compliance.	

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F 371	Continued From page 16 same pair of gloves. DA-A picked up the meal slips and moved them. She then stated, "I should probably not touch the resident meal slips." DA-A instructed staff to spread the meal slips out on the counter then removed her gloves, washed her hands, and put on a new pair of gloves. On 4/19/17, at 10:45 a.m., the Culinary and Food Services Director (CFSD) stated a work order had been put in for the ice scoop rack to be repaired. The CFSD stated, whoever put the scoops and cups in the bulk bins should have placed them on the hooks as it was a sanitation issue. The CFSD stated the servers in the kitchenettes were to wear gloves when working with food and stated if there was a change in activity, staff should remove their gloves, wash their hands and then put on a clean pair of gloves. The CFSD stated it was okay to touch the front counter and the individual resident meal tickets, but stated it was not okay for the server to touch the back cupboards without washing hands and changing gloves. The CFSD stated if a server was going to touch resident food, the facility expectation was they should be using utensils. On 4/19/17, at 2:11 p.m., a facility policy regarding kitchen and food sanitation was requested but not provided.	F 371		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		5/26/17

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F 441	Continued From page 17 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 441		

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F 441	Continued From page 18 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control practices were followed by 1 of 1 resident companion (RC-A) who was observed to assist 1 resident (R3) and R3's three table mates during dining to prevent the spread of infection. Findings include: During an observation on 4/17/17, at 4:54 p.m., R3 was sitting in the dining room. She had a resident companion (RC)-A with her at the dining room table. RC-A was observed walking around the dining area. She took a clothing protector off a large pile of clothing protectors from a tray and placed it around R3's neck. RC-A with her gloved hand pulled open her shirt and sneezed down it. RC-A did not change her gloves. She was noted	F 441	Resident #3□s companion was informed of infection control practices and what we expect at Folkestone immediately. Resident has expired and companion no longer spends time at Folkestone. An update is being provided in the family newsletter regarding practices related to feeding assistance and expectations. The policy and procedures for infection control were reviewed and are current. Nursing staff and culinary serves will be re-educated on infection control practices in the dining area. Care plans for resident companions and family members who provide feeding assistance will be care planned for specific resident supports.	

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F 441	Continued From page 19 to have had her hands in her lap, on the table and on the arms of the chair At 5:30 p.m., RC-A scratched her head with her left hand and got up from her chair, pushing herself up by using the arm rest. As she was walking to the kitchen, she pulled up her pants, still wearing the gloves. When RC-A returned to the table, she touched back of a wheel chair and wiped her mouth with her gloved hand. She then sat down, took a utensil, and assisted R3 to eat but didn't change her gloves. At 5:38 p.m., RC- A pushed herself up using the arm rests of the chair. She walked over to the clean dishes, took a cup and two glass, and pushed the button on the ice machine and filled a glass with ice. RC-A put some ice in the coffee cup, poured some coffee in the cup; added ice to another glass and filled it with a red juice, and then filled the remaining glass with ice in it with water. RC-A brought the items back to the table where she distributed them to other residents at the table. Throughout this observation, RC-A did not remove her gloves or sanitize her hands. During an interview on 4/17/17 at 5:49 p.m., the assistant director of nursing (ADON) stated staff are expected to wash their hands prior to assisting in the dining room and if they contaminate their hands by scratching their head or wiping their mouth, they should be performing hand hygiene. The ADON also stated when a RC leaves the table and returns, they should perform hand hygiene. The ADON stated there had been no training provided by the facility for RC-A in regard to infection control. The ADON verified RC-A was not a family member, but had been hired by the family to assist R3. The ADON stated R3 was the only resident who had a RC who assisted with feeding, and acknowledged RC-A	F 441	Infection control audits will be conducted weekly for 4 weeks with results reported to QA committee to determine ongoing compliance and frequency. The Clinical Administrator and Culinary Director will be responsible for ongoing compliance.	

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F 441	Continued From page 20 should not be providing food or liquid items to other residents. During interview on 4/17/17 at 5:59 p.m., the director of nursing (DON) stated he thought RC-A was a family member and was not aware of the issues. On 4/18/17 at 11:42 a.m., the administrator verified the facility had not provided RC-A any formal training related to infection control, gloves or washing hands. During a subsequent interview on 4/19/17 at 7:40 a.m., the administrator stated, "we would hope that they [resident companions] would follow all infection control policies and procedures. We would hope they would wash their hands and keep the resident safe." The facility's policy, Feeding Residents-Family, Volunteers, and Non-Nursing Staff dated June 2000, included: "Volunteers and Non-Nursing Staff: Volunteers (or any non nursing staff) who will be providing feeding assistance will complete a certified mealtime assistant training program that meets the training standards as defined in the approved state training curriculum.	F 441		

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	245621	A. BUILDING **01 - FOLKESTONE GABLES NH** B. WING _____	**04/19/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 19, 2017. At the time of this survey, Folkestone was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Folkestone is 5-story building with a full basement that was constructed in 2014 and determined to be Type II (222) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection on the corridors, spaces open to the corridors, and resident rooms that is monitored for automatic fire department notification. The building contains independent living, assisted living and skilled nursing beds. Folkestone is located on the fourth floor south wing and is separated from other occupancies on the same floor by a 3-hour fire wall. The three egress stairs and elevators serving Folkestone are surveyed as part of the certification. The facility has a capacity of 30 beds and had a census of 29 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.