		N SERVICES			CENTERS FOR MED	
					ND TRANSMITTAL	ID: 0USP
	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00096
1. MEDICARE/MEDICAID PROVID	DER NO.	3. NAME AND AI		ILITY		4. TYPE OF ACTION: $7(L8)$
(L1) 245271		(L3) PROVIDEN (L4) 3720 23RD A		ти		1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 797948100	NO.			11	(L6) 55407	3. Termination 4. CHOW
		(L5) MINNEAPO	JLIS, MIN			5. Validation6. Complaint7. On-Site Visit9. Other
5. EFFECTIVE DATE CHANGE OF	FOWNERSHIP	7. PROVIDER/SU		ORY	<u>02</u> (L7)	8. Full Survey After Complaint
(L9) 08/08/2007		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. 1 un Sui vey riter comprante
6. DATE OF SURVEY 04/0	05/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		· · · · · · · · · · · · · · · · · · ·
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO)N	10.THE FACILITY	IS CERTIFIED A	AS:		
From (a):		× A. In Complia	ance With		And/Or Approved Waivers Of 3	The Following Requirements:
To (b):		Program Re	equirements		2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
	100 (110)	<u>1.</u> A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size
12. Total Facility Beds	190 (L18)	D. N. C.	1		5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	190 (L17)	1	liance with Progra and/or Applied W		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKD	OWN	requirements	and of Applied W	urvers.	15. FACILITY MEETS	
18 SNF 18/19 SNF		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
18 5101 18/19 5101	17 5101	icr	IID		1801 (e) (1) 01 1801 (j) (1).	
(L37) (L38)	(L39)	(L42)	(L43)			
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REP	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION D	ATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
			AU15/2016		Mark mea	
Lisa Hakanson, HFE	NEII	0	04/15/2016	(L19)	Enforcement Speci	alist 06/02/2016
				(L19) GIONAL		alist 06/02/2016 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	Enforcement Speci	TATE AGENCY 06/02/2016 (L20)
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245271

May 19, 2016

Ms. Megan Luukkonen, Administrator Providence Place 3720 23rd Avenue South Minneapolis, Minnesota 55407

Dear Ms. Luukkonen:

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 March 23, 2016 the above facility is certified for:

190 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 190 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 eNotice.

Sincerely,

Mark meath

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 15, 2016

Ms. Megan Luukkonen, Administrator Providence Place 3720 23rd Avenue South Minneapolis, MN 55407

RE: Project Number S5271027

Dear Ms. Luukkonen:

On March 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on February 12, 2016. 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 April 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on February 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2016 and therefore remedies outlined in our letter to you dated March 4, 2016, will not be imposed.

However, as we notified you in our letter of March 4, 2016, 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 May 12, 2016.

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		1	DATE OF REVISI	Т
IDENTIFICATION NUMBER	A. Building				
245271 _{Y1}	B. Wing	Yz	2	4/5/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
PROVIDENCE PLACE		3720 23RD AVENUE SOUTH			
		MINNEAPOLIS. MN 55407			

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

ITE			DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0156		Correction	ID Prefix	F0241		Correction	ID Prefix	F0244		Correction
Reg. #	483.10(b)(5) - (483.10(b)(1)	10),	Completed	Reg. #	483.15	i(a)	Completed	Reg. #	483.15(c)(6)		Completed
LSC			03/23/2016	LSC			03/23/2016	LSC			03/23/2016
ID Prefix	F0279		Correction	ID Prefix	F0280)	Correction	ID Prefix	F0309		Correction
Reg. #	483.20(d), 483.	20(k)(1)	Completed	Reg. #	483.20 (2)	0(d)(3), 483.10(k)	Completed	Reg. #	483.25		Completed
LSC			03/23/2016	LSC			03/23/2016	LSC			03/23/2016
ID Prefix	F0314		Correction	ID Prefix	F0329)	Correction	ID Prefix	F0364		Correction
Reg. #	483.25(c)		Completed	Reg. #	483.25	ō(l)	Completed	Reg. #	483.35(d)(1)-(2)		Completed
LSC			03/23/2016	LSC			03/23/2016	LSC			03/23/2016
ID Prefix	F0497		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.75(e)(8)		Completed	Reg. #			Completed	Reg. #			Completed
LSC			03/23/2016	LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
REVIEWI STATE A		REVIEW (INITIAL		DATE		SIGNATURE OF	SURVEYOR			DATE	
		(GL/kfd	04/15/20)16		28230			4/5	5/2016
REVIEWI CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/12/2016				CK FOI ORREC	R ANY UNCORREC	CTED DEFICIEN ES (CMS-2567)	ICIES. WAS SENT TO T	A SUMMARY OF HE FACILITY?		s 🗌 no	

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01			DATE OF REVIS	IT
	B. Wing	Y	′2	4/4/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
PROVIDENCE PLACE		3720 23RD AVENUE SOUTH			
		MINNEAPOLIS, MN 55407			

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

ITEM	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
NFPA 101 Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC K0025	03/23/2016	LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR		DATE	
	TL/kfd	4/15/2016	 	370	009		4/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVE 2/10/2016	EY COMPLETED ON		R ANY UNCORREC	CTED DEFICIEN ES (CMS-2567)	NCIES. WAS A SENT TO THE		s 🗌 no

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	EDICARE/MEDICAID CERTIFICAT RT I - TO BE COMPLETED BY THE		ID: 0USP			
I. MEDICARE/MEDICAID PROVIDER NO. (L1) 245271 2.STATE VENDOR OR MEDICAID NO. (L2) 797948100	3. NAME AND ADDRESS OF FACILITY (L3) PROVIDENCE PLACE (L4) 3720 23RD AVENUE SOUTH (L5) MINNEAPOLIS, MN	(L6) 55407	Facility ID: 00096 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other			
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 08/08/2007	· ·	9 ESRD 13 PTIP 22 CLIA	8. Full Survey After Complaint			
6. DATE OF SURVEY 02/12/2016 (L34) 8. ACCREDITATION STATUS:	03 SNF/NF/Distinct 07 X-Ray 1	0 NF 14 CORF 1 ICF/IID 15 ASC 2 RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30			
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 190 (L18)	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	And/Or Approved Waivers Of The 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			
13. Iotal Certined Beds	X B. Not in Compliance with Program Requirements and/or Applied Waivers:	* Code: B *	(L12)			
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 190	F ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38) (L39)	(L42) (L43)					
16. STATE SURVEY AGENCY REMARKS (IF APPLICABL	E SHOW LTC CANCELLATION DATE):	I				
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY AP	PPROVAL Date:			
Douglas Stevens, HFE NE	II 03/15/2016	(L19) Kate JohnsTon, Pr	Kate JohnsTon, Program Specialist 03/28/2016 (L20)			
PART II - T	O BE COMPLETED BY HCFA REG	IONAL OFFICE OR SINGLE STAT	TE AGENCY			
DETERMINATION OF ELIGIBILITY I. Facility is Eligible to Participate 2. Facility is not Eligible	20. COMPLIANCE WITH CIVI RIGHTS ACT:		Interest Disclosure Stmt (HCFA-1513)			
(L21)						
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN 05/29/1984		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety			
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement			
	IVE SANCTIONS on of Admissions:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active			
(L27) B. Rescind	(L44) Suspension Date: (L45)		of Addre			
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS				
(L28)	03001	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE	Posted 03/29/2016 Co.				
(L32)		(L33) DETERMINATION APPRO	VAL			



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered March 4, 2016

Mr. Tyler Donahue, Administrator Providence Place 3720 23rd Avenue South Minneapolis, MN 55407

RE: Project Number

Dear Mr. Donahue:

On February 12, 2016, an extended 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 Gayle.Lantto@state.mn.us Telephone: (651) 201-3794 Fax: (651) 215-9697

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 March 23, 2016, 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 March 23, 2016 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician

of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Providence Place is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective May 12, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644

Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 May 12, 2016 (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 August 12, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Tom Linhoff, Fire Safety SupervisorHealth Care Fire InspectionsState Fire Marshal DivisionEmail: tom.linhoff@state.mn.usPhone: (651) 430-3012Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

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

		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245271	B. WING			02 / ⁻	12/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 156 SS=D	483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governi responsibilities duri facility must also pr notice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re any amendments to writing. The facility must inf entitled to Medicaid of admission to the resident becomes e items and services facility services und which the resident r other items and serving (i)(A) and (B) of this The facility must inf at the time of admiss the resident's stay, facility and of charg	483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in form each resident who is benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing ler the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and nt when changes are made to ces specified in paragraphs (5)	1	156			3/23/16
	The facility must fur legal rights which in	by the facility's per diem rate. rnish a written description of ncludes: manner of protecting personal					
	-	DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
	ically Signed		WI OIL				03/14/2016

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 03/15/2016

		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245271	B. WING		02/-	12/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	funds, under parage A description of the for establishing elig the right to request 1924(c) which deter non-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid e A posting of names numbers of all perti- groups such as the agency, the State lie ombudsman progra- advocacy network, unit; and a stateme complaint with the S- agency concerning misappropriation of facility, and non-cor- directives requirement The facility must infiname, specialty, an physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Medi-	raph (c) of this section; requirements and procedures jibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending eligibility levels. A addresses, and telephone inent State client advocacy State survey and certification censure office, the State am, the protection and and the Medicaid fraud control ont that the resident may file a State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance	F 156			

Facility ID: 00096

If continuation sheet Page 2 of 51

	-	AND HUMAN SERVICES			FORM	03/15/201 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245271	B. WING _		02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD		
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 156	Continued From pa	lge 2	F 15	56		
	by: Based on interview facility failed to prov residents (R44) rev beneficiary appeal Findings include: R44's Admission R- was admitted to the progress note dated resident discharged facility, R44 receive therapy services. R44's Medicare det according to the No Non-Coverage (NC the resident's respondent form was also date A registered nurse on 2/12/16, at 11:1 for issuing denial new was not progression was denied Medicat R44 was not able to his cognitive deficient received notice from R44's Medicare cov contacted R44's rest regarding the end of The son signed the 10/29/15. RN-C fur-	ecord indicated the resident e facility on 10/2/15. A nursing d 11/4/15, indicated the d on 11/4/15. While at the ed physical and occupational nial date was 10/29/15, otices of Medicare DMNC) it was noted, however, onsible party's signature on the		F156 The preparation of the followin correction for this deficiency de constitute and should not be in as an admission nor an agreer facility of the truth of the facts a conclusions set forth in the stat deficiencies. The plan of corre- prepared for this deficiency wa solely because it is required by provisions of state and federal Without waiving the foregoing the facility states that: 1. With respect to R#44, a ver for non coverage was provided 10/28/2015 and written notice non-coverage was provided to decision maker on 10/29/2015 discharged from the facility 11/ 2. Any resident who is current skilled stay and pending discha discussed daily mon-fri at the interdisciplinary meeting. Notic liability will be completed and s the appropriate party with 48 h advanced notice. 3. The IDT meeting minutes (f Guidelines has been revised to discussion of all pending discha admissions, billing, social serv and case manager and therap receive education regarding th for communicating discharges beneficiary notices within the r	bes not terpreted nent by the alleged on tement of ection s executed r the law. statement, bal notice l on of his . R#44 4/2015. ly on a arge will be ces of igned by ours form) and o include arges. All ice, MDSC y staff will e process and	

Facility ID: 00096

If continuation sheet Page 3 of 51

		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245271	B. WING		02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE		-	720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156 F 241 SS=D	have been given wi withdrawn. RN-C st notice, not a 48 hou A progress note wri indicated RN-C spo party regarding NO Medicare services of place to the son on left in the business as a copy. The Form Instruction Non-Coverage (NC 10/31/11 stated: "A plan must give in act the NOMNC to ben skilled careservice before the terminat An interview with th on 2/12/16,at 11:43 staff to use the prot provide a 48-our not time to plan for disc 483.15(a) DIGNITY INDIVIDUALITY The facility must pri- manner and in an e enhances each res full recognition of his This REQUIREMEN	an a two day notice should hen Medicare services were tated, "I gave him a 24 hour ur notice." itten 10/29/15, at 2:23 p.m. oke with R44's responsible MNC and last covered day for was 10/30/15. The call was 10/28/15. The NOMNC was office for him to sign as well ons for the Notice of Medicare DMNC) CMS-10123, approved Medicare provider or health dvance, a completed copy of reficiaries/enrollees receiving es no later than two days ion of services." the interim director of nursing a.m. revealed she expected tocol set forth by CMS to otice so residents would have charge. ' AND RESPECT OF omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.	F 156	time frames. 4. The administrator and or/design audit two residents admitted within past 30 days each week for one mo and then one resident each week for months to assure there is documer of appropriate notifications. 5. The data collected will be resent the QAPI committee by the adminis and/or designee. The data will be reviewed/discussed at the monthly meeting. At this time the committee make the decision/re-commendation regarding any neccesary follow up studies.	the onth or two ntation ted to strator quality e will on	3/23/16
	by:	tion, interview, and document		1. With respect to R #22, and R#	186:	

Facility ID: 00096

If continuation sheet Page 4 of 51

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	0938-039 SURVEY PLETED
		245271	B. WING			
	PROVIDER OR SUPPLIER	243271		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	12/2016
	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 241	attire was maintaine R186) who reported Findings include: R22 was interviewe follow up on concerviewe follow up on concerviewe to concerviewe voiced by the reside on 2/8/16, at 2:39 p R22 was admitted to that time arrived with much of her clothin The resident explait pair of pants, and for R22 explained that she had been inform with the exception of complained of her massistant (NA) she happens." The NA missing clothing in find any of the reside stated she was "stu- horrible hospital go found her a pair of	ailed to ensure appropriate ed for 2 of 2 residents (R22, d missing clothing. ed on 2/10/16, at 2:43 p.m. to rns regarding various concerns ent during a formal interview o.m. voiced by the resident. to the facility in 5/15, and at th seven pair of pants, and g had since "disappeared." ned she currently had only one our other pair were "missing." on Saturday morning (2/6/16) med "I had nothing to wear" of a shirt. When R22 missing clothing to the nursing reportedly responded, "It then went to look for R22's the laundry and was unable to dent's pants. The resident uck in the chair with the wn" until noon, when the NA "very ugly" men's pants to	F 24	 social services has approached th residents regarding missing clothin items. All items that were not four been replaced. 2. All feedback forms for the past months have been reviewed for M property. All residents identified w missing items have been followed the items found or replaced as abl 3. The system for logging in concard action plan results is revised t include a three day time frame. Concerns/forms are brought up dat the morning idt meeting all staff wir receive re-education regarding the missing property guideline and feet form for reporting missing items by 3/23/16. 4. The director of nursing and/or designee will audit three residents week for two months for assuring resident is dressed in a dignified m and has appropriate attire availabl 5. The data collected will be preset the QAPI committee by the director nursing. The data will be 	ng nd have three issing ith up and e. erns o aily in II edback y each that the nanner e. ented to or of	
	without clothing and something for me to staff for help and to she "gave up weari laundry and "noboo bra on." The reside permission to look the only clothing av sweaters, shawl, co R22's 1/21/16, Mini	liating to be defenseless d having someone looking for o wearI'm dependent on the take care of me." R22 stated ng bras" as they got lost in the ly caresI feel better with a nt gave the surveyor in her closet and dressers and railable was six shirts, two bat, and no pants, and no bras.		reviewed/discussed at the monthly meeting. At this time the committe make the decision/recommendation regarding any necessary follow up studies.	ee will on	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245271	B. WING _			02 / ⁻	12/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	and required extens dress. The licensed gradu interviewed on 2/10 and stated she did clothing, and had ne was missing pants. On 2/11/16, at 9:08 services (DSS) exp grievance for R22 c missing clothing. T ombudsman had in clothing over the we order clothing for th a.m. the DSS said f and obtained a list of meantime, they had laundry which was l	sive assistance from staff to atte social worker (LGSW) was	F 2	41			
		sing stated in an interview on n. the staff should have sing clothing.					
	a.m that approxima had been complain He thought the prot was inadvertently b an outside laundry s should have instead facility. He said par some staff were unit	explained on 2/12/16, at 10:05 tely three months prior there ts of missing resident clothing. olem was personal laundry eing sent out with the linens to service, when the laundry d been laundered at the r of the problem was that sure how to pass on such cility's policy was to replace y were responsible.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245271	B. WING	i		02/*	12/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVID	ENCE PLACE				8720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	R186 (whose room hallway from the nu observed wearing of wheelchair at the nu 2/12/15, at approxin registered nurse (R resident, "Let's go of room] and take a lo underwear, R186 a At 1:21 p.m. R186 two to three times in laundry. I was miss and said he had rep LGSW that day. R' wait another ten we like they did the las had to buy them my to come out in my u supposed to do?" R186's 11/28/15, M cognitively intact. RN-D was approact and immediately sta blanket on him [R18 around in his under shorts. We went do of his shorts. He tol The facility's 2/11 P indicated the facility or missing items, ho recovery of items w person reporting the Feedback Form" wi executive director."	was at the far end of the rsing station/elevator) was only underwear as he was in	F	241			

L

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		E SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CON	IPLETED
		245271	B. WING _	·····	02/	/12/2016
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	ЭЕ	
ROVIDI	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 241	and Dignity policy n	ge 7 4, Promoting Resident Rights oted each staff member was ecting and promoting each	F 24	.1		
F 244 SS=F		N/ACT ON GROUP OMMENDATION	F 24	4		3/23/16
	must listen to the vi grievances and rec and families concer	family group exists, the facility ews and act upon the ommendations of residents rning proposed policy and ns affecting resident care and				
	by: Based on observat review, the facility fa addressing residen was implemented to to residents' satisfa This practice had th residents including several residents (F R48, R192, R129, F un-addressed conc served cold and ina well as residents (F missing clothing. Findings include: SNF [Skilled Nursin Meeting Agenda an were reviewed. The	erns regarding residents being appropriately cooked food, as (186, R22) who reported ag Facility] Resident Council d Minutes from 8/15 to 1/16		 With respect to the identifive residents: each resident was individually and an action plar for resolution to concerns. A meeting with each of the identified residents will be conducted to level of satisfaction and any furneeded. The previous 6 months of council minutes have been rea plan of action developed for identified concerns regarding: food quality, and missing item follow up resident council meeting and concerns an continued areas of concerns. The system for logging in a continued a response within a 3 frame. Concerns/forms are bear such as the system for logging in the system. 	met with developed follow up tified determine urther action resident viewed and the call lights, s/laundry. A eting is taken, and n. concerns sed to day time	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
NU FLAN (IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	
		245271			02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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) COMPLETIC DATE
F 244		ge 8 locumentation showing the	F 24	4 leadership team will receive educ	ation	
	facility's actual resc Examples were as	olutions to residents' concerns. follows:		regarding the procedure for follow resident council concerns and ac plans for correction. Education	v up to tion	
	1) On 8/19/15, Old Business: a) a resident on 2 north reported room trays were late and "luke-warm" and two other residents on 2 north stated nursing assistants (NAs) who served meals need to be "more attentive and They			 completed by march 23 2016. 4. The executive director and/or will audit the resident council min areas of concern identified and an areas of concern identified and areas of concern identified areas of concern identifi	utes, ction	
	[residents] feel like Additional issues in knocking c) missing	they are getting ignored." cluded b) staff "still" not g clothing d) bathroom		 plans post council. Action plans of audited to assure satisfactory out as much as possible. 5. The data collected will be presented as a plan of the presented of the presented of the plan of t	comes	
	The Action was to f The Resolution and Business included	usic selection during meals. ollow up with appropriate staff. I Date was "Ongoing." New a) salads were "still" being ain meal, and b) suggested		the qapi committee by the execut director. The data will be reviewed/discussed at the month meeting. At this time the commit make the decision/re-commenda	y quality tee will	
	residents complete their dining experie (continued issue) a	anonymous audits related to nce, staff not knocking nd residents wanted a plan of action or responsible		regarding any necessary follow u studies.		
	party was designate suggested resident completed audits fr	ed. Although council members s complete audits, staff om 8/14/15 to 8/31/15. The de whether food was served at				
	the proper tempera 2) On 9/16/15, Old action including foll	tures. Business was noted, with ow up with appropriate staff on				
	of nursing (DON) to Resolution and Dat Business: request t	the administrator and director the meetings. The e was "Ongoing." New o know where to find				
	housekeeping issue bathrooms), missin	gnage by the community book, es (smells, cleaning g clothing, staff not knocking. additional grievance forms,				
	adding requested s housekeeping, and	ignage, follow up with follow up with nursing staff. of Rights for right to voice				

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		AND HUMAN SERVICES & MEDICAID SERVICES				F	ITED: 03/15/20 ORM APPROVE NO. 0938-039	ΞD
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED	
		245271	B. WING				02/12/2016	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PROVID	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE		N
F 244	grievances was covindicate whether stawhether they felt the adequately address 3) On 10/21/15, Old Resolution for griev completed. "Completed. "Completed. "Completed." Completed. "Completed." Completed. "Completed." Completed. "Completed." New Business: Call would like name tags including elevator of food temperature a member voting. Act at unit meetings, all name tags, housek issues"-under new bathroom, but was explained food serve effort with nursing to 4) On 11/9/15, Old "ongoing education and shower cleaned times getting better still improve. No Act 5) On 12/16/15, Old resolution was "ong Request to continue call lights are longe "night shift needs a who is supervisor o 6) On 1/20/16, Old knocking at unit me light system works improving over the	vered, however, did not aff asked the residents eir grievances were eed by facility staff. I Business included ance forms and signage was eted/ongoing: New ctor has been hired and resolved. Ongoing: education o assist with these concerns." lights still remain a concern, gs visible, cleaning issues arpet and mold in the shower, nd serving times, council ion Plan: Continue to educate staff reminded regarding eeping is addressing "many management and no mold in cleaned, dietary manager ice delivery process is a team o pass meals. Business: Resolutions , new housekeeping manager, d. New Business: call light but some residents felt could tion listed. I Business: Call light oing." New Business: e education on door knocking, r than residents would like, refresher," want sign as to	F2	244				

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CENTER STATEMENT	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		FORM MB NO. (X3) DATE	03/15/2016 APPROVED 0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		COM	PLETED
		245271	B. WING			02/*	12/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	In addition, the resident for the second sec	dent grievance log from also included resident it with concerns brought up in betings such as: 11/20 room ghts; 12/3 room cleaning; 12/8, (3N); 12/8 lack of food variety d (3N); 12/16 food issue (3N); m odors, showers; 12/22 N); 12/22 meal concern (3N); ts" meal concerns; 1/6 call I (2N); 1/13 food concerns ary concerns (3N). The d various staff members ent concerns.	F2	244			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY IPLETED
		245271	B. WING			02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PROVID	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244	resident expressed follow up. During an interview the dietary manage had called in and he rushing around the on duty. The DM si were 8:00 a.m. 12:0 Continuous dining of conducted on 2/8/1 p.m. Twenty-five re- dining room waiting served. A cart conta near the serving do p.m. a NA began as wanted a salad. At serving salads whe kitchenette to indica to be served. The f at 12:37 p.m. Forty p.m. a resident roor resident. R17 reported on 2/8 often served late. T she had recently be R105 reported on 2/8 was often served lut food. When she rec it was often not mic	ge 11 satisfaction regarding the on 2/8/16, at 8:26 a.m. with r (DM) he explained two staff e apologized that he was kitchen to help the other staff tated meals times for all floors 00 p.m. and 6:00 p.m. observations on 2N were 6, from 12:09 p.m. to 12:37 sidents were seated in the for the noon meal to be aining salad ingredients was or by the kitchenette. At 12:17 sking residents whether they 12:26 p.m. the NA continued n the doors opened into the ate the main meal was ready first plate of food was served r-five minutes later at 12:48 m tray was delivered to a 8/16, at 12:24 p.m. food was he meat was often tough and een served slimy mushrooms. //8/16, at 12:30 p.m. he did not id he had been served rgers and burnt eggs. 8/16, at 12:30 p.m. the food kewarm and she preferred hot quested the food be reheated, rowaved until it was hot. an interview on 2/8/16, at 3:30		244			

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM MB NO.	03/15/2016 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245271	B. WING			02/1	12/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(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 244	p.m. he ate his meat the noon meal that was cold and was m meatloaf was awful beans." Then R195 "here see it states of R195 stated that so about the food and DM, but instead and sent. In a follow up p.m. R195 describe and always late. Th was frozen." R195 conference four we to come to his room this morning my bre 8:00 a.m. and delive have my daughter b always chickenno bananaseverythin R217 stated in an ir p.m. that the food a facility were a "failur menu in one week t the food as "horribl seasoningmushy. reportedly routinely meetings, and said brought up by resid personally spoke up concerns. The dieta some of the meetin there were plans for changed since last the same menus. W could not get more items were "season"	als in his room. He did not eat day because it arrived late, not what he had ordered. "The and I wanted corn not green 5 pointed to the monthly menu corn today not green beans." mething needed to be done had requested to speak to the other dietary staff person was interview on 2/11/16, at 4:36 ed the food as "Always cold e eggs are cold and my milk explained that at a care eks ago he asked for the DM n to discuss food issues. "Just eakfast order was taken before ered to me at 8:25 a.m. "I oring in food because it's o fresh fruit like ng comes in a can."	F2	244			

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
		245271	B. WING			02/		
NAME OF	PROVIDER OR SUPPLIER	•	·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
PROVID	ENCE PLACE				20 23RD AVENUE SOUTH INNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 244	specifically request she would not be so was served broccol R217 stated that to the second option f not get broccol and anyway. Vegetables and foods were offe overcooked." That veal patty that was middlealmost cold in her room and he served cold. Althou begin at 12:00 p.m. between 12:30 and were the last to be other residents con undercooked and p told by the DM to ha microwave. R217 m "once," but staff did When she was served staff never returned she was given pure regular diet, the nur away and did bring reported food often due to dishwasher plates did not keep Approximately half delivered to her roo warmer and the cov keep the food warm she was served a h mustard and ketchu In addition, the resi snacks were not be	In the middle, they were ave their food be reheated in the middle, they were ave their food be reheated in the middle, they were ave their food be reheated in the middle, they mene in the middle, they mene is mener. The mener mener is the mener is mener mener is more mener mener is mener mener mener mener mener mener is mener mener mener mener mener mener is mener	F 2	244				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/15/2016 APPROVED 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245271	B. WING		02/-	12/2016
NAME OF PRO	OVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDEN	CE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
re bo or M re R a a a e rc a a th " to to so a c M re F D si g R re re R a ta u th "	rought up to staff a n here and keeps (esident council me linimum Data Set of esident was cogniti 48 reported in an in pproximately 1:00 ttended resident con- xplained she prefe- born, but "the food nd always late." A t 4:26 p.m. R48 st neal tray was delived in late." R48 expla- neeal tray was delived in late." R48 expla- to then they give old food but I pay a /hy can't I get a go esidents suggested rito pie and cream M just tells the res- ure all residents ca et it." 192 said on 2/10/1 egularly served late exportedly being ser 192 stated, "ish."	and "is not being followed up getting mentioned at every eting." R217's quarterly dated 12/14/15, revealed the	F 244			

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		AND HUMAN SERVICES				FORM	: 03/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245271	B. WING	i		02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 244	Continued From pa	ge 15	F	244			
		16, at 12:15 p.m. the food often cold and was often					
	11:55 a.m. the DM complaints about m R195. The DM star milk so fast that it d expiration date on t explained he was o and this was the first to speak to him, an DM verified a dietar	t on 2/10/16, at approximately stated he had heard of hilk being always spoiled from ted the facility went through lidn't even get close to the he container. The DM n vacation the previous week, st time he heard R195 wanted d had not yet done so. The ry staff person had spoken to sues, mainly about spoiled					
	LAUNDRY:						
	he was in wheelcha 2/12/16, at approxin R186 explained, "I shorts todayI don weeks for them to r last time when I los myself. It bothers r	d wearing only underwear as air at the nursing station on mately 1:10 p.m. At 1:21 p.m. was missing eight pair of 't want to wait another ten eplace them like they did the t six pair. I had to buy them ne that I had to come out in what am I supposed to do?"					
	2/6/16 she had bee wear" with the exce complained of her r assistant (NA) she happens." The NA missing clothing in find any of the resid	10/16, at 2:43 p.m. that on n informed "I had nothing to eption of a shirt. When R22 missing clothing to the nursing reportedly responded, "It then went to look for R22's the laundry and was unable to dent's pants. R22 also stated ng bras" as they got lost in the					

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245271	B. WING			02 / ⁻	12/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	laundry and "nobod bra on." The reside permission to look if the only clothing av sweaters, shawl, co The administrator e a.m that approxima had been complain He thought the prob been inadvertently so outside laundry ser have instead been said part of the prob unsure how to pass clothing). During an interview director of commun the representative f attend all meetings. grievances. The DC concerns during the issue was brought f appropriate staff for issues to the DM). brought up the sam meeting, she starte except this time she "the issue has com On 2/11/16, at 4:07 attended resident c they talked to reside DM verified he was regarding food tem 3N. The DM explain had purchased ther	ly caresI feel better with a nt gave the surveyor in her closet and dressers and ailable was six shirts, two bat, and no pants and no bras. explained on 2/12/16, at 10:05 thely three months prior there ts of missing resident clothing. Dem was personal laundry had sent out with the linens to an vice, when the laundry should laundered at the facility. He blem was that some staff were is on such information (missing or n2/11/16, at 3:57 p.m. the hity life (DCL) stated she was for resident council and tried to . She handled related resident CL explained if residents had e meeting, she ensure the forth and delivered to the r follow up (such as food The DCL stated if a resident be concern at the next id the process all over again, e would tell the staff person	F 2	244			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245271	B. WING			02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH /IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244 F 279 SS=D	plates "go up the lin preparedWe put the hotthen I'm not sup plate is ready to be staff to deliver it to the effort. Sometimes mand there are no nup plates." The facility's 2/1/15 meeting Guidelines department will reprise issues/concerns/ch follow-up of any pre- identified by resider Feedback Form Gu indicated the "Depart investigate the griev and record the findi well as the action pla appropriate area or Action PlanExecut Head is responsible who initiated the Fe them with feedback concern within (3) w concern." 483.20(d), 483.20(k COMPREHENSIVE A facility must use the to develop, review a comprehensive plant	a food in the hot wells, and he as soon as they are he food on the plate and it's re what happens once the served. It's up to the nursing the resident roomit's a team my staff is just standing/waiting arsing assistants to serve the , Resident Council and Tenant indicated "each individual ort on anges etc. and will report on evious issues or concerns hts." The facility's 2/15, hideline and Action Plan thent Head or designee will vance/comment/suggestion ngs of the investigation as lan for the resolution on the the attached Feedback Form tive Director/Department of contacting the person edback Form and provide on the resolution on the vorking days of receiving the exo(1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's	F 2				3/23/16

Facility ID: 00096

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY		
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED 02/12/2016		
							NAME OF PROVIDER OR SUPPLIER
PROVIDENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 279	Continued From pa	age 18	F 27	9			
	medical, nursing, a	nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment the.					
	by: Based on interview facility failed to ens interventions were prior to administrat 1 of 5 residents (RS medication use; in ensure the care pla necessary interven minimize the risk for breakdown for 1 of with pressure ulcer Findings include: R56's current care the use of psychotr appropriate interve R56. In addition, th current assignment	NT is not met as evidenced v and document review, the ure non-pharmacological developed and implemented ion of a psychotropic drugs for 56) reviewed for unnecessary addition, the facility failed to an was developed to include tions to promote healing and or further pressure ulcer 2 residents (R222) reviewed s. plan lacked identification of opic medications, goals, and ntions to promote sleep for e nursing assistant (NA) t sheet for R56 lacked any egarding measures to promote		 With respect to R#56: the can has been revised to include the n pharmacological measures to prosleep prior to administration of medications. With respect to R#2 care plan has been revised to incomeasures in place to promote wo healing and prevent further break well as R#222 rejection of care. It has been provided the risks asso with rejection of care. The NAR assignment sheets have been reviewed to assure non-pharmacomeasures are identified prior to administration of any prn medications with current with current with a sheet with current with cu	on mote 222, the lude all und down as R#222 ciated vised to g ve been blogical ions for vounds		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245271 **B** WING 02/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH **PROVIDENCE PLACE MINNEAPOLIS, MN 55407** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 Continued From page 19 F 279 R56 was prescribed Trazodone HCL breakdown including any rejections of (anti-depressant) 25 milligrams (mg) as needed care. The NAR assignment sheet has (prn) at bedtime to promote sleep according to been updated to reflect any changes. the resident's 2/16. Medication Administration 3. All nursing staff will be re-educated Record (MAR). After the pharmacy consultant regarding non pharmacological measures recommended a dosage change of Trazodone to promote sleep and measures to from 25 mg to 25 mg prn the dose was prevent skin breakdown, what to report decreased to prn on 10/19/15. Although the and how the information/interventions are hours of sleep were documented on the to be communicated. Education will be Treatment Administration Record (TAR), it lacked completed by 3/23/16. any information related to non-pharmacological 4. The director of nursing and/or designee interventions that may have been attempted prior will audit three residents each week for to administering the as needed medication. one month and then two residents per week for two months to assure the plan of An interview with the pharmacy consultant on care for the individual resident is being 2/10/16. at 11:16 a.m. revealed Trazodone was revised and followed. first prescribed for R56 on 3/9/15, at 50 mg at 5. The data collected will be presented to bedtime to promote sleep, and the current dose the QAPI committee by the director of was 25 mg prn. The medication had been 10 nursing. The data will be times in 1/16. The consultant further stated reviewed/discussed at the monthly quality non-pharmacological interventions should have meeting. At this time the committee will been attempted at least an hour prior to use of make the decision/re-commendation psychotropic medications including Trazodone, regarding any necessary follow up especially when it was prescribed as needed. She studies. also stated she expected side-effects and effectiveness would be monitored. On 2/10/16, at 11:53 a.m. a registered nurse (RN)-C reported the facility did not have specific non-pharmacological interventions identified to improve the resident's sleep. She stated, "We try to figure out her day. If she had enough to eat, if she is in pain, if she needs to be toileted or repositioned. If all else fails we give her a prn." RN-C verified the interventions were not documented in R56's MAR/TAR or outlined in her care plan. During an interview on 2/12/16, at 11:54 a.m. the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES			FORM	: 03/15/2016 APPROVED . 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245271	B. WING		02/	12/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVIDENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	director of nursing (Trazodone use, "W for prn medications did to help them res At least you should further explained sh non-pharmacologic of side effects and sleep medications f At 11:53 a.m. a regi the facility did not h nonpharmacologica sleep. She stated, she had enough to needs to be toileted fails we give her pri interventions were pri records or care plan The Providence Pla Procedure for Sleep directs staff to indiv non-pharmacologic increase comfort ar will be added to a re (nursing assistant) A 9/13, Practice Gu Sleep Monitoring, d staff non-pharmaco to increase comfort will be added to a re (nursing assistant) A 9/13, Psychoactiv Monitoring policy, n "provide monitoring	DON) stated regarding the hen it is for sleep, especially , you should chart what you st and not just give them a pill. talk to them." The DON ne was unaware of current al interventions or monitoring effectiveness for sleep and for R56. istered nurse (RN)-C stated ave specific al interventions to improve "We try to figure out her day, if eat, if she is in pain, if she d or repositioned. If all else n." RN-C verified these not documented in R56's n. ace Practice guideline and o Monitoring, dated Sept 2013, idualize staff al interventions intended to nd promote adequate sleep esident care plan and NA sheet. ideline and Procedure for lirected staff to "individualize ological interventions intended and promote adequate sleep esident care plan and NA	F 279	9		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			0MB NO. 0938-039 (X3) DATE SURVEY COMPLETED 02/12/2016	
		PROVIDI	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 279	Continued From pa change in psychop	age 21 harmacological medication."	F 2	79		
	R222's care plan was not developed to incorporate all necessary interventions to promote healing/prevent further breakdown. R222's care plan last reviewed 12/15/15, revealed the resident had diagnoses including paraplegia (paralysis of lower limbs) and a history of multiple pressure ulcers related to immobility, including surgical repairs of a sacral ulcer on 2/23/15, and a stage 4 right ischial tuberosity (buttock) ulcer identified 11/24/15. The care plan indicated stage 2 pressure ulcers had developed on the resident's coccyx while he was hospitalized. Staff interventions included for staff to "educate resident/family/caregivers as to causes of breakdownEncourage reposition/position changes during Customer Service RoundsAvoid positioning on areas of concern. Pressure relieving device for bed, rotating low air loss mattress, turn, reposition at least every 2 hours, more often as needed or requested." The care plan did not indicate any concerns with the resident rejecting care (e.g. refusal to turn/reposition), and there were no approaches identified to educate the resident regarding the risks and benefits of his choices. In					
	regarding the need cushion for proper for further pressure The current 2/9/16 directed staff to as [Reposition: assist	blan lacked any information to check the wheelchair inflation to minimize the risk e ulcer complications. , Nursing Assistant Care Plan sist R222 to "Repos: A2-4" every two to four hours] and ery two] hours/Nurse&NAR"				

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	FORM	03/15/2016 APPROVED 0938-0391							
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245271	B. WING			02/-	12/2016		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
PROVID	ENCE PLACE		3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 279	(nursing assistant). on the Nursing Assis monitoring the inflat R222 was observed air mattress in bed electric, tilt-in-space The wheelchair had front and cutout in the bladder where the r contoured backrest on the air-filled port During interview with a.m. he reported he ulcer in June of 201 air-containing prote wound deteriorated surgical repair. R22 discovery of the pre- was low and neede soretelling my nur had a hand pump in told them it was low wouldn't do anythin the rear of both legs severe (larger and developed a big ulc part meets the air p the right ulcer even debridements (surg and surgery to close R222 said that he h Kenny rehabilitation [the air cushion] wa specified. R222 sta had inflated it and a	There were no instructions istant Care Plan related to tion of the wheelchair cushion. d in his room while lying on an on 2/11/16, at 8:45 a.m. An e wheelchair was in the room. d a seat cushion with a foam the rear filled with an air resident would sit, as well as a t. The surveyor briefly pressed tion, which contained air. th R222 on 2/11/16, at 8:45 e had developed a pressure 15. Despite the use of an ective wheelchair cushion, the l and eventually required 22 asserted that prior to the essure ulcer, the air bladder ed refilling. "I was getting rse that my Roho air cushion in the closet to fill my seat. I v and needed to be filledstaff g about it." Ulcers formed at s, with the right one becoming deeper). "[The area] cer at the point where the foam part in an edge." R222 stated		279					

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245271	B. WING			02 / [.]	12/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	said the physician h learn the proper ass The resident explai to "come and put while it was under r idea of what a prop would bethat never registered nurse (R R222 then showed illustrating how muc between the cushio the resident was se A 6/2/15, a quarterly R222 indicated: "Do more pressure ulce However, the reside pressure ulcer dever interventions were i extensive assistant transfer. MDS asse R222 was cognitive care or present othe A physician order d "Please contact wo managing Left IT [is ulcer and coccyx [ta appointment ASAP seen in wound clinic colleague." An appointment ref Courage Kenny 6/2 cushion was compl further indicated Co during the session of ensure proper positi	had directed the facility staff to sessment/inflation technique. ned the staff were supposed their hands on the cushion my butt so they would get the erly inflated cushion for me er happened," except by N)-E "a couple of times." the surveyor a paper diagram ch space should have been on base and the buttocks when	F 2	79			

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		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED
STATEMENT	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245271	B. WING		02/	12/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	orders: Check cush pressure sores." Further review of R treatment administr failed to indicate sta cushion daily to ens R222's needs. In ad in any progress not was ever checked f Wound Summary d back" (a photo reve tuberosity/IT) indica dated 6/23/15, of a (healthy) base whic (cm) in length, 5.1 of (2.5 x 5.1 x 0 cm). If increased to stage 4.5 x 5.8 x 5.5 cm (depth). Following surgical of dated 8/6/15 include Kenny and position for [R222]. Braden MODERATE RISK" infections, diabetes dependence on sta and current pressur from 8/8/15 indicate refusing to get out of A significant change indicated R222 had pressure ulcer, with x 06. x 05.5 cm.	222's medical record including ration sheets, and care plan, aff had been checking the sure proper inflation to meet ddition, there was no evidence es to indicate R222's cushion for proper inflation. Allocuments for "Right thigh ealed it was the right ischial ated an initial measurement stage 2 ulcer with a red th measured: 2.5 centimeters cm in width, and 0 cm in depth By 7/29/15, the ulcer was 3 and was greater in size at a significant increase in debridment, a progress note ed, "Comprehensive Courage ing evaluation was completed score 14.0 indicating due to co-morbidities, wound a, narcotic use, immobility, ff for activities of daily living, re ulcers." A progress note ed, "Wound vacresident	F 279	, 		

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245271	B. WING	i		02/-	12/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	 9/8/15, included: "Fwheelchair cushid well and [no] conce Physician orders: F. [check] manual inflaweek. Roho cells a [standard] guidance However, a review summary did not ad appointment or phy monitor the resident therapy progress not "Physical Therapy/ Requires Courage resident's medical af such that there is p condition without C intervention." A physician's progratic included: "wound in foam in the underrry you call [physician to care had been disc requested. In additi care plan for that the no changes made to The physician's progratic indicated, "Pressure cushion slightly air 	age 25 Reason for appointment on mapping. Cushion mapped orns when is properly inflated. Recommend therapist at facility ation of cushion one [time per] re slightly under-inflated per e for best pressure relief." of the facility's charting ddress the resident's 9/8/15 risician's order for therapists to at's wheelchair cushion. A bote dated 9/9/15 included: Occupational Therapy Kenny nursing to meet needs. Promote recovery, and ety. Condition of resident is otential for changes in ourage Kenny nursing ess note from 10/26/15, nprovedcontinue to pack nined area of the wound. Can name] in 1 week to discuss per provided]." A nursing note 2 was at the wound clinic for a lithough it was noted staff were ac and drainage from the id not reflect any follow-up call ensure that R222's plan of ussed as the physician had on, review of the resident's me indicated there had been to R222's care plan. or R222's care plan.	F	279	λ		

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		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245271	B. WING		02/12/2016		
NAME OF	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
PROVID	ENCE PLACE		3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 279	Recommend therag [one time per] week following this visit d therapists were che proper inflation. A th indicated, "Therapy [incomplete sentem SUMMARY: Patient minutes at 2000 [8: on its [sic] own. Dre like it is healing wel [sic] on his right but blanchable compar Therapy notes from services include Ph services are Post-s Nursing." On 12/29, indicated, "refused indicated the reside help when he was r note did not reflect related to his choice During an interview confirmed the cush R222's wheelchair i instructions had be following his last we repair (11/2015) wh proper inflation wee to be up in the chai believed he was su every two hours. Sh repositioning was n the care sheets. RN-E was again int a.m. RN-E stated t	age 26 bists check inflation on cushion k." Review of the therapy notes id not identify whether the ecking the cushion weekly for herapy note dated 12/26/15 y services provided include. ce] Additional services are t was in his chair for 15 00 p.m.]. Repositioned twice easing changed; incision looks I. The spot the surgeon cirled ttock is firm and mildly ed to the surrounding" n 12/28/15 indicated, "Therapy hysical Therapy. Additional urgical services Restorative /15, a nursing progress note turning and repositioning" and ent had said he would call for ready to be repositioned. The education of the resident e to decline repositioning.	F 279				

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245271	B. WING			02/	12/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				20 23RD AVENUE SOUTH INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279 F 280 SS=D	hours a day, refusir then requested doc assessment, or risk pressure having be and any related car stated, "I did expres up so much," which discussed during w documentation to th resident's record. F whether the care pl R222's refusal to be The facility's 9/10, F Program policy indi prevention would be standards of practic the interdisciplinary made based on cha or when new risk fa assessment of the repositioning based The summary analy any others that affe pressure ulcer prev 7. The plan of care stabilize and/or red risk factors for Pres and/or promote hea Ulcers13. Ongoin and family in Press 483.20(d)(3), 483.1 PARTICIPATE PLA	ng to lie down. The surveyor sumentation regarding any (/benefit of not relieving en reviewed with the resident, e plan interventions. RN-E ss concerns about him being n she stated she had ound care, although nat effect was not found in the RN-E stated she was unsure an had been updated to reflect e repositioned. Pressure Ulcer Prevention cated pressure ulcer e based on community ce that would be monitored by team. Revisions were to be anges in a resident's condition toctors were identified. "2. An resident's need for turning and d on individual risk factors6. ysis of these assessments and ct the resident's individual rention and/or treatment plan. reflects approaches to uce or remove the individuals sure Ulcer development aling of existing Pressure ig education of the resident ure Ulcer Prevention." 0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2				3/23/16

Facility ID: 00096

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		AND HUMAN SERVICES			FOF	D: 03/15/2016 M APPROVED O. 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X3) D	ATE SURVEY OMPLETED
		245271	B. WING			2/12/2016
NAME OF	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	ENCE PLACE			37	720 23RD AVENUE SOUTH	e neet m
				Ν	IINNEAPOLIS, MN 55407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
F 280	changes in care an A comprehensive c within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	-	F 2	280		
	by: Based on interview facility failed to ens reviewed and revise 1 of 1 residents (R ⁻ changed following I Findings include: R167's hospital dis 2/5/16, revealed the lower extremity dee significant lower leg discomfort on 1/25/ a prescription for w minimize the risk for blood clots). A Quic leg swelling was inc	charge summary, dated e resident developed a left ep vein thrombosis (DVT) with g extremity swelling and some (16. R167 was discharged with arfarin (anticoagulant used to or heart attack, stroke, and ck Wrap instruction sheet for			 With respect to R#167: physician orders have been clarified and the care plan has been updated to reflect any changes to his treatment plan post hospital stay. The NAR assignment she has been updated to reflect these changes. The resident has since discharged from the facility. All residents who have returned from the hospital within the past three months have had their records reviewed for any changes to their plan of care with revisions/updates to the care plan as indicated. The NAR assignment sheet has been updated to reflect any changes All nursing staff will be re educated by 3/23/16 regarding updating the resident care plan upon receipt of new orders, hospital return or change in condition 	5.

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245271 B. WING 02/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH **PROVIDENCE PLACE MINNEAPOLIS, MN 55407** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 280 Continued From page 29 F 280 12/17/15, however, did not include any problems, including revisions to the NAR assignment goals or interventions related to R167's DVT and sheet when changes occur. use of warfarin. A 2/5/16 individual temporary 4. The director of Nursing and/or care plan lacked any identification of R167's new designee will audit three resident care problems with appropriate goals and interventions plans each week for one month and then to manage the problems. two resident care plans per week for two months to assure the plan of care for the individual resident is being revised and On 2/10/16, at 1:49 p.m. the RN-B and RN-A confirmed R167 had been hospitalized on followed. 1/21/16, and discharged back to the facility on 5. The data collected will be presented to 2/5/16. RN-A and RN-B confirmed R167 had new the QAPI committee by the director of diagnoses including DVT and was prescribed nursing. The data will be warfarin. RN-A reported a new care plan had not reviewed/discussed at the monthly quality been developed for R167 since he was meeting. At this time the committee will make the decision/re-commendation scheduled for a significant change Minimum Data Set (MDS) assessment in the next few weeks. regarding any necessary follow-up RN-A explained a temporary care plan could have studies. been initiated to address concerns the new issues, however, the care plan had not yet been developed. RN-B reported therapy staff were wrapping R167's legs and nursing staff was applying Jobst stockings. However, on 2/11/16, at 8:35 a.m. RN-B clarified the Jobst stockings were an order prior to R167's hospitalization and a new order had been obtained to instead wrap R167's legs. RN-B reported the care plan should have been updated on 2/5/16, when R167 returned from the hospital. R167's physical therapy (PT) plan of care, dated 2/5/16, revealed R167 had lower legs bandaged for the assessment. No care plan goal related to leg bandaging or wrapping. A PT note dated 2/5/16, read "pt [patient] has LE [lower extremities] bandaged and instructions were sent. however no actual order for either therapy or nursing to performR [sic]." On 2/11/16, at 8:30 a.m. the director of

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 03/15/2016

		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245271	B. WING		02/-	12/2016
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE		-	720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280 F 309 SS=D	rehabilitation therap staff was not wrapp not have a current of A review of progress 2/10/16, did not ind contact with R167's leg bandaging or w could be out of bed R167's orders repo an order for warfari until 2/10/16, at whi normalized ratio (IN determine how thick be obtained. An or obtained on 2/10/16 for staff to now allow wheelchair for great The facility's 8/13, 0 directed, "A resident admission. The cor updated/revised as directed staff to inc current and acute of which they are rece and/or care, which therapy/Treatment/ Coumadin [warfarin edema)." 483.25 PROVIDE Of HIGHEST WELL B Each resident must provide the necess or maintain the high	by reported physical therapy bing R167's legs, as they did goal or physician order. As notes, dated 2/5/16 to icate any information or a primary physician regarding raps or length of time R167	F 280			3/23/16

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	-	AND HUMAN SERVICES			DMB NO.	APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	SURVEY PLETED
		245271	B. WING _		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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) COMPLETIO DATE
F 309	Continued From pa accordance with the and plan of care.	ge 31 e comprehensive assessment	F 30	99		
	by: Based on observat review, the facility f hospitalization for 1 for post-hospital ca Findings include: R167's family mem 2/9/16, at 12:58 p.n R167 returned to th 2/5/16. The residen while in the hospita him sitting up for lo reported she had so wheelchair for seve the hospital. She h staff over the week care concerns were Monday noted R16 for long periods of t there must have be the staff about R16 2/10/16, F-A again was not addressing Although R167 was the hospital, this wa F-A reported R167 in his legs. F-A sho which were covered swollen and bare w reported R167's leg	NT is not met as evidenced tion, interview and document ailed to coordinate care after of 1 resident (R167) reviewed re. ber (F)-A was interviewed on n. F-A, reported concerns after the facility from the hospital on it reported had a blood clot I and F-A was worried about ing stretches of time. F-A een R167 sitting in his eral hours after his return from ad reported her concerns to end. On Sunday, she thought e resolved, but then on 7 was again sitting in his chair time. F-A reported she thought en a miscommunication with 7's changing needs. On reiterated her concerns staff R167's change in condition. a getting his legs wrapped in as not occurring at the facility. had gained a lot of fluid weight wed the surveyor R167's legs d by a blanket. The legs were ithout wraps or stockings. F-A gs were less swollen prior to A reported she had spoken to a		 With respect to R#167: physi orders have been clarified and the plan has been updated to reflect a changes to his treatment plan pos hospital stay. The NAR assignment has been updated to reflect these changes. All residents who have been hospitalized within the past three have had their records reviewed f changes to their plan of care with revisions/updates to the care plan indicated. The NAR assignment is has been updated to reflect any c 3. All nursing staff will be re educe 3/23/2016 regarding updating the care plan upon receipt of new ord hospital return or change in condi including revisions to the NAR assisheet when changes occur. The director of nursing and /or designee will audit three resident plans each week for one month a two resident care plans per week months to assure the plan of care individual resident is being revised followed. The data collected will be press the QAPI committee by the Direct Nursing. The data will be reviewed/discussed at the monthl meeting. At this time the committing. 	e care any st ent sheet months or any as sheet hanges. ated by resident ers, tion signment care nd then for two for the d and ented to or of y Quality	

Facility ID: 00096

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		& MEDICAID SERVICES	r		OMB NC	1 APPROVE). 0938-039	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		245271	B. WING _		02	/12/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETIC DATE	
F 309	registered nurse(R was not sure how t communicated and expressed concern appropriate size for R167's hospital dis 2/5/16, revealed th lower extremity dee significant lower leg discomfort on 1/25, a prescription for w minimize the risk fo blood clots). A Quid leg swelling was in R167's plan of care 12/17/15, and did r or interventions relave warfarin. A 2/5/16 i lacked any identific with appropriate go manage the proble On 2/10/16, at 1:49 confirmed R167 ha 1/21/16, and discha 2/5/16. RN-A and F diagnoses including warfarin. RN-A rep been developed for scheduled for a sig Set (MDS) assess RN-A explained a t been initiated to ad issues, however, th developed. RN-B ref	N)-B about her concerns, but he changes were being d addressed. F-A also is the bed was no longer an r R167. charge summary, dated e resident developed a left ep vein thrombosis (DVT) with g extremity swelling and some /16. R167 was discharged with varfarin (anticoagulant used to or heart attack, stroke, and ck Wrap instruction sheet for cluded. e had been last revised not include any problems, goals ated to R167's DVT and use of ndividual temporary care plan sation of R167's new problems bals and interventions to	F 30	99 make the decision/re-commend regarding any necessary follow studies.			

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245271	B. WING			02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	8:35 a.m. RN-B cla an order prior to R1 order had been obt legs. RN-B reported been updated on 2/ from the hospital. R167's physical the 2/5/16, revealed R1 for the assessment leg bandaging or w 2/5/16, read "pt [pa extremities] bandag however no actual nursing to performF On 2/11/16, at 8:30 rehabilitation therap staff was not wrapp not have a current of A review of progress 2/10/16, did not ind contact with R167's leg bandaging or w could be out of bed R167's orders repo an order for warfari until 2/10/16, at whi normalized ratio (IN determine how thick be obtained. An or obtained on 2/10/16 for staff to now allow wheelchair for great The facility's 8/13, 0	rified the Jobst stockings were 167's hospitalization and a new ained to instead wrap R167's d the care plan should have /5/16, when R167 returned erapy (PT) plan of care, dated 167 had lower legs bandaged No care plan goal related to rapping. A PT note dated tient] has LE [lower ged and instructions were sent, order for either therapy or R [sic]." a.m. the director of by reported physical therapy bing R167's legs, as they did goal or physician order. es notes, dated 2/5/16 to icate any information or s primary physician regarding raps or length of time R167	F	309			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245271	B. WING		02	/12/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 F 314 SS=D	admission. The com updated/revised as directed staff to incl current and acute c which they are rece and/or care, which it therapy/Treatment/I Coumadin [warfarin edema)." 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observat review, the facility fa proper care and ser development to pro the risk of further pr 1 of 3 residents (R2 ulcers. Findings include: R222 was observed air mattress in bed	Apprehensive plan is changes occur." The policy ude on the care plan "All hronic clinical conditions for iving medication, treatment, may includeMedication _abs/monitoring such as] (abnormal bleeding/bruising, ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and		314	1. A comprehensive assessment for skir risk factors including the braden and turning and repositioning guidance was completed for R#222. The information was documented on the residents plan of care and the NAR assignment sheet. R #222 roho cushion is checked for proper inflation as instructed and documented when complete. Rejection of care and interventions to promote healing has beer updated on the resident plan of care. The NAR assignment sheet reflects all changes. R#222 has been educated	n

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE			SURVEY
D PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COMF	PLETED
		245271	B. WING _			02/1	2/2016
AME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROVIDE	NCE PLACE				20 23RD AVENUE SOUTH INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 314	Continued From pa	-	F 3	14			
	front and cutout in t bladder where the r contoured backrest on the air-filled port During interview wit a.m. he reported he ulcer in June of 201 air-containing prote wound deteriorated surgical repair. R22 discovery of the pre- was low and neede soretelling my nur had a hand pump ir told them it was low wouldn't do anything the rear of both legs severe (larger and of developed a big ulc part meets the air p the right ulcer even debridements (surg and surgery to close R222 said that he h Kenny rehabilitation [the air cushion] wa specified. R222 stat had inflated it and a his needs. After two	ically removing dead tissue) e it with a flap of tissue. ad been going to Courage a, where there they'd noted it s completely flat, no date ted the Courage Kenny staff adjusted the pressure to meet o debridement surgeries, R222 had directed the facility staff to			regarding the risks of not following plan of care for preventing further s breakdown. The negotiated risk wa reviewed with R#222 on 3/9/2016. 2. All residents with current wound had their care plans reviewed to en the inclusion of all measures to pro- healing and prevent further breakd including rejections of care. The N assignment sheet has been update reflect any changes. Nursing leader meets weekly to review wounds an progression of healing with discuss new strategies for delayed or worse wounds. 3. All nursing staff will be re-educa regarding measures to prevent skir breakdown, what to report and how information/interventions are to be communicated. Education will be complete by 3/23/2016. 4. The director of nursing and/or designee will audit three residents week for one month and then two residents each week for one month the two residents per week for two to assure the plan of care for the individual resident is being revised followed for promoting healing and preventing further breakdown. 5. The data collected will be prese the QAPI committee by the director nursing. The data will be reviewed/discussed at the monthly	skin as s have isure mote own AR ed to ership d sion of ening ted n ted n ted n ted n and months and nted to r of	

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		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING		02/-	12/2016
NAME OF F	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVID	ENCE PLACE			720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	registered nurse (R R222 then showed illustrating how muc between the cushio the resident was se A 6/2/15, a quarterly R222 indicated: "Do more pressure ulce However, the reside pressure ulcer deve interventions were i extensive assistant transfer. MDS asse R222 was cognitive care or present othe A physician order d "Please contact wo managing Left IT [is ulcer and coccyx [ta appointment ASAP seen in wound clinic colleague." An appointment ref Courage Kenny 6/2 cushion was compl further indicated Co during the session of ensure proper posit Must check cushior orders: Check cush pressure sores."	RN)-E "a couple of times." the surveyor a paper diagram ch space should have been on base and the buttocks when	F 314			

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING _			02/ ⁻	12/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	R222's needs. In ac in any progress not was ever checked f Wound Summary d back" (a photo rever tuberosity/IT) indica dated 6/23/15, of a (healthy) base whice (cm) in length, 5.1 of (2.5 x 5.1 x 0 cm). If increased to stage 4.5 x 5.8 x 5.5 cm (depth). Following surgical of dated 8/6/15 include Kenny and position for [R222]. Braden MODERATE RISK" infections, diabetes dependence on sta and current pressur from 8/8/15 indicate refusing to get out of A significant change indicated R222 had pressure ulcer, with x 06. x 05.5 cm. A progress note fro 9/8/15, included: "R wheelchair cushic well and [no] conce Physician orders: R [check] manual infla week. Roho cells an	ddition, there was no evidence es to indicate R222's cushion for proper inflation. documents for "Right thigh ealed it was the right ischial ated an initial measurement stage 2 ulcer with a red the measured: 2.5 centimeters cm in width, and 0 cm in depth By 7/29/15, the ulcer was 3 and was greater in size at a significant increase in debridment, a progress note ed, "Comprehensive Courage ing evaluation was completed score 14.0 indicating due to co-morbidities, wound a, narcotic use, immobility, ff for activities of daily living, re ulcers." A progress note ed, "Wound vacresident	F 3 ¹	14			

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			02 / ⁻	12/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Charting summary 9/8/15 appointment therapists to monito cushion. A therapy included: "Physical Therapy Requires C meet resident's mer recovery, and ensu resident is such that in condition without intervention." A physician's progre- included: "wound in foam in the underm you call [physician r [plan of carenumb also indicated R222 dressing change. A to monitor wound v wound, the notes d to the physician to e care had been disc requested. In additi care plan for that tir no changes made t The physician's pro indicated, "Pressure cushion slightly air mapping is good or Recommend therap [one time per] week following this visit d therapists were che proper inflation. A th indicated, "Therapy	ge 38 of the facility's Courage Kenny did not address the resident's or physician's order for or the resident's wheelchair progress note dated 9/9/15 Therapy/ Occupational Courage Kenny nursing to dical needs. Promote re medical safety. Condition of it there is potential for changes Courage Kenny nursing ess note from 10/26/15, nprovedcontinue to pack ined area of the wound. Can name] in 1 week to discuss ber provided]." A nursing note 2 was at the wound clinic for a lthough it was noted staff were ac and drainage from the id not reflect any follow-up call ensure that R222's plan of ussed as the physician had on, review of the resident's me indicated there had been o R222's care plan. gress notes from 12/22/15 e mapping completed, if filled on [right] side, then n [bilateral ischial tuberosity]. Dists check inflation on cushion k." Review of the therapy notes id not identify whether the ecking the cushion weekly for nerapy note dated 12/26/15 y services provided include. ce] Additional services are	F	314			

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING	i		02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE				3720 23RD AVENUE SOUTH		
					MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	SUMMARY: Patien minutes at 2000 [8: on its [sic] own. Dre like it is healing wel [sic] on his right but blanchable compar Therapy notes from services include Ph services are Post-s Nursing." On 12/29 indicated, "refused indicated the reside help when he was r note did not reflect related to his choice R222's care plan la revealed the reside paraplegia (paralys of multiple pressure including surgical re 2/23/15, and a stag (buttock) ulcer iden indicated stage 2 p on the resident's co hospitalized. Staff it to "educate residen causes of breakdow reposition/position of Service RoundsA concern. Pressure rotating low air loss least every 2 hours requested." A nutrit identified related to ulcers. Intervention supplement) every The care plan did n	t was in his chair for 15 :00 p.m.]. Repositioned twice essing changed; incision looks II. The spot the surgeon circled ttock is firm and mildly red to the surrounding" in 12/28/15 indicated, "Therapy hysical Therapy. Additional surgical services Restorative /15, a nursing progress note turning and repositioning" and ent had said he would call for ready to be repositioned. The education of the resident e to decline repositioning. Ast reviewed 12/15/15, ent had diagnoses including is of lower limbs) and a history e ulcers related to immobility, epairs of a sacral ulcer on ge 4 right ischial tuberosity utified 11/24/15. The care plan ressure ulcers had developed bocyx while he was interventions included for staff at/family/caregivers as to	F	314			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			02 / [.]	12/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	identified to educate risks and benefits of care plan lacked an need to check the w inflation to minimize ulcer complications The current 2/9/16, directed staff to ass [Reposition: assist of "Reposition: assist of "Reposition we confirmed the cush R222's wheelchair instructions had be following his last wo repair (11/2015) wh proper inflation we to be up in the chair believed he was su every two hours. Sh repositioning was n the care sheets. RN-E was again int a.m. RN-E stated t repositioned every thours a day, refusir then requested doc assessment, or risk pressure having be and any related car stated, "I did expression	d there were no approaches e the resident regarding the of his choices. In addition, the ny information regarding the wheelchair cushion for proper e the risk for further pressure	F 3	314			

Facility ID: 00096

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING	 	02 /*	12/2016
NAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	NCE PLACE			720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 F 329 SS=D	Continued From pa discussed during we documentation to the resident's record. Re whether the care pla R222's refusal to be The facility's 9/10, Fe Program policy india prevention would be standards of practic the interdisciplinary made based on char or when new risk fa assessment of the or repositioning based The summary analy any others that affee pressure ulcer prev 7. The plan of care stabilize and/or redu- risk factors for Press and/or promote hear Ulcers13. Ongoin and family in Presse 483.25(I) DRUG RE UNNECESSARY D Each resident's drug unnecessary drugs. drug when used in a duplicate therapy); of without adequate me indications for its us adverse consequent should be reduced a	ge 41 ound care, although hat effect was not found in the N-E stated she was unsure an had been updated to reflect e repositioned. Pressure Ulcer Prevention cated pressure ulcer based on community te that would be monitored by team. Revisions were to be anges in a resident's condition ctors were identified. "2. An resident's need for turning and on individual risk factors6. visis of these assessments and ct the resident's individual ention and/or treatment plan. reflects approaches to uce or remove the individuals sure Ulcer development aling of existing Pressure g education of the resident ure Ulcer Prevention." EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.	F3			3/23/16
	Based on a compre	hensive assessment of a				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 03/15/2016 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X3) DA	(X3) DATE SURVEY COMPLETED	
		245271	B. WING	i	0	2/12/2016	
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	ge 42 must ensure that residents antipsychotic drugs are not inless antipsychotic drug by to treat a specific condition documented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F	329			
	by: Based on interview facility failed to ensu- interventions were of prior to administrati to monitor for effect effects for 1 of 5 res- unnecessary medic Findings include: R56 was prescribed (anti-depressant) 25 (prn) at bedtime to the resident's 2/16, Record (MAR). After recommended a do from 25 mg to 25 m decreased to prn on Although the hours	d Trazodone HCL 5 milligrams (mg) as needed promote sleep according to Medication Administration er the pharmacy consultant sage change of Trazodone ng prn the dose was n 10/19/15. of sleep were documented on inistration Record (TAR), it			 With respect R#56: The care plan has been revised to include the non-pharmacological measures to promote sleep prior to administration of medications. The NAR assignment sheets have been revised to reflect the changes. All residents currently receiving medications to promote sleep have been reviewed to assure non-pharmacological measures are implemented prior to administration of any prn medications for sleep. The NAR assignment sheet has been updated to reflect any changes. All nursing staff will be re educated regarding non-pharmacological measure to promote sleep, what to report and how the information/interventions are to be communicated. Education will be completed by 3/23/2016. The director of nursing and/or designee will audit three residents each 	s	

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 093								
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245271	B. WING			02 /-	12/2016		
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE				
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 329	non-pharmalogical effectiveness, and s 9/1/15 through 2/12 from 2/1/16 through received prn Trazod documentation of n interventions prior t regarding efficacy of The nursing assista sheet for R56 lacker regarding measures R56's current care the use of psychotra appropriate interven R56. An interview with th 2/10/16, at 11:16 a. first prescribed on 3 promote sleep. A d on 7/13/15, to 25 m current dose 25 mg medication had not 12/15, but had been 1/16. The consultar non-pharmalogical been attempted at I psychotropic medic especially when it w also stated she exp effectiveness would On 2/10/16, at 11:5 (RN)-C reported the non-pharmacologic potentiate the resid try to figure out her	interventions, medication side effects in the TARs from 2/16. R56's MAR and TAR n 2/12/16, revealed R56 done four times, but lacked ion-pharmacological to its use or a notation of the medication. ant (NA) current assignment ed any direction for NAs s to promote sleep. In addition plan lacked identification of opic medications, goals, and ntions to promote sleep for the pharmacy consultant on m. revealed Trazodone was 3/9/15, at 50 mg at bedtime to dose reduction was attempted ag and then on 10/19/15, to the g prn. She further the been administered in 11/5 to n administered 10 times in nt further stated interventions should have least an hour prior to use of cations including Trazodone, was prescribed as needed. She bected side-effects and	F 3	29	 week for one month and then two residents per week for two months assure non-pharmacological intervatore are in place and implemented prior administration of a prn medication relexance. 5. The data collected will be preset the QAPI committee by the director nursing. At this time the committee make the decision/recommendation regarding any necessary follow up studies. 	entions to the for nted to r of e will			

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		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245271	B. WING		02 / ⁻	12/2016	
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
PROVID	ENCE PLACE			720 23RD AVENUE SOUTH /IINNEAPOLIS, MN 55407			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
	Continued From parepositioned. If all of RN-C verified the ir documented in R56 care plan. During an interview director of nursing (there was no prn Tr months of 11/15 an administered the m 1/16. She added, "V for prn medications did to help them res At least you should further explained sh non-pharmacologic of side effects and of sleep medications f A 9/13, Practice Gu Sleep Monitoring, d staff non-pharmacot to increase comfort will be added to a re (nursing assistant) a 9/13, Psychoactiv Monitoring policy, n "provide monitoring when a resident has change in psychoph Medication monitor the medication initia	SC IDENTIFYING INFORMATION) age 44 else fails we give her a prn." nterventions were not 5's MAR/TAR or outlined in her on 2/12/16, at 11:54 a.m. the (DON) stated it was "odd " razodone use during the d 12/15, and then was ledication 10 times during When it is for sleep, especially s, you should chart what you st and not just give them a pill. talk to them." The DON ne was unaware of current cal interventions or monitoring effectiveness for sleep and for R56.	TAG F 329	CROSS-REFERENCED TO THE APPROP		DATE	
	and document in th nature of the adver impact on the resid	update the medical provider e clinical record describing the rse effect and the potential ent's mental or physical nal or psychological status.					

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	OPLE CONSTRUCTION	(X3) DAT	E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED	
		245271	B. WING		02/	12/2016	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	_		
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 329 F 364 SS=E	underlying causes of appropriate treatmer reasons are ruled of psychotropic medic dosage or discontir will be ongoing for the Psychotropic medic antidepressant(s)." 483.35(d)(1)-(2) NU PALATABLE/PREF Each resident receipt food prepared by m	s the goal of determining the of sleep disturbance so ent of environment or medical out prior to the use of sations. Efforts to reduce nue psychotropic medications the clinical situation. cations include UTRITIVE VALUE/APPEAR, ER TEMP ives and the facility provides nethods that conserve nutritive ppearance; and food that is	F 32			3/23/16	
	by: Based on observatively fattractively served a residents (R17, R4-R119, R217) who of Findings include: During observation 2/8/16, residents with meal that was scher was were served frikitchenette starting R17 reported on 2/8 served late. The mean that was served late. The mean that was served late. The mean that was served late.	NT is not met as evidenced tion, interview and document ailed to ensure meals were and palatable for 8 of 170 4, R105, R20, R192, R129, ffered food complaints. of the noon dining service on ere seated and waiting for the eduled to begin at noon. Food om the 2 north (2N) at 12:27 p.m. 8/16, at 12:24 p.m. were often eat was often tough and she served slimy mushrooms.		 Facility reviewed diets and pers preferences for R17, R44, R105, F R192, R129, R119, R217. Update completed to their dietary program plan, and diet orders if indicated. The facility has increased dietar management to provide assistance current policies and procedures, as protocols are within guidelines for managing meal preparation. An ev supervisor has been hired to ensur meal services start on time, foods temped and appropriate for service meals are audited at the time serve palatability. All food service staff has been r educated regarding food preparation 	R20, s , care ry e with ssure vening re all are e and ed for re		

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		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING		02/12/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				3720 23RD AVENUE SOUTH		
PROVIDE	ENCE PLACE			MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
PRÉFIX	(EACH DEFICIENCY REGULATORY OR LS REGULATORY OR LS R105 reported on 2 like the food. He sa half-cooked hambu R20 reported on 2/8 was often served lu food. When she rec it was often not mic R192 said on 2/10/7 regularly served late reportedly being set R192 stated, "ish." R129 reported on 2 tasted "terrible," wa undercooked. In ac served a half hour a R119 said on 2/10/1 tasted terrible, was served late. On 2/10/16, at 12:2 started serving trays North dining room fi were frequently obs between the kitcher minutes before beir p.m. after the last p	 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 46 2/8/16, at 12:30 p.m. he did not id he had been served rgers and burnt eggs. 3/16, at 12:30 p.m. the food ikewarm and she preferred hot quested the food be reheated, rowaved until it was hot. 16, at 12:05 p.m. dinner was e, often a half hour. Regarding rved very mushy vegetables 2/10/16, at 12:11 p.m. the food is cold, mushy, and sometimes dition, meals were regularly after the scheduled time. 16, at 12:15 p.m. the food often cold and was often 1 p.m. the dietary aide (DA)-A s from the kitchenette for the 3 or the noon lunch meal. Plates served to sit on the ledge nette and dining room for 5-10 ng served to residents. At 1:13 late was served, a test tray 	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	e, RIATE ce, prior to n tray cold rill have l/or / on a be meal pility, l be nted to r of quality e will	COMPLETION
	palatability included pureed peas, puree chicken, fish filet an bland and lukewarn salad was taken at fillet was mushy. Th	Surveyor. Foods tested for food at a hot dog, potato salad, ad fish, mashed potatoes, ad milk. The potato salad was n. A temperature of the potato 79 F (Fahrenheit). The fish he chicken was tough, with a ance, pink on the inside and				

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245271	B. WING	i		02/	12/2016
NAME OF F	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PROVIDE	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 364	Continued From pa chewy.	.ge 47	F:	364			
	(DM) reported cook foods. DM reported steam tray for over taste good. DM rep times delayed due to	p.m. the dietary manager ts should be taste testing I that if food was sitting the an hour it likely would not orted food service was at to nursing staff not having d at times due to dietary staff					
	staff "All food is tas Procedure: 1. The of all food before it is a procedures should serve food onto a d spoon to taste the f taste test due to se	policy, dated 2010, directed te tested prior to serving. cook is responsible for tasting served. 2. Proper tasting be used. Use one spoon to lish or bowl, and use a new food 3. All food not passing the asoning, toughness, color, or ors is not to be served until the corrected. "					
	p.m. "The food was and they kept bring juice. They consists food) are too high in healthy." She further to cover up the tast about the food item explained she boug money whenever sl 1/21/16, Minimum I	interview on 2/8/16, at 2:39 a disgusting. I have diabetes ing me potatoes, bread and ently bring these. They (the n salt. It is cheap food and not er stated it was often breaded the and quality. When asked as observed in her room she ght "good" food with her own he could afford to. R22's Data Set (MDS) assessment cognitively intact and made ns.					
	dated 2/2/16 initiate	e Grievance/Feedback form ed by R22 read, "Meal options late and is cold. Wants whole					

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STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG				
		245271	B. WING _		02/12/2016			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI				
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
F 364	milk," and a form da R22 read, "I get col R217's quarterly Mi 12/14/15, revealed intact. R217 stated 12:55 p.m. that the the facility were a "f the menu in one we described the food seasoningmushy. reportedly routinely meetings, and said brought up by resid personally spoke up concerns. The dieta some of the meetin there were plans fo changed since last the same menus. V could not get more items were "seasor was served "consta to like it, she no lon specifically request she would not be se was served broccol R217 stated that to the second option f not get broccoli and anyway. Vegetables and foods were ofte overcooked." That veal patty that was middlealmost colo in her room and he	ated 2/8/16 also initiated by d scrambled eggs every day." nimum Data Set dated the resident was cognitively i n an interview on 2/9/16, at food and the snacks served at failure" and 7 of 10 items on eek tasted "awful." R217 as "horribleno lack of variety." R217 attended resident council food issues were always ents at the meetings, and she b about ongoing food ary manager had attended gs, and residents were told r new menus, but nothing had fall and they just kept rotating When asked why the residents variety, the DM said the menu hal." R217 explained broccoli intly," and although she used ger did. That day she had ed the alternate vegetable so erved broccoli, however, then i regardless of her request. day she purposely asked for or the meal so that she would d she was then served broccoli s were served kind of "mushy" en either "undercooked or day the resident was served "a undercookedpink in the 1." R217 stated she ate meals r food was nearly constantly gh mealtime was scheduled to	F 36					

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		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED		
STATEMENT	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			0938-0391 E SURVEY PLETED		
		245271	B. WING			02 / ⁻	12/2016		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
PROVIDE	ENCE PLACE		3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 364 F 497 SS=E	were the last to be of other residents com- undercooked and p told by the DM to ha- microwave. R217 re- "once," but staff did When she was served staff never returned she was given pure- regular diet, the nur- away and did bring reported food often due to dishwasher to plates did not keep Approximately half to delivered to her roo warmer and the cov- keep the food warm she was served a h mustard and ketchu R217 reported ongo been brought up to followed up on here at every resident co 483.75(e)(8) NURS REVIEW-12 HR/YFP The facility must co of every nurse aide months, and must p education based on reviews. The in-ser sufficient to ensure nurse aides, but mu per year; address a determined in nurse and may address the	delivered. When R217 heard pplain chicken was served ink in the middle, they were ave their food reheated in the equested her food be reheated not return in a timely manner. ved the wrong beverage, the with the proper one. When ed peaches instead of her rsing assistant just walked her the correct diet. R217 was served on paper plates being broken, and the paper the food warm. the time food was not m with both the bottom plate ver that was supposed to help n. At 6:20 p.m. R217 reported amburger patty on a bun with up packets, but nothing else. bing concerns with food had staff and "is not being e and keeps getting mentioned buncil meeting."	F 3				3/23/16		

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		AND HUMAN SERVICES			FORM	03/15/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245271	B. WING			02/12/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			-	720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 497	aides providing serr cognitive impairment the cognitively impair This REQUIREMEN by: Based on interview facility failed to com 2 of 5 nursing assist the potential to affe facility where the Naw work. Findings include: A sample of five NA reviewed on 2/12/10 reviewed to annual 1) NA-B was hired of evaluation for NA-E 2) NA-D was hired file contained evide evaluation complete On 2/12/16, at 1:00 for conducting annu The administrator of policy. He stated th	vices to individuals with ints, also address the care of aired. NT is not met as evidenced v and document review, the duct performance reviews for stants (NA-B, NA-D). This had ct multiple residents in the As may have been assigned to A employee records were 6, and the records were evaluations were conducted. on 2/25/13. The most recent 8 was completed on 11/14/15. on 11/7/05. NA-D's employee nce of one performance	F	497	 With respect to the identified evaluation: a current evaluation of performance was completed for em NA-d. All employee files have been rev for current evaluations and those of compliance for annual evaluation we completed over the next quarter. The guideline for completing and performance evaluations has been developed and all leadership traine the expectations for completing evaluations. The human resource director ar designee will audit five employee fill each week for two months to assure evaluations are completed on a tim basis. The data collected will be present the QAPI committee by the human resource director. The data will be reviewed/discussed at the monthly meeting. Ath this time the committed make the decision/recommendation regarding any necessary follow up studies. 	nployee viewed ut of rill be nual d on nd/or es ely nted to quality ee will	

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		AND HUMAN SERVICES				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245271	B. WING _				C 1 2/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	ENCE PLACE				20 23RD AVENUE SOUTH		
				M	INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 00	00			
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an a on-site revisit of you validate that substa	of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance. acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with					
F 156 SS=D	investigated and we 483.10(b)(5) - (10),	79 and H5271180 were ere unsubstantiated. 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 15	56			3/23/16
	and in writing in a la understands of his regulations governin responsibilities duri facility must also prinotice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Ref	orm the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in					
	entitled to Medicaid of admission to the resident becomes e	orm each resident who is benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						03/14/2016

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

PRINTED: 04/01/2016

		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245271	B. WING	i		02/12/2016	
NAME OF P	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVIDE	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	which the resident r other items and ser and for which the re- the amount of charg- inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admis- the resident's stay, facility and of charg- including any charg- under Medicare or b The facility must fur- legal rights which in A description of the for establishing elig- the right to request 1924(c) which deter non-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid e A posting of names numbers of all perti- groups such as the agency, the State line	der the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and nt when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or ssion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate. Trnish a written description of ncludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending	F1	156			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	04/01/2016 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245271	B. WING	B. WING			C 12/2016	
NAME OF	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PROVID	ENCE PLACE		3720 23RD AVENUE SOUTH					
FROVID				N	MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 156	advocacy network, unit; and a stateme complaint with the S agency concerning misappropriation of facility, and non-cor directives requirem The facility must inf name, specialty, an physician responsite The facility must pre- written information, applicants for admis- information about h Medicare and Medi receive refunds for such benefits. This REQUIREMEN by: Based on interview facility failed to prov- residents (R44) rev beneficiary appeal of Findings include: R44's Admission Re- was admitted to the progress note dated resident discharged facility, R44 received therapy services.	And the Medicaid fraud control nt that the resident may file a State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance ents. Form each resident of the d way of contacting the ole for his or her care. cominently display in the facility and provide to residents and ssion oral and written ow to apply for and use caid benefits, and how to previous payments covered by NT is not met as evidenced v and document review, the vide liability notices for 1 of 3 iewed for liability notices and	F	156	F156 The preparation of the following plan correction for this deficiency does no constitute and should not be interpre as an admission nor an agreement b facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exect solely because it is required by the provisions of state and federal law. Without waiving the foregoing statement the facility states that: 1. With respect to R#44, a verbal no for non coverage was provided on	bt eted by the d on nt of cuted nent,		

Facility ID: 00096

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMI	E SURVEY PLETED
		245271	B. WING			C 02/12/2016	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 156	the resident's response form was also dated A registered nurse (on 2/12/16, at 11:12 for issuing denial not was not progressing was denied Medica R44 was not able to his cognitive deficie received notice from R44's Medicare cow contacted R44's res regarding the end o The son signed the 10/29/15. RN-C fur from Centers for Mar required no less that have been given wh withdrawn. RN-C st notice, not a 48 hou A progress note wri indicated RN-C spo party regarding NOI Medicare services w place to the son on left in the business as a copy. The Form Instruction Non-Coverage (NO 10/31/11 stated: "A plan must give in act the NOMNC to ben	tices of Medicare MNC) it was noted, however, nsible party's signature on the d 10/29/15. RN)-C stated in an interview 2 a.m. she was responsible otices. RN-C explained R44 g in therapy and was therefore re services for skilled care. o sign the denial notice do to ncy. RN-C explained she in therapy on 10/27/15, that rerage was ending. She sponsible party on 10/28/15, f therapy date of 10/29/15. NOMNC and dated it ther verified the guidance edicare Services (CMS) in a two day notice should hen Medicare services were ated, "I gave him a 24 hour ir notice." tten 10/29/15, at 2:23 p.m. ke with R44's responsible MNC and last covered day for vas 10/30/15. The call was 10/28/15. The NOMNC was office for him to sign as well	F	156	 10/28/2015 and written notice of non-coverage was provided to his decision maker on 10/29/2015. R# discharged from the facility 11/4/20 2. Any resident who is currently on skilled stay and pending discharge discussed daily mon-fri at the interdisciplinary meeting. Notices of liability will be completed and signe the appropriate party with 48 hours advanced notice. 3. The IDT meeting minutes (form) Guidelines has been revised to incl discussion of all pending discharge admissions, billing, social service, N and case manager and therapy star receive education regarding the profor communicating discharges and beneficiary notices within the requiring time frames. 4. The administrator and or/design audit two residents admitted within past 30 days each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and then one resident each week for one more and/or designee. The data will be reviewed/discussed at the monthly meeting. At this time the committee make the decision/re-commendation regarding any neccesary follow up studies. 	15. a will be of of by) and lude is. All MDSC ff will occess red hee will the onth or two ntation ted to strator quality e will	

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	OF DEFICIENCIES	& MEDICAID SERVICES			NO. 0938-039 3) DATE SURVEY			
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED			
					С			
		245271	B. WING		02/12/2016			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PROVID	ENCE PLACE		3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)				
F 156	Continued From pa	ige 4	F 156	;				
F 241 SS=D	on 2/12/16,at 11:43 staff to use the prot provide a 48-our no time to plan for disc	e interim director of nursing a.m. revealed she expected tocol set forth by CMS to otice so residents would have charge. YAND RESPECT OF	F 241		3/23/16			
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.						
	by: Based on observative review, the facility f attire was maintaine R186) who reported Findings include: R22 was interviewed follow up on concerviewed follow up on concerviewed follow up on concerviewed on 2/8/16, at 2:39 p R22 was admitted to that time arrived with much of her clothin The resident explait pair of pants, and for R22 explained that she had been inform with the exception of	ed on 2/10/16, at 2:43 p.m. to rns regarding various concerns ent during a formal interview b.m. voiced by the resident. to the facility in 5/15, and at th seven pair of pants, and g had since "disappeared." ned she currently had only one bur other pair were "missing." on Saturday morning (2/6/16) med "I had nothing to wear" of a shirt. When R22 missing clothing to the nursing		 With respect to R #22, and R# 18 social services has approached the residents regarding missing clothing items. All items that were not found h been replaced. All feedback forms for the past three months have been reviewed for Missi property. All residents identified with missing items have been followed up the items found or replaced as able. The system for logging in concerns and action plan results is revised to include a three day time frame. Concerns/forms are brought up daily it the morning idt meeting all staff will receive re-education regarding the missing property guideline and feedbaf form for reporting missing items by 3/23/16. The director of nursing and/or designee will audit three residents eace 	ave ee and s n ack			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245271	B. WING			C 02/12/2016	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE			-	720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG				(X5) COMPLETION DATE
F 241	missing clothing in find any of the resid stated she was "stu horrible hospital go found her a pair of wear. "It was humil without clothing and something for me to staff for help and to she "gave up weari laundry and "nobod bra on." The reside permission to look if the only clothing av sweaters, shawl, co R22's 1/21/16, Mini assessment indicat and required extens dress. The licensed gradu interviewed on 2/10 and stated she did clothing, and had ne was missing pants. On 2/11/16, at 9:08 services (DSS) exp grievance for R22 of missing clothing. To ombudsman had in clothing over the we order clothing for th a.m. the DSS said I and obtained a list of meantime, they had	then went to look for R22's the laundry and was unable to lent's pants. The resident ck in the chair with the wn" until noon, when the NA 'very ugly" men's pants to iating to be defenseless d having someone looking for o wearl'm dependent on the take care of me." R22 stated ng bras" as they got lost in the y caresl feel better with a nt gave the surveyor n her closet and dressers and ailable was six shirts, two pat, and no pants, and no bras. mum Data Set (MDS) ed she was cognitively intact sive assistance from staff to ate social worker (LGSW) was	F2	241	week for two months for assuring the resident is dressed in a dignified mand has appropriate attire availables. The data collected will be presended the QAPI committee by the director nursing. The data will be reviewed/discussed at the monthly meeting. At this time the committee make the decision/recommendation regarding any necessary follow up studies.	anner e. nted to r of quality e will	

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245271	B. WING			C 02/12/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(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 241	facility's plan was to missing clothing. The director of nurs 2/12/16, at 9:55 a.m reported R22's miss The administrator e a.m that approxima had been complain He thought the prok was inadvertently b an outside laundry s should have instead facility. He said par some staff were un information. The fac missing items if the R186 (whose room hallway from the nu observed wearing of wheelchair at the nu 2/12/15, at approxin registered nurse (R resident, "Let's go of room] and take a lo underwear, R186 a At 1:21 p.m. R186 two to three times in laundry. I was miss and said he had rep LGSW that day. R ⁺ wait another ten we like they did the last had to buy them my	b replace the resident's sing stated in an interview on h. the staff should have sing clothing. explained on 2/12/16, at 10:05 ttely three months prior there ts of missing resident clothing. olem was personal laundry eing sent out with the linens to service, when the laundry d been laundered at the r of the problem was that sure how to pass on such cility's policy was to replace y were responsible. was at the far end of the ursing station/elevator) was only underwear as he was in	F 2	241			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
		245271	B. WING _) 12/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241 F 244 SS=F	cognitively intact. RN-D was approact and immediately sta blanket on him [R18 around in his under shorts. We went do of his shorts. He tol The facility's 2/11 P indicated the facility or missing items, he recovery of items w person reporting the Feedback Form" wi executive director." process for looking The facility's 6/18/1 and Dignity policy n responsible for prot resident's rights. 483.15(c)(6) LISTE GRIEVANCE/RECC When a resident or must listen to the vi grievances and reco and families concer operational decision life in the facility. This REQUIREMEN by: Based on observat	DS indicated he was hed at 2/12/16, at 1:30 p.m. ated, "I should have put a 36] instead of letting him go wear. It is dignity. He had no wnstairs and found two pairs d me six were still missing." ersonal Property Loss policy was not responsible for lost owever, would facilitate the henever possible. "The e loss should complete a hich was then given to the The policy delineated a for the missing items. 4, Promoting Resident Rights oted each staff member was ecting and promoting each N/ACT ON GROUP	F 24	1	vith	3/23/16
	life in the facility. This REQUIREMEN by: Based on observat	NT is not met as evidenced ion,interview and document			vith	

Facility ID: 00096

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			OI	FORM / MB NO.	04/01/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245271	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	ENCE PLACE			-	720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	was implemented to to residents' satisfa This practice had the residents including several residents (F R48, R192, R129, F un-addressed concest served cold and inavell well as residents (R missing clothing. Findings include: SNF [Skilled Nursin Meeting Agenda anvere reviewed. The Concerns/Issues, A and Responsible Parevealed a lack of d facility's actual reso Examples were as the 1) On 8/19/15, Old Inorth reported room "luke-warm" and tw stated nursing assiss meals need to be "r [residents] feel like Additional issues in knocking c) missing cleaning, and e) mu The Action was to for The Resolution and Business included a served after the ma residents complete their dining experient	g Facility] Resident Council d Minutes from 8/15 to 1/16 minutes included ction, Resolution and Date, arty. The minutes, however, ocumentation showing the lutions to residents' concerns.	F 2	244	 individually and an action plan deversion resolution to concerns. A follow meeting with each of the identified residents will be conducted to deter level of satisfaction and any further needed. 2. The previous 6 months of reside council minutes have been reviewers a plan of action developed for the identified concerns regarding: call food quality, and missing items/laur follow up resident council meeting is scheduled to discuss actions taken an continued areas of concern. 3. The system for logging in concern and action plan results is revised to include a response within a 3 day ti frame. Concerns/forms are brough daily in the morning idt meeting. The leadership team will receive educat regarding the procedure for follow up resident council concerns and action plans for correction. Education wil completed by march 23 2016. 4. The executive director and/or dewill audit the resident council minutareas of concern identified and action plans post council. Action plans wi audited to assure satisfactory outcoms and action. The data collected will be present the qapi committee by the executive director. The data will be reviewed/discussed at the monthly meeting. At this time the committee make the decision/re-commendation regarding any necessary follow up studies. 	rmine action ent d and lights, ndry. A s , and rns me nt up ne ion up to on I be esignee es, on II be esignee es, on II be omes nted to e quality e will	

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` '	VG		MPLETED
						С
		245271	B. WING _			2/12/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
PROVIDE	NCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 244	Continued From pa	age 9	F 24	14		
		plan of action or responsible				
	party was designate	ed. Although council members				
		s complete audits, staff				
		om 8/14/15 to 8/31/15. The de whether food was served at				
	the proper tempera					
		Business was noted, with				
	action including foll	ow up with appropriate staff on				
		the administrator and director				
		the meetings. The				
		te was "Ongoing." New to know where to find				
		gnage by the community book,				
		es (smells, cleaning				
		g clothing, staff not knocking.				
		additional grievance forms,				
		ignage, follow up with follow up with nursing staff.				
		of Rights for right to voice				
		vered, however, did not				
		aff asked the residents				
		eir grievances were				
	adequately address					
		d Business included				
	completed. "Compl	vance forms and signage was				
		ector has been hired and				
	concerns should be	e resolved. Ongoing: education				
		to assist with these concerns."				
		l lights still remain a concern,				
		gs visible, cleaning issues				
		arpet and mold in the shower, and serving times, council				
		tion Plan: Continue to educate				
	at unit meetings, al	l staff reminded regarding				
		eeping is addressing "many				
		management and no mold in cleaned, dietary manager				
	DOTOROOM BUILINGO					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			IPLETED C
		245271	B. WING _				0 12/2016
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	ENCE PLACE			-	720 23RD AVENUE SOUTH /IINNEAPOLIS, MN 55407		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 244	Continued From pa	ge 10	F 24	44			
	effort with nursing to	o pass meals.					
		Business: Resolutions , new housekeeping manager,					
		d. New Business: call light					
		but some residents felt could					
	still improve. No Ac 5) On 12/16/15, Old	d Business: Call light					
	resolution was "ong	going." New Business:					
		e education on door knocking, er than residents would like,					
	"night shift needs a	refresher," want sign as to					
	who is supervisor o	on each shift. Business: Continue to discuss					
	knocking at unit me	eeting, DON explained how call					
		and has been steadily					
		last few months, DON will find upervisors' names. Resolution					
	was "Ongoing. "						
		dent grievance log from					
		also included resident at with concerns brought up in					
		eetings such as: 11/20 room					
		ghts; 12/3 room cleaning; 12/8,					
		(3N); 12/8 lack of food variety d (3N); 12/16 food issue (3N);					
	showers; 12/18 roo	m odors, showers; 12/22					
		N); 12/22 meal concern (3N); ts" meal concerns; 1/6 call					
		(2N); 1/13 food concerns					
	(2N); and 1/25 dieta	ary concerns (3N). The					
	reviewed the reside	d various staff members ent concerns.					
	FOOD AND CALL L	LIGHTS:					
		ms revealed concerns					
		nments made in resident 1) On 12/9/15, a resident					

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PRINTED: 04/01/2016

		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER	-			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVID	ENCE PLACE			-	720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244	voiced, "Concerns of room." Follow up wi indicated staff "Exp trays are delivered room has been serve eat in dining room. steam table temper correct." 2) On 1/6/ a resident on 2N exi is cold for all meals times being too long encouraged the residents in the dining Kitchen staff were t correct temperatures temperature. The re- discussed with the did not include infor resident expressed follow up. During an interview the dietary manage had called in and he rushing around the on duty. The DM si were 8:00 a.m. 12:0 Continuous dining of conducted on 2/8/1 p.m. Twenty-five re- dining room waiting served. A cart conta near the serving do p.m. a NA began as wanted a salad. At serving salads whe	age 11 of cold food delivered to his ith the resident on 12/11/15, lained to resident that room after everyone in the dining vedencouraged resident to Staff will continue to monitor ratures to ensure they are 16, a staff person reported for coressed concerns that "Food " and "Concerns of call light g." The Action Plan was staff sident to eat meals in the m trays were delivered after ing room have been served. to ensure food was served at es/steam table at right esolution was noted as resident on 1/11/16, however, rmation as to whether the satisfaction regarding the on 2/8/16, at 8:26 a.m. with er (DM) he explained two staff e apologized that he was kitchen to help the other staff tated meals times for all floors 00 p.m. and 6:00 p.m. observations on 2N were 6, from 12:09 p.m. to 12:37 sidents were seated in the g for the noon meal to be aning salad ingredients was or by the kitchenette. At 12:17 sking residents whether they in 12:26 p.m. the NA continued in the doors opened into the ate the main meal was ready	F 2	44			

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244	to be served. The f at 12:37 p.m. Forty p.m. a resident roor resident. R17 reported on 2/8 often served late. T she had recently be R105 reported on 2/8 was often served late. R20 reported on 2/8 was often served lut food. When she rec it was often not mic R195 stated during p.m. he ate his mea the noon meal that was cold and was r meatloaf was awful beans." Then R198 "here see it states of R195 stated that so about the food and DM, but instead and sent. In a follow up p.m. R195 describe and always late. Th was frozen." R195 conference four we to come to his room this morning my bre 8:00 a.m. and delive	 a. A. A.	F 2	244			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING			C 12/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	ENCE PLACE		:	3720 23RD AVENUE SOUTH		
PROVIDI				MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244	Continued From pa	ge 13	F 244	4		
	R217 stated in an in p.m. that the food a facility were a "failu menu in one week" the food as "horribl seasoningmushy, reportedly routinely meetings, and said brought up by resid personally spoke up concerns. The dieta some of the meetin there were plans fo changed since last the same menus. V could not get more items were "seasor was served "consta to like it, she no lon specifically request she would not be se was served broccol R217 stated that to the second option f not get broccoli and anyway. Vegetables and foods were ofte overcooked." That ove served cold. Althou begin at 12:00 p.m. between 12:30 and were the last to be other residents corr undercooked and p	nterview on 2/9/16, at 12:55 and the snacks served at the re" and 7 of 10 items on the tasted "awful." R217 described				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244	microwave. R217 re "once," but staff did When she was served staff never returned she was given pure regular diet, the nur away and did bring reported food often due to dishwasher he plates did not keep Approximately half delivered to her roo warmer and the cov keep the food warm she was served a he mustard and ketch. In addition, the resid snacks were not be rather were left at the reported ongoing co brought up to staff a on here and keeps resident council me Minimum Data Set resident was cognit R48 reported in an approximately 1:00 attended resident c explained she prefer room, but "the food and always late." A at 4:26 p.m. R48 si meal tray was delive and late." R48 expla the DM about the for "It not his faultthe to you on time."" Sh	equested her food be reheated not return in a timely manner. ved the wrong beverage, the l with the proper one. When ed peaches instead of her rsing assistant just walked her the correct diet. R217 was served on paper plates being broken, and the paper the food warm. the time food was not m with both the bottom plate ver that was supposed to help h. At 6:20 p.m. R217 reported amburger patty on a bun with up packets, but nothing else. dent expressed concerns ing passed to residents, he nursing station. R217 oncerns with food had been and "is not being followed up getting mentioned at every eting." R217's quarterly dated 12/14/15, revealed the	F 2	244			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT OF DI AND PLAN OF COF	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 1 2/2016
NAME OF PROVI	DER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDENCE	PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
so I at o cold Why resid Frito DM sure get R19 regu repo R19 R12 taste und serv Duri 11:5 com R19 milk expl and to sp DM R19 milk	r then they give I food but I pay a y can't I get a go dents suggested o pie and cream just tells the res e all residents ca it." 22 said on 2/10/1 ularly served late ortedly being ser 02 stated, "ish." 29 reported on 2 ed "terrible," wa ercooked. In ac yed a half hour a 9 said on 2/10/1 ed terrible, was yed late. ing an interview 55 a.m. the DM stat s so fast that it d iration date on the lained he was of this was the firs peak to him, and verified a dietar 05 about food iss	ge 15 use I don't want to get hollered me an attitude. I just eat the a lot of money to live here. bod meal?" R48 stated other d more choices like lasagna, ed tuna over toast/rice. The sidents they have to make an eat the food, "so we never 16, at 12:05 p.m. dinner was e, often a half hour. Regarding rved very mushy vegetables /10/16, at 12:11 p.m. the food s cold, mushy, and sometimes ddition, meals were regularly after the scheduled time. 16, at 12:15 p.m. the food often cold and was often on 2/10/16, at approximately stated he had heard of ilk being always spoiled from red the facility went through idn't even get close to the he container. The DM n vacation the previous week, st time he heard R195 wanted d had not yet done so. The y staff person had spoken to sues, mainly about spoiled	F	244			

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER	·	- -		TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244	R186 was observed he was in wheelcha 2/12/16, at approxin R186 explained, "I's shorts todayI don weeks for them to r last time when I los myself. It bothers r my underwear, but R22 reported on 2/ 2/6/16 she had bee wear" with the exce complained of her r assistant (NA) she happens." The NA missing clothing in find any of the reside permission to look if the only clothing av sweaters, shawl, co The administrator et a.m that approximal had been complain He thought the prot been inadvertently outside laundry ser have instead been said part of the prol unsure how to pass clothing). During an interview director of commun	age 16 d wearing only underwear as air at the nursing station on mately 1:10 p.m. At 1:21 p.m. was missing eight pair of 't want to wait another ten eplace them like they did the t six pair. I had to buy them ne that I had to come out in what am I supposed to do?" 10/16, at 2:43 p.m. that on informed "I had nothing to eption of a shirt. When R22 missing clothing to the nursing reportedly responded, "'It then went to look for R22's the laundry and was unable to dent's pants. R22 also stated ng bras" as they got lost in the ly caresI feel better with a nt gave the surveyor in her closet and dressers and ailable was six shirts, two pat, and no pants and no bras. explained on 2/12/16, at 10:05 ttely three months prior there ts of missing resident clothing. Dem was personal laundry had sent out with the linens to an vice, when the laundry should laundered at the facility. He blem was that some staff were as on such information (missing		244			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE			-	720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	attend all meetings. grievances. The DC concerns during the issue was brought fa appropriate staff for issues to the DM). brought up the sam meeting, she starte except this time she "the issue has com On 2/11/16, at 4:07 attended resident c they talked to reside DM verified he was regarding food tem 3N. The DM explain had purchased ther keep the food warm temperatures of the plates "go up the lin preparedWe put th hotthen I'm not su plate is ready to be staff to deliver it to the effort. Sometimes r and there are no nu plates." The facility's 2/1/15 meeting Guidelines department will rep- issues/concerns/ch follow-up of any pre- identified by resider Feedback Form Gu- indicated the "Depart investigate the grief	She handled related resident CL explained if residents had e meeting, she ensure the orth and delivered to the follow up (such as food The DCL stated if a resident e concern at the next d the process all over again, e would tell the staff person e up again." p.m. the DM stated he ouncil with the DLC, where ents about food issues. The aware of resident concerns peratures from mostly 2N and hed the dietary department mal cover and bottoms to help her. Staff measured e food in the hot wells, and he as soon as they are he food on the plate and it's re what happens once the served. It's up to the nursing the resident roomit's a team my staff is just standing/waiting ursing assistants to serve the , Resident Council and Tenant indicated "each individual	F 2	244			

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	04/01/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
	245271	B. WING				C 12/2016
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
PREFIX (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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
appropriate area on Action PlanExecut Head is responsible who initiated the Fet them with feedback concern within (3) w concern." F 279 483.20(d), 483.20(k SS=D COMPREHENSIVE A facility must use th to develop, review a comprehensive plar The facility must der plan for each reside objectives and time medical, nursing, ar needs that are ident assessment. The care plan must to be furnished to at highest practicable psychosocial well-be §483.25; and any se be required under § due to the resident's §483.10, including t under §483.10(b)(4) This REQUIREMEN by: Based on interview facility failed to ensu	an for the resolution on the the attached Feedback Form tive Director/Department of contacting the person edback Form and provide on the resolution on the vorking days of receiving the (1) DEVELOP CARE PLANS the results of the assessment and revise the resident's nof care. velop a comprehensive care ent that includes measurable tables to meet a resident's not mental and psychosocial tified in the comprehensive describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided is exercise of rights under he right to refuse treatment		244	1. With respect to R#56: the care has been revised to include the nor pharmacological measures to prom	ı.	3/23/16

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	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION		0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						0)
		245271	B. WING			02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			-	720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 279	Continued From pa	ige 19	F 2	79			
	prior to administrati 1 of 5 residents (R5 medication use; in a ensure the care pla necessary intervent minimize the risk for breakdown for 1 of with pressure ulcer Findings include: R56's current care the use of psychotr appropriate intervent R56. In addition, the current assignment direction for NAs re- sleep. R56 was prescriber (anti-depressant) 2 (prn) at bedtime to the resident's 2/16, Record (MAR). After recommended a do from 25 mg to 25 m decreased to prn on hours of sleep were Treatment Administion rela- interventions that m	on of a psychotropic drugs for 56) reviewed for unnecessary addition, the facility failed to an was developed to include tions to promote healing and or further pressure ulcer 2 residents (R222) reviewed s. plan lacked identification of opic medications, goals, and ntions to promote sleep for e nursing assistant (NA) t sheet for R56 lacked any egarding measures to promote			 sleep prior to administration of medications. With respect to R#22 care plan has been revised to inclu measures in place to promote woul healing and prevent further breakdow well as R#222 rejection of care. Rathas been provided the risks associ with rejection of care. The NAR assignment sheets have been revise reflect the changes. 2. All residents currently receiving medications to promote sleep have reviewed to assure non-pharmacol measures are identified prior to administration of any prn medication sleep. All residents with current wo have had their care plans reviewed ensure the inclusion of all measure promote healing and prevent furthe breakdown including any rejections care. The NAR assignment sheet been updated to reflect any change 3. All nursing staff will be re-education regarding non pharmacological me to promote sleep and measures to prevent skin breakdown, what to re and how the information/intervention to be communicated. Education with completed by 3/23/16. 4. The director of nursing and/or de will audit three residents each weel one month and then two residents week for two months to assure the 	de all nd own as #222 ated sed to e been ogical ounds to s to er s to er s of has es. ted asures port ons are ill be esignee < for per	
	2/10/16, at 11:16 a. first prescribed for bedtime to promote was 25 mg prn. Th	te pharmacy consultant on m. revealed Trazodone was R56 on 3/9/15, at 50 mg at sleep, and the current dose ne medication had been 10 consultant further stated			 care for the individual resident is be revised and followed. 5. The data collected will be prese the QAPI committee by the director nursing. The data will be reviewed/discussed at the monthly 	nted to	

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT CON	<u>. 0938-039</u> E SURVEY IPLETED C
		245271	B. WING _			12/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ROVID	ENCE PLACE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 279	been attempted at psychotropic medic especially when it v also stated she exp effectiveness would On 2/10/16, at 11:5 (RN)-C reported the non-pharmacologic improve the residen to figure out her da she is in pain, if she repositioned. If all RN-C verified the in documented in R56 care plan. During an interview director of nursing Trazodone use, "W for prn medications did to help them res At least you should further explained sl non-pharmacologic of side effects and sleep medications At 11:53 a.m. a reg the facility did not h nonpharmacologica sleep. She stated, she had enough to needs to be toileted fails we give her pr	cal interventions should have least an hour prior to use of cations including Trazodone, was prescribed as needed. She bected side-effects and d be monitored. 3 a.m. a registered nurse e facility did not have specific cal interventions identified to nt's sleep. She stated, "We try y. If she had enough to eat, if e needs to be toileted or else fails we give her a prn." nterventions were not 5's MAR/TAR or outlined in her y on 2/12/16, at 11:54 a.m. the (DON) stated regarding the 'hen it is for sleep, especially s, you should chart what you st and not just give them a pill. talk to them." The DON he was unaware of current cal interventions or monitoring effectiveness for sleep and for R56. istered nurse (RN)-C stated have specific al interventions to improve "We try to figure out her day, if eat, if she is in pain, if she d or repositioned. If all else n." RN-C verified these not documented in R56's	F 27	9 meeting. At this time the comake the decision/re-comm regarding any necessary fol studies.	endation	

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245271	B. WING _				C 12/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVIDE	ENCE PLACE) 23RD AVENUE SOUTH NEAPOLIS, MN 55407		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	The Providence Pla Procedure for Sleep directs staff to indiv non-pharmacologic increase comfort ar will be added to a re (nursing assistant) A 9/13, Practice Gu Sleep Monitoring, d staff non-pharmaco to increase comfort will be added to a re (nursing assistant) A 9/13, Psychoactiv Monitoring policy, n "provide monitoring when a resident has change in psychopt R222's care plan w incorporate all nece promote healing/pre R222's care plan la revealed the reside paraplegia (paralys of multiple pressure including surgical re 2/23/15, and a stag	ace Practice guideline and p Monitoring, dated Sept 2013, vidualize staff cal interventions intended to nd promote adequate sleep esident care plan and NA sheet. uideline and Procedure for directed staff to "individualize plogical interventions intended t and promote adequate sleep esident care plan and NA	F 27	79			
	indicated stage 2 pl on the resident's co hospitalized. Staff in	ressure ulcers had developed occyx while he was nterventions included for staff nt/family/caregivers as to					

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245271	B. WING				C 12/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE			-	720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	reposition/position of Service RoundsA concern. Pressure rotating low air loss least every 2 hours requested." The cal concerns with the ro- refusal to turn/reposi approaches identifie regarding the risks addition, the care p regarding the need cushion for proper if for further pressure The current 2/9/16, directed staff to ass [Reposition: assist of "Reposition: assist of "Reposition	ge 22 changes during Customer void positioning on areas of relieving device for bed, mattress, turn, reposition at , more often as needed or re plan did not indicate any esident rejecting care (e.g. sition), and there were no ed to educate the resident and benefits of his choices. In lan lacked any information to check the wheelchair inflation to minimize the risk ulcer complications. Nursing Assistant Care Plan sist R222 to "Repos: A2-4" every two to four hours] and ry two] hours/Nurse&NAR" There were no instructions istant Care Plan related to tion of the wheelchair cushion. d in his room while lying on an on 2/11/16, at 8:45 a.m. An e wheelchair was in the room. d a seat cushion with a foam the rear filled with an air resident would sit, as well as a . The surveyor briefly pressed ion, which contained air. th R222 on 2/11/16, at 8:45 e had developed a pressure 15. Despite the use of an ctive wheelchair cushion, the and eventually required 22 asserted that prior to the assure ulcer, the air bladder	F 2	279			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED C
		245271	B. WING				12/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	soretelling my nur had a hand pump in told them it was low wouldn't do anything the rear of both legs severe (larger and of developed a big ulc part meets the air p the right ulcer even debridements (surg and surgery to close R222 said that he h Kenny rehabilitation [the air cushion] wa specified. R222 stat had inflated it and a his needs. After two said the physician h learn the proper ass The resident explain to "come and put while it was under n idea of what a prop would bethat never registered nurse (R R222 then showed illustrating how muc between the cushio the resident was se A 6/2/15, a quarterly R222 indicated: "Do more pressure ulce However, the reside pressure ulcer dever	d refilling. "I was getting rese that my Roho air cushion in the closet to fill my seat. I and needed to be filledstaff g about it." Ulcers formed at s, with the right one becoming deeper). "[The area] er at the point where the foam art in an edge." R222 stated tually required four ically removing dead tissue) e it with a flap of tissue. ad been going to Courage n, where there they'd noted it s completely flat, no date ted the Courage Kenny staff idjusted the pressure to meet o debridement surgeries, R222 had directed the facility staff to sessment/inflation technique. ned the staff were supposed their hands on the cushion ny butt so they would get the erly inflated cushion for me er happened," except by N)-E "a couple of times." the surveyor a paper diagram ch space should have been n base and the buttocks when	F2	279			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245271	B. WING	i			C 12/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	transfer. MDS asse R222 was cognitive care or present othe A physician order d "Please contact wo managing Left IT [is ulcer and coccyx [ta appointment ASAP seen in wound clinic colleague." An appointment ref Courage Kenny 6/2 cushion was compl further indicated Co during the session of ensure proper posit Must check cushior orders: Check cushior ord	essments consistently revealed ely intact and did not reject er behavioral concerns. lated 6/20/15 directed staff to: bund clinic for input on schial tuberosity] decubitus ailbone] ulcer, and arrange [as soon as possible] to be ic by [name of physician] or ferral form completed by 23/15 indicated, "[R222's] letely flat!!!" The referral note burage Kenny had added air of an "appropriate amount to tioning and pressure relief. n for inflation daily. Physician nion daily for inflation to avoid 2222's medical record including ration sheets, and care plan, aff had been checking the sure proper inflation to meet ddition, there was no evidence tes to indicate R222's cushion	F	279			

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245271	B. WING	i		(02 /1) 12/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	ENCE PLACE			-	8720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa depth).	ge 25	F 2	279			
	Following surgical of dated 8/6/15 include Kenny and positioni for [R222]. Braden a MODERATE RISK" infections, diabetes dependence on stat and current pressur from 8/8/15 indicate refusing to get out of A significant change indicated R222 had pressure ulcer, with x 06. x 05.5 cm. A progress note from 9/8/15, included: "R wheelchair cushic well and [no] conce Physician orders: R [check] manual infla week. Roho cells at [standard] guidance However, a review of summary did not ac appointment or phy monitor the residen therapy progress not "Physical Therapy/ Requires Courage I resident's medical re such that there is po	debridment, a progress note ed, "Comprehensive Courage ing evaluation was completed score 14.0 indicating ' due to co-morbidities, wound a, narcotic use, immobility, ff for activities of daily living, re ulcers." A progress note ed, "Wound vacresident of bed." e MDS dated 8/12/15, I one stage 3 and one stage 4 measurements noted as 08. m a wound appointment dated Reason for appointment on mapping. Cushion mapped orns when is properly inflated. Recommend therapist at facility ation of cushion one [time per] re slightly under-inflated per e for best pressure relief." of the facility's charting ddress the resident's 9/8/15 sician's order for therapists to tt's wheelchair cushion. A ote dated 9/9/15 included: Occupational Therapy Kenny nursing to meet needs. Promote recovery, and ety. Condition of resident is otential for changes in ourage Kenny nursing					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/01/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI COM	E SURVEY IPLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER		-	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	A physician's progre included: "wound in foam in the underm you call [physician r [plan of carenumb also indicated R222 dressing change. A to monitor wound v wound, the notes d to the physician to e care had been disc requested. In additi care plan for that tir no changes made t The physician's pro indicated, "Pressure cushion slightly air mapping is good or Recommend therap [one time per] week following this visit d therapists were che proper inflation. A th indicated, "Therapy [incomplete senten SUMMARY: Patient minutes at 2000 [8: on its [sic] own. Dre like it is healing wel [sic] on his right but blanchable compar Therapy notes from services are Post-s Nursing." On 12/29 indicated the reside	ess note from 10/26/15, nprovedcontinue to pack ined area of the wound. Can name] in 1 week to discuss per provided]." A nursing note 2 was at the wound clinic for a lthough it was noted staff were ac and drainage from the id not reflect any follow-up call ensure that R222's plan of ussed as the physician had on, review of the resident's me indicated there had been	F	279			

Facility ID: 00096

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	note did not reflect related to his choice During an interview confirmed the cush R222's wheelchair i instructions had bee following his last we repair (11/2015) wh proper inflation wee to be up in the chai believed he was su every two hours. Sh repositioning was n the care sheets. RN-E was again int a.m. RN-E stated t repositioned every th hours a day, refusir then requested doc assessment, or risk pressure having be and any related car stated, "I did expres up so much," which discussed during w documentation to th resident's record. R whether the care pl R222's refusal to be The facility's 9/10, F Program policy indi prevention would be standards of practic the interdisciplinary made based on char	education of the resident e to decline repositioning. on 2/11/16, at 1:48 p.m. RN-E ion pump was on the back of in a bag. RN-E stated detailed en sent from Courage Kenny bund debridement/surgical nich directed staff to check for ekly. RN-E stated R222 wanted r for longer periods of time, but pposed to be repositioned ne explained the two hour noted on his care plan and on the resident was being two hours, and was up several ng to lie down. The surveyor sumentation regarding any k/benefit of not relieving nen reviewed with the resident, re plan interventions. RN-E ss concerns about him being n she stated she had round care, although nat effect was not found in the RN-E stated she was unsure an had been updated to reflect		279			

Facility ID: 00096

If continuation sheet Page 28 of 52

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245271	B. WING			C 12/2016
NAME OF I	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE			720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From para assessment of the repositioning based The summary analy any others that affe pressure ulcer prev 7. The plan of care stabilize and/or red risk factors for Pres and/or promote hea Ulcers13. Ongoin and family in Press 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plannic changes in care an A comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	age 28 resident's need for turning and d on individual risk factors6. ysis of these assessments and ect the resident's individual vention and/or treatment plan. reflects approaches to luce or remove the individuals ssure Ulcer development aling of existing Pressure og education of the resident sure Ulcer Prevention." 0(k)(2) RIGHT TO NNING CARE-REVISE CP ne right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or		CROSS-REFERENCED TO THE APPROPR		
	each assessment. This REQUIREMEN	NT is not met as evidenced				

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	-	AND HUMAN SERVICES			FORM	04/01/201 APPROVE 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	СОМ	E SURVEY PLETED
		245271	B. WING _			C 12/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 280	Based on interview facility failed to ens reviewed and revise 1 of 1 residents (R changed following H Findings include: R167's hospital dist 2/5/16, revealed the lower extremity dee significant lower leg discomfort on 1/25/ a prescription for w minimize the risk for blood clots). A Quid leg swelling was ind R167's plan of care 12/17/15, however, goals or interventio use of warfarin. A 2 care plan lacked ar problems with appr to manage the prot On 2/10/16, at 1:49 confirmed R167 ha 1/21/16, and discha 2/5/16. RN-A and F diagnoses including warfarin. RN-A repo been developed for scheduled for a sig Set (MDS) assess RN-A explained a to been initiated to ad issues, however, th	v and document review, the ure the care plan was ed following hospitalization for 167) whose treatments hospitalization. charge summary, dated e resident developed a left ep vein thrombosis (DVT) with g extremity swelling and some /16. R167 was discharged with rarfarin (anticoagulant used to or heart attack, stroke, and ck Wrap instruction sheet for cluded. e had been last revised did not include any problems, ns related to R167's DVT and 2/5/16 individual temporary hy identification of R167's new ropriate goals and interventions	F 28	 With respect to R#167: phys orders have been clarified and th plan has been updated to reflect changes to his treatment plan por hospital stay. The NAR assignmen has been updated to reflect these changes. The resident has since discharged from the facility. All residents who have returned the hospital within the past three have had their records reviewed to changes to their plan of care with revisions/updates to the care plan indicated. The NAR assignment has been updated to reflect any of 3. All nursing staff will be re eduo 3/23/16 regarding updating the re- care plan upon receipt of new oro- hospital return or change in cond including revisions to the NAR as sheet when changes occur. The director of Nursing and/or designee will audit three resident plans each week for one month a two resident care plans per week months to assure the plan of care individual resident is being revise followed. The data collected will be press the QAPI committee by the direct nursing. The data will be reviewed/discussed at the month meeting. At this time the commit make the decision/re-commenda regarding any necessary follow-u studies. 	e care any st ent sheet ed from months for any n as sheet changes. cated by esident ders, ition signment care and then for two e for the id and sented to tor of ly quality tee will tion	

Facility ID: 00096

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	wrapping R167's lea applying Jobst stoc 8:35 a.m. RN-B clar an order prior to R1 order had been obta legs. RN-B reported been updated on 2/ from the hospital. R167's physical the 2/5/16, revealed R1 for the assessment leg bandaging or wr 2/5/16, revealed R1 for the assessment leg bandaging or wr 2/5/16, read "pt [pat extremities] bandag however no actual of nursing to performF On 2/11/16, at 8:30 rehabilitation therap staff was not wrapp not have a current of A review of progress 2/10/16, did not indic contact with R167's leg bandaging or wr could be out of bed R167's orders repo an order for warfari until 2/10/16, at whin normalized ratio (IN determine how thicl be obtained. An orr obtained on 2/10/16 for staff to now allow	gs and nursing staff was kings. However, on 2/11/16, at rified the Jobst stockings were 67's hospitalization and a new ained to instead wrap R167's d the care plan should have '5/16, when R167 returned erapy (PT) plan of care, dated 67 had lower legs bandaged . No care plan goal related to rapping. A PT note dated tient] has LE [lower ged and instructions were sent, order for either therapy or R [sic]." a.m. the director of by reported physical therapy ing R167's legs, as they did goal or physician order. s notes, dated 2/5/16 to icate any information or s primary physician regarding raps or length of time R167	F 2	280			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE COMF	SURVEY PLETED
		245271	B. WING			(02 /1) 2/2016
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	INCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 280 F 309 SS=D	directed, "A residen admission. The con updated/revised as directed staff to incl current and acute c which they are rece and/or care, which in therapy/Treatment/I Coumadin [warfarin edema)." 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care.	Care Plan Completion policy t care plan is initiated on aprehensive plan is changes occur." The policy ude on the care plan "All hronic clinical conditions for iving medication, treatment, may includeMedication _abs/monitoring such as] (abnormal bleeding/bruising, CARE/SERVICES FOR EING receive and the facility must ary care and services to attain test practicable physical,	F 2				3/23/16
	by: Based on observat review, the facility fa	ion, interview and document ailed to coordinate care after of 1 resident (R167) reviewed			1. With respect to R#167: physician orders have been clarified and the car plan has been updated to reflect any changes to his treatment plan post hospital stay. The NAR assignment sl has been updated to reflect these	re	
	2/9/16, at 12:58 p.m R167 returned to th 2/5/16. The residen while in the hospital	ber (F)-A was interviewed on n. F-A, reported concerns after e facility from the hospital on t reported had a blood clot and F-A was worried about ng stretches of time. F-A			 changes. All residents who have been hospitalized within the past three mont have had their records reviewed for an changes to their plan of care with revisions/updates to the care plan as indicated. The NAR assignment shee 	ny	

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	NG	COI	C
		245271	B. WING _		02	/12/2016
NAME OF	PROVIDER OR SUPPLIER	·	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP (CODE	
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 309	reported she had s wheelchair for seve the hospital. She h staff over the week care concerns were Monday noted R16 for long periods of there must have be the staff about R16 2/10/16, F-A again was not addressing Although R167 was the hospital, this wa F-A reported R167 was the hospital, this wa F-A reported R167 was the hospital, this wa F-A reported R167 was the hospital the were covered swollen and bare w reported R167's leg hospitalization. F-A registered nurse(R was not sure how t communicated and expressed concern appropriate size for R167's hospital dis 2/5/16, revealed the lower extremity dee significant lower leg discomfort on 1/25, a prescription for w minimize the risk for blood clots). A Quid leg swelling was inter R167's plan of care 12/17/15, and did r	een R167 sitting in his eral hours after his return from had reported her concerns to end. On Sunday, she thought e resolved, but then on 7 was again sitting in his chair time. F-A reported she thought een a miscommunication with 57's changing needs. On reiterated her concerns staff g R167's change in condition. s getting his legs wrapped in as not occurring at the facility. had gained a lot of fluid weight wed the surveyor R167's legs d by a blanket. The legs were vithout wraps or stockings. F-A gs were less swollen prior to A reported she had spoken to a N)-B about her concerns, but he changes were being I addressed. F-A also is the bed was no longer an r R167. charge summary, dated e resident developed a left ep vein thrombosis (DVT) with g extremity swelling and some (16. R167 was discharged with varfarin (anticoagulant used to or heart attack, stroke, and ck Wrap instruction sheet for	F 30	 has been updated to reflect All nursing staff will be r 3/23/2016 regarding updaticare plan upon receipt of methospital return or change in including revisions to the N sheet when changes occur The director of nursing a designee will audit three replans each week for one metwo resident care plans permonths to assure the plan of individual resident is being followed. The data collected will be the QAPI committee by the Nursing. The data will be reviewed/discussed at the meeting. At this time the camake the decision/re-committees. 	e educated by ng the resident ew orders, i condition AR assignmen and /or sident care onth and then week for two of care for the revised and e presented to Director of monthly Quality ommittee will nendation	t

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING			C 12/2016
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVID	ENCE PLACE		-	720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	lacked any identific with appropriate go manage the problem On 2/10/16, at 1:49 confirmed R167 ha 1/21/16, and discha 2/5/16. RN-A and F diagnoses including warfarin. RN-A repo- been developed for scheduled for a sig Set (MDS) assessm RN-A explained a tr been initiated to ad issues, however, th developed. RN-B reported been initiated to ad issues, however, th developed. RN-B reported 8:35 a.m. RN-B cla an order prior to R1 order had been obt legs. RN-B reported been updated on 2/ from the hospital. R167's physical the 2/5/16, revealed R1 for the assessment leg bandaging or w 2/5/16, read "pt [pa extremities] bandag however no actual on nursing to performF On 2/11/16, at 8:30 rehabilitation therap staff was not wrapp	action of R167's new problems bals and interventions to ms. P.m. the RN-B and RN-A ad been hospitalized on arged back to the facility on RN-B confirmed R167 had new g DVT and was prescribed orted a new care plan had not r R167 since he was nificant change Minimum Data ment in the next few weeks. emporary care plan could have dress concerns the new he care plan had not yet been eported therapy staff were ogs and nursing staff was skings. However, on 2/11/16, at urified the Jobst stockings were 167's hospitalization and a new tained to instead wrap R167's d the care plan should have /5/16, when R167 returned erapy (PT) plan of care, dated 167 had lower legs bandaged t. No care plan goal related to rrapping. A PT note dated titient] has LE [lower ged and instructions were sent, order for either therapy or	F 309			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245271	B. WING	····		C 12/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/1	12/2010
PROVIDE	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 34	F 30	99		
	2/10/16, did not ind contact with R167's	s notes, dated 2/5/16 to icate any information or primary physician regarding raps or length of time R167				
	an order for warfari until 2/10/16, at whi normalized ratio (IN determine how thick be obtained. An orr obtained on 2/10/16 for staff to now allow	rt for 1/16 and 2/16, revealed n five days, effective 2/5/16 ch date the international IR/ laboratory testing to k or thin the blood is) was to der was requested and 5, for leg wraps and directions w the resident to sit in the ter than three hours.				
F 314 SS=D	directed, "A residen admission. The con updated/revised as directed staff to incl current and acute c which they are rece and/or care, which therapy/Treatment/	changes occur." The policy lude on the care plan "All hronic clinical conditions for iving medication, treatment, may includeMedication Labs/monitoring such as [] (abnormal bleeding/bruising, ENT/SVCS TO	F 31	4		3/23/16
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida	rehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and				

Facility ID: 00096

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PRINTED: 04/01/2016

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				IG	(C
		245271	B. WING		02/12/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 314	Continued From pa	age 35	F 31	4		
	services to promot prevent new sores	e healing, prevent infection and from developing.				
	by: Based on observa review, the facility to proper care and se development to pro- the risk of further p 1 of 3 residents (Ri- ulcers. Findings include: R222 was observe air mattress in bed electric, tilt-in-spac The wheelchair have front and cutout in bladder where the contoured backres on the air-filled por During interview wi a.m. he reported he ulcer in June of 20 air-containing prote wound deteriorated surgical repair. R22 discovery of the pro- was low and neede	NT is not met as evidenced tion, interview, and document failed to develop provide ervices including care plan pmote healing and/or minimize pressure ulcer development for 222) reviewed for pressure d in his room while lying on an on 2/11/16, at 8:45 a.m. An e wheelchair was in the room. d a seat cushion with a foam the rear filled with an air resident would sit, as well as a t. The surveyor briefly pressed tion, which contained air. ith R222 on 2/11/16, at 8:45 e had developed a pressure 15. Despite the use of an ective wheelchair cushion, the d and eventually required 22 asserted that prior to the essure ulcer, the air bladder ed refilling. "I was getting pres that my Roho air cushion		1. A comprehensive assessment risk factors including the braden ar turning and repositioning guidance completed for R#222. The informa- was documented on the residents care and the NAR assignment she #222 roho cushion is checked for p inflation as instructed and docume when complete. Rejection of care interventions to promote healing ha updated on the resident plan of car NAR assignment sheet reflects all changes. R#222 has been educat regarding the risks of not following plan of care for preventing further s breakdown. The negotiated risk w reviewed with R#222 on 3/9/2016. 2. All residents with current wound had their care plans reviewed to en the inclusion of all measures to pro- healing and prevent further breakd including rejections of care. The N assignment sheet has been update reflect any changes. Nursing leader meets weekly to review wounds an progression of healing with discuss new strategies for delayed or wors wounds.	nd was ation plan of et. R proper nted and as been re. The ed the skin as ds have nsure own IAR ed to ership id sion of	
	told them it was lov wouldn't do anythir the rear of both leg	n the closet to fill my seat. I w and needed to be filledstaff ng about it." Ulcers formed at ys, with the right one becoming deeper). "[The area]		3. All nursing staff will be re-educa regarding measures to prevent ski breakdown, what to report and how information/interventions are to be communicated. Education will be	n	

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STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	0938-039 E SURVEY PLETED
		245271	B. WING	<u> </u>		C 12/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	12/2010
	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 314	developed a big uld part meets the air p the right ulcer ever debridements (surg and surgery to closs R222 said that he h Kenny rehabilitation [the air cushion] was specified. R222 sta had inflated it and a his needs. After two said the physician learn the proper as The resident expla to "come and put while it was under idea of what a prop would bethat new registered nurse (F R222 then showed illustrating how mu between the cushio the resident was see A 6/2/15, a quarter R222 indicated: "D more pressure ulce However, the resid pressure ulcer dev interventions were extensive assistant transfer. MDS assee R222 was cognitive care or present oth A physician order of	cer at the point where the foam bart in an edge." R222 stated intually required four gically removing dead tissue) the it with a flap of tissue. The deen going to Courage in, where there they'd noted it as completely flat, no date ated the Courage Kenny staff adjusted the pressure to meet o debridement surgeries, R222 had directed the facility staff to sessment/inflation technique. ined the staff were supposed their hands on the cushion my butt so they would get the perly inflated cushion for me rer happened," except by RN)-E "a couple of times." the surveyor a paper diagram ch space should have been on base and the buttocks when	F 31	4 complete by 3/23/2016. 4. The director of nursing and/d designee will audit three resident week for one month and then two residents each week for one more the two residents per week for one more the two residents per week for one more to assure the plan of care for the individual resident is being revisis followed for promoting healing a preventing further breakdown. 5. The data collected will be previewed/discussed at the more nursing. The data will be reviewed/discussed at the more make the decision/re-commence regarding and necessary follow studies.	nts each vo onth and wo months e eed and and esented to ctor of hly quality ittee will ation	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY IPLETED
		245271	B. WING				C 12/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			-	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	ulcer and coccyx [ta appointment ASAP seen in wound clinic colleague." An appointment refe Courage Kenny 6/2 cushion was comple further indicated Co during the session of ensure proper posit Must check cushior orders: Check cushior orders: Check cushior orders: Check cushior orders: Check cushior orders: Check cushior orders: Check cushior and prosent administrification failed to indicate static cushion daily to ensist R222's needs. In action in any progress not was ever checked f Wound Summary db back" (a photo revertuberosity/IT) indicated dated 6/23/15, of a (healthy) base whic (cm) in length, 5.1 of (2.5 x 5.1 x 0 cm). If increased to stage 3 4.5 x 5.8 x 5.5 cm (depth). Following surgical of dated 8/6/15 include Kenny and position for [R222]. Braden 3	ailbone] ulcer, and arrange [as soon as possible] to be c by [name of physician] or erral form completed by 3/15 indicated, "[R222's] etely flat!!!" The referral note burage Kenny had added air of an "appropriate amount to cioning and pressure relief. In for inflation daily. Physician ion daily for inflation to avoid 222's medical record including ration sheets, and care plan, aff had been checking the sure proper inflation to meet ddition, there was no evidence es to indicate R222's cushion	F	314			

Facility ID: 00096

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245271	B. WING			(02/1) 12/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDI	ENCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	dependence on sta and current pressur from 8/8/15 indicate refusing to get out of A significant change indicated R222 had pressure ulcer, with x 06. x 05.5 cm. A progress note fro 9/8/15, included: "R wheelchair cushic well and [no] conce Physician orders: R [check] manual infla week. Roho cells at [standard] guidance However, a review Charting summary 9/8/15 appointment therapists to monito cushion. A therapy included: "Physical Therapy Requires 0 meet resident's mer recovery, and ensu resident is such tha in condition without intervention." A physician's progre- included: "wound in foam in the underm you call [physician r [plan of carenumb also indicated R222	, narcotic use, immobility, ff for activities of daily living, re ulcers." A progress note ed, "Wound vacresident	F3	114			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		245271	B. WING	i			C 12/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
PROVID	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	to monitor wound v wound, the notes di to the physician to e care had been disc requested. In additi care plan for that tir no changes made t The physician's pro- indicated, "Pressure cushion slightly air i mapping is good or Recommend therap [one time per] week following this visit d therapists were che proper inflation. A th indicated, "Therapy [incomplete sentem SUMMARY: Patien minutes at 2000 [8: on its [sic] own. Dre like it is healing wel [sic] on his right but blanchable compar Therapy notes from services are Post-s Nursing." On 12/29, indicated the reside help when he was r note did not reflect related to his choice R222's care plan la revealed the reside paraplegia (paralys	ac and drainage from the id not reflect any follow-up call ensure that R222's plan of ussed as the physician had on, review of the resident's me indicated there had been	F	314			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	including surgical re 2/23/15, and a stag (buttock) ulcer iden indicated stage 2 pr on the resident's co hospitalized. Staff in to "educate residen causes of breakdow reposition/position of Service RoundsA concern. Pressure r rotating low air loss least every 2 hours requested." A nutrit identified related to ulcers. Interventions supplement) every The care plan did n the resident rejection turn/reposition), and identified to educate risks and benefits of care plan lacked an need to check the w inflation to minimize ulcer complications The current 2/9/16, directed staff to ass [Reposition: assist of "Reposition q2 [eve (nursing assistant). on the Nursing Assis monitoring the inflat During an interview confirmed the cush R222's wheelchair i	epairs of a sacral ulcer on e 4 right ischial tuberosity tified 11/24/15. The care plan ressure ulcers had developed occyx while he was nterventions included for staff t/family/caregivers as to wnEncourage changes during Customer void positioning on areas of relieving device for bed, mattress, turn, reposition at , more often as needed or ional problem was also morbid obesity and pressure s included Prostat (a protein day to promote ulcer healing. ot indicate any concerns with ng care (e.g. refusal to d there were no approaches e the resident regarding the of his choices. In addition, the py information regarding the wheelchair cushion for proper e the risk for further pressure	F	314			

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			OI	FORM. MB NO.	04/01/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	COM	E SURVEY PLETED C
		245271	B. WING				
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE				720 23RD AVENUE SOUTH /INNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	following his last wor repair (11/2015) wh proper inflation wee to be up in the chain believed he was sur every two hours. Sh repositioning was n the care sheets. RN-E was again int a.m. RN-E stated t repositioned every th hours a day, refusin then requested doc assessment, or risk pressure having be and any related car stated, "I did express up so much," which discussed during w documentation to th resident's record. R whether the care pl R222's refusal to be The facility's 9/10, F Program policy indi- prevention would be standards of practic the interdisciplinary made based on cha- or when new risk fa assessment of the in repositioning based The summary analy any others that affe pressure ulcer prev 7. The plan of care	bund debridement/surgical ich directed staff to check for ekly. RN-E stated R222 wanted r for longer periods of time, but pposed to be repositioned ne explained the two hour oted on his care plan and on erviewed on 2/12/16, at 11:53 he resident was being two hours, and was up several ng to lie down. The surveyor sumentation regarding any t/benefit of not relieving en reviewed with the resident, e plan interventions. RN-E as concerns about him being n she stated she had ound care, although nat effect was not found in the tN-E stated she was unsure an had been updated to reflect	F	314			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUF COMPLET	
				G	C	
		245271	B. WING		02/12/2	016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH		
PROVIDI	ENCE PLACE			MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CON	(X5) /IPLETIO DATE
F 314	and/or promote hea Ulcers13. Ongoin	ige 42 ssure Ulcer development aling of existing Pressure ig education of the resident ure Ulcer Prevention."	F 314	4		
F 329 SS=D		EGIMEN IS FREE FROM	F 329	9	3/23	3/16
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any e reasons above.				
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	ehensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical the who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these				
	by: Based on interview facility failed to ens	NT is not met as evidenced v and document review, the ure non-pharmacological developed and implemented		1. With respect R#56: The care has been revised to include the non-pharmacological measures to		

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TATEMENT	OF DEFICIENCIES	KANNERS KANNERS			DNSTRUCTION	(X3) DATE COM	0938-039 E SURVEY PLETED
		245271	B. WING _	i		C 02/12/2016	
NAME OF I	PROVIDER OR SUPPLIER	•			ET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVIDI	ENCE PLACE				23RD AVENUE SOUTH IEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 329		-	F 32				
	prior to administration of a psychotropic drug and to monitor for effectiveness and potential side effects for 1 of 5 residents (R56) reviewed for unnecessary medication use.			m sh ch	omote sleep prior to administrati edications. The NAR assignmer neets have been revised to reflec nanges. All residents currently receiving	nt t the	
	Findings include: R56 was prescriber			m re m	edications to promote sleep have viewed to assure non-pharmaco easures are implemented prior to	e been logical o	
	(prn) at bedtime to the resident's 2/16, Record (MAR). Afte	5 milligrams (mg) as needed promote sleep according to Medication Administration er the pharmacy consultant psage change of Trazodone		sle be 3.	dministration of any prn medication eep. The NAR assignment sheet een updated to reflect any chang All nursing staff will be re education garding non-pharmacological me	t has es. ated	
	decreased to prn o			the co	promote sleep, what to report an e information/interventions are to pmmunicated. Education will be		
	the Treatment Adm lacked any informa non-pharmalogical	interventions, medication		4. de we	ompleted by 3/23/2016. The director of nursing and/or esignee will audit three residents eek for one month and then two		
	9/1/15 through 2/12 from 2/1/16 through received prn Trazo documentation of n	side effects in the TARs from 2/16. R56's MAR and TAR n 2/12/16, revealed R56 done four times, but lacked ion-pharmacological to its use or a notation of the medication.		as ar ac sle 5.	sidents per week for two months soure non-pharmacological interv- re in place and implemented prio dministration of a prn medication eep. The data collected will be prese e QAPI committee by the directo	ventions r to the for ented to	
	The nursing assista sheet for R56 lacke regarding measure R56's current care the use of psychotr	ant (NA) current assignment ed any direction for NAs s to promote sleep. In addition plan lacked identification of opic medications, goals, and ntions to promote sleep for		nu ma re	ursing. At this time the committe ake the decision/recommendatic garding any necessary follow up udies.	e will on	
	2/10/16, at 11:16 a.	ne pharmacy consultant on .m. revealed Trazodone was 3/9/15, at 50 mg at bedtime to					

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		AND HUMAN SERVICES			FORM	04/01/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING			C 12/2016
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PROVID	ENCE PLACE			720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	promote sleep. A c on 7/13/15, to 25 m current dose 25 mg medication had not 12/15, but had been 1/16. The consultar non-pharmalogical been attempted at psychotropic medic especially when it v also stated she exp effectiveness would On 2/10/16, at 11:5 (RN)-C reported the non-pharmacologic potentiate the resid try to figure out her eat, if she is in pain repositioned. If all RN-C verified the ir documented in R56 care plan. During an interview director of nursing of there was no prn Th months of 11/15 an administered the m 1/16. She added, "V for prn medications did to help them res At least you should further explained sh non-pharmacologic of side effects and sleep medications of	dose reduction was attempted by and then on 10/19/15, to the g prn. She further the been administered in 11/5 to n administered 10 times in nt further stated interventions should have least an hour prior to use of vations including Trazodone, was prescribed as needed. She bected side-effects and d be monitored. 3 a.m. a registered nurse e facility did not have specific val interventions identified to lent's sleep. She stated, "We day. If she had enough to h, if she needs to be toileted or else fails we give her a prn." herventions were not S's MAR/TAR or outlined in her on 2/12/16, at 11:54 a.m. the (DON) stated it was "odd " razodone use during the d 12/15, and then was ledication 10 times during When it is for sleep, especially s, you should chart what you st and not just give them a pill. talk to them." The DON ne was unaware of current cal interventions or monitoring effectiveness for sleep and	F 329			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVID	ENCE PLACE			-	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 329 F 364 SS=E	Sleep Monitoring, d staff non-pharmacc to increase comfort will be added to a re (nursing assistant) = A 9/13, Psychoactiv Monitoring policy, n "provide monitoring when a resident has change in psychop! Medication monitor the medication initia days. If any adverse 7 days, nursing will and document in th nature of the adver impact on the resid condition or function The facility supports underlying causes of appropriate treatmer reasons are ruled of psychotropic medic dosage or discontin will be ongoing for t Psychotropic medic antidepressant(s)." 483.35(d)(1)-(2) NL PALATABLE/PREF Each resident recei food prepared by m	irected staff to "individualize ological interventions intended and promote adequate sleep esident care plan and NA sheet." we Medication Adverse Effect oted was the purpose was to guidelines to nursing staff s been ordered a new or a narmacological medication. ing will begin on the first day of ation and continue for seven e effect if found within the first update the medical provider e clinical record describing the rse effect and the potential ent's mental or physical nal or psychological status. s the goal of determining the of sleep disturbance so ent of environment or medical out prior to the use of ations. Efforts to reduce oue psychotropic medications the clinical situation. eations include UTRITIVE VALUE/APPEAR, ER TEMP ves and the facility provides pethods that conserve nutritive ppearance; and food that is		329			3/23/16

Facility ID: 00096

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						E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
			/		_	С
		245271	B. WING		02/	12/2016
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, S	TATE, ZIP CODE	
PROVID	ENCE PLACE			3720 23RD AVENUE SOU MINNEAPOLIS, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 364	Continued From pa	ge 46	F3	64		
		NT is not met as evidenced				
	review, the facility f attractively served a residents (R17, R4- R119, R217) who o Findings include: During observation 2/8/16, residents w meal that was sche was were served fr kitchenette starting R17 reported on 2/ served late. The me had recently been s R105 reported on 2/ like the food. He sa half-cooked hambu R20 reported on 2/ was often served lu food. When she red it was often not mice	 tion, interview and document ailed to ensure meals were and palatable for 8 of 170 4, R105, R20, R192, R129, ffered food complaints. of the noon dining service on ere seated and waiting for the duled to begin at noon. Food om the 2 north (2N) at 12:27 p.m. B/16, at 12:24 p.m. were often eat was often tough and she served slimy mushrooms. 2/8/16, at 12:30 p.m. he did not id he had been served rgers and burnt eggs. B/16, at 12:30 p.m. the food kewarm and she preferred hot guested the food be reheated, rowaved until it was hot. 16, at 12:05 p.m. dinner was 		 preferences for R1 R192, R129, R119 completed to their plan, and diet orde 2. The facility has management to pr current policies an protocols are within managing meal pro supervisor has bee meal services start temped and appro meals are audited palatability. 3. All food service educated regarding procedure for tastif measures for temp meal service to as temperature of foo expectations, and a food items. All foo received educatior The director of designee will audit weekly basis. Com 	dietary program, care ers if indicated. increased dietary ovide assistance with d procedures, assure n guidelines for eparation. An evening en hired to ensure all t on time, foods are priate for service and at the time served for staff has been re g food preparation, ng prior to service, berature testing prior to sure appropriate ds, plating, room tray serving hot and cold d service staff will have	
	regularly served late, often a half hour. Regarding reportedly being served very mushy vegetables R192 stated, "ish." R129 reported on 2/10/16, at 12:11 p.m. the food tasted "terrible," was cold, mushy, and sometimes undercooked. In addition, meals were regularly served a half hour after the scheduled time.			meal and service r gathered and addr 5. The data collec the QAPI committe Food service. the reviewed/discusse	ted will be presented to be by the Director of data will be d at the monthly quality ne the committee will	

Facility ID: 00096

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED		
		0.1707.4	5 14/11/0		С			
		245271	B. WING		02/	12/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH				
PROVID	ENCE PLACE		MINNEAPOLIS, MN 55407					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE		
F 364	R119 said on 2/10/ tasted terrible, was served late. On 2/10/16, at 12:2 started serving tray North dining room f were frequently obs between the kitcher minutes before beir p.m. after the last p was requested by s palatability included pureed peas, pure chicken, fish filet ar bland and lukewarr salad was taken at fillet was mushy. Th	age 47 16, at 12:15 p.m. the food often cold and was often 21 p.m. the dietary aide (DA)-A is from the kitchenette for the 3 for the noon lunch meal. Plates served to sit on the ledge nette and dining room for 5-10 ing served to residents. At 1:13 plate was served, a test tray surveyor. Foods tested for food d: a hot dog, potato salad, ed fish, mashed potatoes, ind milk. The potato salad was in. A temperature of the potato 79 F (Fahrenheit). The fish he chicken was tough, with a ance, pink on the inside and	F 364	regarding any necessary follow u studies.	р			
	(DM) reported cook foods. DM reported steam tray for over taste good. DM rep times delayed due residents ready and shortages. The Taste Testing p staff "All food is tas Procedure: 1. The o all food before it is procedures should serve food onto a d spoon to taste the f	p.m. the dietary manager as should be taste testing I that if food was sitting the an hour it likely would not orted food service was at to nursing staff not having d at times due to dietary staff policy, dated 2010, directed te tested prior to serving. cook is responsible for tasting served. 2. Proper tasting be used. Use one spoon to lish or bowl, and use a new food 3. All food not passing the asoning, toughness, color, or						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETE B. WING NAME OF PROVIDER OR SUPPLIER 245271 B. WING 02/12/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
245271 B. WING 02/12/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PROVIDENCE PLACE 3720 23RD AVENUE SOUTH	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
PROVIDENCE PLACE 3720 23RD AVENUE SOUTH			245271	B. WING	i			
	NAME OF P	PROVIDER OR SUPPLIER	•		;	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	PROVIDE	ENCE PLACE						
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE
F 364 Continued From page 48 problem has been corrected." F 364 R44 reported in an interview on 2/8/16, at 2:39 p.m. "The food was disgusting. I have diabetes and they kept bringing me potatees, bread and juice. They consistently bring these. They (the food) are too high in sait. It is cheap food and not healthy." She further stated it was often breaded to cover up the taste and quality. When asked about the food tiems observed in her room she explained she bought "good" food with her own money whenever she could afford to. R22's 1/21/16, Minimum Data Set (MDS) assessment indicated she was cognitively intact and made appropriate decisions. A Providence Place Grievance/Feedback form dated 22/16 initiated by P22 read, "Meal options are poor. It comes late and is cold. Wants whole milk," and a form dated 2/8/16 also initiated by R22 read, "I get cold scrambled eggs every day." R217's quarterly Minimum Data Set dated 12/14/15, revealed the resident was cognitively intact. R217 stated in an interview on 2/9/16, at 12:55 p.m. that the food and the snacks served at the facility were a "failure" and 7 of 10 terms on the menu in one week tasted "awdul." R217 described the food as "hortibleno seasoningmushylack of variety." R217 reportedly routinely attended resident council meetings, and said food issues were always brought up by residents at the meetings, and she personally spoke up about congoing food concerns. The dietary manager had attended some of the meetings, and residents were told there were plans for new menus, but nothing had changed since last fall and they just kept rotating the same menus. When asked whythe residents	F 364	problem has been of R44 reported in an p.m. "The food was and they kept bring juice. They consists food) are too high in healthy." She further to cover up the tast about the food item explained she boug money whenever sl 1/21/16, Minimum I indicated she was of appropriate decisio A Providence Place dated 2/2/16 initiate are poor. It comes I milk," and a form da R22 read, "I get col R217's quarterly Mi 12/14/15, revealed intact. R217 stated 12:55 p.m. that the the facility were a "f the menu in one we described the food seasoningmushy, reportedly routinely meetings, and said brought up by resid personally spoke up concerns. The dieta some of the meeting there were plans fo changed since last	interview on 2/8/16, at 2:39 disgusting. I have diabetes ing me potatoes, bread and ently bring these. They (the n salt. It is cheap food and not er stated it was often breaded e and quality. When asked is observed in her room she ght "good" food with her own he could afford to. R22's Data Set (MDS) assessment cognitively intact and made ns. e Grievance/Feedback form ed by R22 read, "Meal options late and is cold. Wants whole ated 2/8/16 also initiated by d scrambled eggs every day." inimum Data Set dated the resident was cognitively I in an interview on 2/9/16, at food and the snacks served at failure" and 7 of 10 items on eek tasted "awful." R217 as "horribleno lack of variety." R217 attended resident council food issues were always ents at the meetings, and she o about ongoing food ary manager had attended gs, and residents were told r new menus, but nothing had fall and they just kept rotating	F	364			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	3720 23RD AVENUE SOUTH		
PROVIDE	ENCE PLACE				MINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From par could not get more items were "season was served "constat to like it, she no lon specifically requests she would not be se was served broccol R217 stated that too the second option fe not get broccoli and anyway. Vegetables and foods were offe overcooked." That of veal patty that was middlealmost color in her room and her served cold. Althout begin at 12:00 p.m. between 12:30 and were the last to be of other residents com undercooked and p told by the DM to has microwave. R217 re "once," but staff did When she was serves staff never returned she was given pure regular diet, the nur away and did bring reported food often	ge 49 variety, the DM said the menu hal." R217 explained broccoli antly," and although she used ger did. That day she had ed the alternate vegetable so erved broccoli, however, then i regardless of her request. day she purposely asked for or the meal so that she would d she was then served broccoli s were served kind of "mushy" en either "undercooked or day the resident was served "a undercookedpink in the d." R217 stated she ate meals r food was nearly constantly gh mealtime was scheduled to she received her meal 12:50 p.m. and room trays delivered. When R217 heard nplain chicken was served ink in the middle, they were ave their food reheated in the equested her food be reheated not return in a timely manner. ved the wrong beverage, the l with the proper one. When ed peaches instead of her rsing assistant just walked her the correct diet. R217 was served on paper plates peing broken, and the paper	TAG		DEFICIENCY)	RIATE	DATE
	delivered to her roo warmer and the cov keep the food warm she was served a h	the time food was not m with both the bottom plate ver that was supposed to help n. At 6:20 p.m. R217 reported amburger patty on a bun with up packets, but nothing else.					

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		(X1) PROVIDER/SUPPLIER/CLIA	· /	IPLE CONSTRUCTION			
IND PLAIN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG			
		245271	B. WING _		C 02/12/2016		
NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	12/2010	
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 364	R217 reported ongo been brought up to	bing concerns with food had staff and "is not being and keeps getting mentioned	F 36	64			
F 497 SS=E	483.75(e)(8) NURS	E AIDE PERFORM	F 49	07		3/23/16	
	The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.						
	by: Based on interview facility failed to cond 2 of 5 nursing assis the potential to affe facility where the Na work. Findings include: A sample of five NA reviewed on 2/12/10	NT is not met as evidenced v and document review, the duct performance reviews for stants (NA-B, NA-D). This had ct multiple residents in the As may have been assigned to A employee records were 6, and the records were evaluations were conducted.		 With respect to the identified evaluation: a current evaluation performance was completed for NA-d. All employee files have been for current evaluations and those compliance for annual evaluatio completed over the next quarter The guideline for completing performance evaluations has be developed and all leadership tra the expectations for completing 	of work employee reviewed e out of n will be annual en		

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		AND HUMAN SERVICES				FORM	04/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245271	B. WING				C 12/2016
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PROVID	ENCE PLACE		3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 497	evaluation for NA-E 2) NA-D was hired file contained evide evaluation complete On 2/12/16, at 1:00 for conducting annu The administrator of policy. He stated th	on 2/25/13. The most recent 8 was completed on 11/14/15. on 11/7/05. NA-D's employee once of one performance	F	197	 The human resource director ar designee will audit five employee fi each week for two months to assur evaluations are completed on a tim basis. The data collected will be prese the QAPI committee by the human resource director. The data will be reviewed/discussed at the monthly meeting. Ath this time the committ make the decision/recommendation regarding any necessary follow up studies. 	les re ely nted to quality ee will	

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		AND HUMAN SERVICES & MEDICAID SERVICES	F	5	271025	FORM	03/24/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A ₀ BUILDING 01 - MAIN BUILDING 01				E SURVEY PLETED
		245271	B. WING			02 / ⁻	10/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDE	INCE PLACE				720 23RD AVENUE SOUTH IINNEAPOLIS, MN 55407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio the time of this surv found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			3	-	
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	R THE FIRE SAFETY -TAGS) TO: pections Division Suite 145			EPOC		
	By email to:						
	director's or provid	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE 03/14/2016

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.

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
		245271	B. WING		02	/10/2016
	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407	X	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pre 3. The name and/or responsible for corre- prevent a reoccurred Providence Place is basement. The build different times. The constructed in 1984 Type II(222) constru- was constructed to that was determine construction. Becau the addition meet th for existing building one building. The building is fully facility has a compli- smoke detection in open to the corridor automatic fire depa has a licensed capa	tate.mn.us n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency. oposed, completion date.	К 000			
K 025	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 02	5		3/23/16

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	A. BUILDING 01 - MAIN BUILDING 01		02/10/2016	
		245271	B. WING	02/*			
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
PROVID	ENCE PLACE			3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETI DATE	
K 025 SS=E	Continued From pa	age 2	K 025				
33-E	least a one half hou constructed in acco barriers shall be per atrium wall. Window fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD i Based on observat facility has failed to doors in accordance deficient practice co Findings include: On facility tour betw on February 10, 20 the smoke compart side, east wing had smoke barrier wall, This deficient pract	s not met as evidenced by: tions and staff interview, the maintain smoke/fire barrier we with LSC 19.3.7.5. This ould affect 41 residents. veen 09:30 AM and 01:00 PM 16, observation revealed that tment, on the third floor, south I penetrations through the		 with respect to the smoke compartment on third floor the penetrations have been sealed retardant caulk as of 2/11/16. Any resident residing in the f the potential to be affected by th sealing of a smoke compartmer All smoke compartments hav reviewed by the director of main for penetrations and all have be Director of maintenance or d will audit penetrations monthly ta all are sealed timely. Data will be collected and ret QAPI committee monthly. 	acility has le non lt. ve been tenance en sealed. esignee o ensure		

PRINTED: 03/24/2016