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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 21CX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 26105

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245627**

2.STATE VENDOR OR MEDICAID NO.
(L2) **513928200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE BIRCHES AT TRILLIUM WOODS**
(L4) **14585 59TH AVENUE NORTH**
(L5) **PLYMOUTH, MN** (L6) **55446**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/17/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date:
Susanne Reuss, Unit Supervisor — 11/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 11/19/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/30/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/16/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245627

November 19, 2018

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

Dear Administrator:

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 September 25, 2018 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 19, 2018

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

RE: Project Numbers S5627003, H5627003

Dear Administrator:

On October 25, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective September 24, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 16, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on August 16, 2018, and an abbreviated standard survey to investigate complaint number H5627003 completed on September 6, 2018. The most serious deficiencies at the time of the abbreviated standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 16, 2018, as of September 25, 2018.

On November 16, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard survey, completed on September 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 21, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey, completed on September 6, 2018, as of September 21, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 25, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 25, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 16, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 16, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 16, 2018, is to be rescinded.

In our letter of October 25, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 16, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 25, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 19, 2018

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

Re: Reinspection Results - Project Number S5627003

Dear Administrator:

On October 17, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 16, 2018 with orders received by you on August 29, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 21CX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 26105

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245627**

2.STATE VENDOR OR MEDICAID NO.
(L2) **513928200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE BIRCHES AT TRILLIUM WOODS**
(L4) **14585 59TH AVENUE NORTH**
(L5) **PLYMOUTH, MN** (L6) **55446**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/16/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Barbara White, HFE NE II 10/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 10/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/30/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 29, 2018

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

RE: Project Number S5627003

Dear Administrator:

On August 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
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 September 25, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 16, 2018 (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 February 16, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on August 13- 16, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted August 13- 16, 2018. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		8/31/18

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

Electronically Signed | 09/07/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 1 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R36) or legal representatives had been informed of bed hold rights at the time of hospitalization. Findings include: R36's diagnoses included atrial fibrillation, coronary artery disease, hypertension, obstructive uropathy, cerebrovascular accident (CVA) and liver transplant obtained from the discharge and admission Minimum Data Set (MDS) dated 7/16/18. In addition the MDS indicated resident had intact cognition. A review of the interdisciplinary notes revealed on 7/16/18, a staff nurse had noted at 7:20 a.m. R36 was extremely drowsy, dizzy, was difficult to arouse and was not able to communicate. Follow up nurse note at 8:30 a.m. indicated R36's	F 625	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Birches at Trillium Woods of the truth or the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Birches at Trillium Woods reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on September 17th, 2018.	

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	245627	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

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F 625	Continued From page 2 oxygen reading was 81% at 4 liters of oxygen, blood pressure was 88/48, pulse was 71, respirations were 16 and temperature was 96.4. The nurse practitioner had assessed R36 and gave an order to send R36 to the hospital. In addition, the note indicated R36 had black/tarry extra large stool with foul smelling odor. The note further noted the ambulance had transported R36 to the hospital at 12:10 p.m. Review of the interdisciplinary notes lacked evidence of the facility providing or attempting to inform R36 or the responsible representative of the bed hold during the hospital transfer. On 8/14/18, at 2:06 p.m. the licensed social worker (LSW) stated at the time R36 was being sent to the hospital he was not in the state to review the notice with him. LSW stated a call had been made to the a family member who indicated R36 was not doing to well. When asked for the documentation of staff informing the family member about the bed hold notice, LSW stated she would find the documentation and the nurse to find out the details as she was unclear and there was no documentation in the medical record. On 8/15/18, at 1:26 p.m. the director of nursing (DON) explained that at the time of a transfer to a hospital the staff were supposed to fill the transfer form out, call family and ask if the resident or family wanted to hold the bed. The DON stated sometimes the staff did not get a straight answer. The DON further stated on the next day after the transfer, the admissions staff would follow up to ask if to hold or not hold the bed. When asked if this information was documented somewhere she	F 625	How the nursing home will correct the deficiency as it relates to the resident: Resident 36 (R 36) is no longer a resident at The Birches at Trillium Woods so the medical record is closed and no update can occur. R 36 did not experience an adverse effect as a result of this practice. As stated in the statement of deficiencies, R 36 was not in a state to review and respond to the bed hold notice prior to transfer. Because of this, per our community standard procedure the notice of bed hold was sent with the resident in the Transfer to Hospital packet. Per our EMR Bed Hold/Leave of Absence Policy and Procedure (Policy #3003) if the resident is unable to respond and the resident representative is not present to respond, the Manager of Admissions or designee is responsible for contacting the resident representative the following day to inquire about their bed hold decision. In R 36s case, R 36 passed away on 07/16/2018, the same day of transfer, and R 36□s family came onsite the following morning to pick up all of the personal belongings prior to the Manager of Admissions or Designee having the opportunity to make any further contact. How the nursing home will identify other residents having the potential to be affected by the same practice: Residents who were transferred to an	

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F 625	Continued From page 3 stated she did not know and directed this surveyor to the administrator. On 8/15/18, at 1:42 p.m. the administrator stated all the residents regardless of the payment source were supposed to be given a bed hold notice. When asked where staff were supposed to document or if staff were supposed to document, the administrator stated it was standard of practice and staff were supposed to provide the form to the resident to sign before the transfer. The administrator further stated the staff was supposed to write a note in the medical record about discussion of the bed hold and if staff had made a follow up call regarding the bed hold to the resident and/or the family representative.	F 625	acute care setting have the potential to be affected by the same practice. Measures the nursing home will put in place or systemic changes made to ensure the practice will not recur: The Birches at Trillium Woods will continue to follow our standard policy and procedure as it relates to all transfers to the hospital. This procedure includes notifying all new residents about our bed hold policy upon admission as well as providing an additional notice, in the Transfer to Hospital packet, each time a resident is transferred to the hospital. Per our policy, we will continue to make follow-up phone calls the following day to inquire about a bed hold decision if the resident and/or resident representative was unable to make a bed hold decision prior to the transfer. As of August 15th, 2018, our policy has been updated to indicate that the responsibility of documenting a bed hold decision in the Electronic Medical Record (EMR) falls on the person; nursing, Manager of Admissions,or designee, who receives the decision from the resident or their representative. Education on the updated policy was conducted with the Quality Assurance Committee, including the Manager of Admissions, on August 20th, 2018. Education on this updated policy was conducted with the Health Coordinators (nurses) the week of August 20th, 2018.	

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F 625	Continued From page 4	F 625	How the nursing home plans to monitor its performance to make sure that solutions are sustained: The Administrator or Designee will conduct random audits of the EMR notes for one resident who has been transferred to the hospital per week for two months to ensure the appropriate documentation exists. If no concerns have been found, the Administrator or Designee will continue to conduct random audits on a monthly basis for the following six months. All findings will be reported to the monthly Quality Assurance and Performance Improvement meetings. Dates when corrective action will be completed: September 1, 2018 The title of the person responsible to ensure correction: Administrator	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		9/25/18

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F 880	Continued From page 5	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 6 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate hand hygiene practices for 1 of 1 resident (R10) reviewed for pressure ulcers and failed to assure hand hygiene was conducted after leaving a contact precaution room for 1 of 1 resident (R238) reviewed for contact precautions. Findings include: R10 On 8/15/18, at 7:45 a.m. nursing assistant (NA)-A entered R10's room to provide cares. NA-A approached R10, wearing gloves, stating she was going to assist R10 to get ready for the day. -At 7:46 a.m. NA-A approached R10's bed, moved the bedside table out of the way, took the blanket off R10, applied compression stockings on R10 and then lowered the bed. R10 was assisted to sit on the edge of the bed and NA-A applied shoes on R10. NA-A then cued resident	F 880	How the nursing home will correct the deficiency as it relates to the resident: No residents, including R 10 and R 238, experienced adverse effects as a result of this practice. R 238 has been cleared and is no longer on precautions. Education and observations have been completed to prevent future occurrences with all residents. How the nursing home will identify other residents having the potential to be affected by the same practice: All residents have the potential to be affected. Education and observations have been completed to prevent future occurrences with all residents. Measures the nursing home will put in	

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F 880	Continued From page 7 she was going to raise the bed up and NA-A applied a transfer belt around R10's waist. -At 7:52 a.m. NA-A cued R10 to stand and ambulated with R10 to the bathroom, assisted R10 to remove the pad and assisted R10 to sit on the toilet, who indicated she needed to urinate. -At 7:57 a.m. NA-A cued R10 to stand and was observed to use moist wipes to provide personal hygiene cares to R10. NA-A then, with the same gloves, pulled both R10's pull-up and pants then assisted R10 to sit on the wheelchair as she held onto the transfer belt. After R10 was seated in the wheelchair NA-A removed the gloves and wheeled R10 to the sink area. -At 7:59 a.m. NA-A came out of bathroom, without washing hands, and took the bed remote with her right hand and then asked R10 if she needed the sling on her right arm removed, which R10 stated "yes." NA-A went into the bathroom and removed the sling and then NA-A washed her hands. -At 8:51 a.m. NA-A acknowledged she had not removed gloves and washed hands after providing pericare on R10. NA-A stated she was supposed to remove gloves and wash her hands. During an interview on 8/15/18, at 1:26 p.m. the director of nursing stated staff were always supposed to wash their hands before and after cares. She further stated that staff should wash their hands each time after removing soiled gloves. R238's admission face sheet dated 1/4/17, indicated diagnoses of Zoster (shingles) without complications. R238's quarterly Minimum Data Set dated 7/11/18, indicated R238 was able to make self	F 880	place or systemic changes made to ensure the practice will not recur: Re-education on the Handwashing/Hand Hygiene Policy and Procedure (Policy #4009) was conducted the week of August 27th during the monthly nursing associates meetings. This re-education focused on the situations in which appropriate hand hygiene are required, such as when completing pericares and when exiting isolation precaution settings, and all nursing associates reviewed and signed off on this policy. Observations of care, to ensure hand hygiene is being utilized appropriately, began the week of August 20th. The Director of Nursing (DON) and designees continue to randomly select Health Coordinators (nurses) and Health Support Associates (nursing assistants) to observe a variety of cares and treatments to ensure that the Handwashing/Hand Hygiene policy is being followed. How the nursing home plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or Designee will continue to conduct random observations of, at a minimum, one Health Coordinator and one Health Support Associate per week for three months. If no concerns have been found, the DON or designee will continue with random observations on a monthly basis for the following six months. All findings will be reported to the monthly Quality Assurance and	

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F 880	Continued From page 8 understood and was able to understand others and was cognitively intact. Care plan dated 1/16/17, indicated self care deficit in regards to bed mobility, dressing, grooming, feeding, toileting, transfers and locomotion on and off unit which R238 would perform self care activities with assistance and used walker for mobility with limited assist. Care plan further indicated R238 was at risk for pain due to shingles and to monitor pain every shift. During random observations on 8/15/18, at 7:47 a.m. nursing assistant (NA)-B was in R238's room and asked for assistance. Licensed practical nurse (LPN)-A was observed to don a gown and gloves and entered R238's room. R238 had a sign on door for contact precaution. NA-B and LPN-A were observed to use the mechanical stand to transfer R238 from the bathroom to R238's chair in R238's sitting area. LPN-A was observed to remove the gown and gloves, then walked out of R238's contact precaution room to the hallway. LPN-A then took the medication cart to go to another resident's room, take out a cup with medications already set up out of the medication cart drawer, and placed the cup on top of the medication cart. As LPN-A was about to give the medications to another resident surveyor intervened and suggested that LPN-A wash hands or use hand sanitizer. During an interview on 8/15/18, at 7:57 a.m. LPN-A confirmed she should have washed hands after leaving a contact precaution room. During an interview on 8/16/18, at 9:29 a.m. the DON indicated she expected staff to remove gloves and PPE (personal protective equipment)	F 880	Performance Improvement meetings. Dates when corrective action will be completed: All education and initial observations will be completed by September 25th, 2018. Follow-up audits will be ongoing per the above schedule. The title of the person responsible to ensure correction: Director of Nursing	

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F 880	Continued From page 9 and wash hands when leaving contact precaution rooms. The facility Handwashing/Hand Hygiene policy dated June 2015, directed staff to wash their hands or use an alcohol-based hand rub containing at least 62% or soap and water for the following situations: "b. Before and after direct contact with residents; c. Before preparing or handling medications; h. Before moving from a contaminated body site to a clean resident care; j. After contact with blood or body fluids; m. After removing gloves; n. Before and after entering isolation precaution setting..."	F 880		

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	245627	A. BUILDING **01 - TRILLIUM WOODS** B. WING _____	**08/14/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 14, 2018. At the time of this survey, The Birches at Trillium Woods, was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. Trillium Woods is a 3-story building with a partial basement built of Type II(111) construction. Each floor is divided into 2 smoke compartments by smoke barriers. The basement and first floor are separated from the rest of the campus by a 2 hour fire barrier. The facility is fully sprinklered and has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 36 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

Electronically delivered
August 29, 2018

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

Re: State Nursing Home Licensing Orders - Project Number S5627003

Dear Administrator:

The above facility was surveyed on August 13, 2018 through August 16, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss at (651) 201-3793 or susanne.reuss@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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	26105	A. BUILDING: _____ B. WING _____	08/16/2018

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THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26105	A. BUILDING: _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 13- 16, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate hand hygiene practices for 1 of 1 resident (R10) reviewed for pressure ulcers and failed to assure hand hygiene was conducted after leaving a contact precaution room for 1 of 1 resident (R238) reviewed for contact precautions. Findings include: R10 On 8/15/18, at 7:45 a.m. nursing assistant (NA)-A entered R10's room to provide cares. NA-A approached R10, wearing gloves, stating she was going to assist R10 to get ready for the day. -At 7:46 a.m. NA-A approached R10's bed, moved the bedside table out of the way, took the blanket off R10, applied compression stockings on R10 and then lowered the bed. R10 was assisted to sit on the edge of the bed and NA-A applied shoes on R10. NA-A then cued resident	21385	corrected	9/25/18

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21385	Continued From page 3	21385		

she was going to raise the bed up and NA-A applied a transfer belt around R10's waist.
-At 7:52 a.m. NA-A cued R10 to stand and ambulated with R10 to the bathroom, assisted R10 to remove the pad and assisted R10 to sit on the toilet, who indicated she needed to urinate.
-At 7:57 a.m. NA-A cued R10 to stand and was observed to use moist wipes to provide personal hygiene cares to R10. NA-A then, with the same gloves, pulled both R10's pull-up and pants then assisted R10 to sit on the wheelchair as she held onto the transfer belt. After R10 was seated in the wheelchair NA-A removed the gloves and wheeled R10 to the sink area.
-At 7:59 a.m. NA-A came out of bathroom, without washing hands, and took the bed remote with her right hand and then asked R10 if she needed the sling on her right arm removed, which R10 stated "yes." NA-A went into the bathroom and removed the sling and then NA-A washed her hands.
-At 8:51 a.m. NA-A acknowledged she had not removed gloves and washed hands after providing pericare on R10. NA-A stated she was supposed to remove gloves and wash her hands.

During an interview on 8/15/18, at 1:26 p.m. the director of nursing stated staff were always supposed to wash their hands before and after cares. She further stated that staff should wash their hands each time after removing soiled gloves.

R238's admission face sheet dated 1/4/17, indicated diagnoses of Zoster (shingles) without complications.

R238's quarterly Minimum Data Set dated 7/11/18, indicated R238 was able to make self

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21385	Continued From page 4	21385		

understood and was able to understand others and was cognitively intact.

Care plan dated 1/16/17, indicated self care deficit in regards to bed mobility, dressing, grooming, feeding, toileting, transfers and locomotion on and off unit which R238 would perform self care activities with assistance and used walker for mobility with limited assist. Care plan further indicated R238 was at risk for pain due to shingles and to monitor pain every shift.

During random observations on 8/15/18, at 7:47 a.m. nursing assistant (NA)-B was in R238's room and asked for assistance. Licensed practical nurse (LPN)-A was observed to don a gown and gloves and entered R238's room. R238 had a sign on door for contact precaution. NA-B and LPN-A were observed to use the mechanical stand to transfer R238 from the bathroom to R238's chair in R238's sitting area. LPN-A was observed to remove the gown and gloves, then walked out of R238's contact precaution room to the hallway. LPN-A then took the medication cart to go to another resident's room, take out a cup with medications already set up out of the medication cart drawer, and placed the cup on top of the medication cart. As LPN-A was about to give the medications to another resident surveyor intervened and suggested that LPN-A wash hands or use hand sanitizer.

During an interview on 8/15/18, at 7:57 a.m. LPN-A confirmed she should have washed hands after leaving a contact precaution room.

During an interview on 8/16/18, at 9:29 a.m. the DON indicated she expected staff to remove gloves and PPE (personal protective equipment) and wash hands when leaving contact precaution

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21385	Continued From page 5 rooms. The facility Handwashing/Hand Hygiene policy dated June 2015, directed staff to wash their hands or use an alcohol-based hand rub containing at least 62% or soap and water for the following situations: "b. Before and after direct contact with residents; c. Before preparing or handling medications; h. Before moving from a contaminated body site to a clean resident care; j. After contact with blood or body fluids; m. After removing gloves; n. Before and after entering isolation precaution setting..." Based on observation, interview and document review, the facility failed to implement appropriate hand hygiene practices for 1 of 1 resident (R10) reviewed for pressure ulcers and failed to assure hand hygiene was conducted after leaving a contact precaution room for 1 of 1 resident (R238) reviewed for contact precautions. Findings include: R10 On 8/15/18, at 7:45 a.m. nursing assistant (NA)-A entered R10's room to provide cares. NA-A approached R10, wearing gloves, stating she was	21385		

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21385	Continued From page 6 going to assist R10 to get ready for the day. -At 7:46 a.m. NA-A approached R10's bed, moved the bedside table out of the way, took the blanket off R10, applied compression stockings on R10 and then lowered the bed. R10 was assisted to sit on the edge of the bed and NA-A applied shoes on R10. NA-A then cued resident she was going to raise the bed up and NA-A applied a transfer belt around R10's waist. -At 7:52 a.m. NA-A cued R10 to stand and ambulated with R10 to the bathroom, assisted R10 to remove the pad and assisted R10 to sit on the toilet, who indicated she needed to urinate. -At 7:57 a.m. NA-A cued R10 to stand and was observed to use moist wipes to provide personal hygiene cares to R10. NA-A then, with the same gloves, pulled both R10's pull-up and pants then assisted R10 to sit on the wheelchair as she held onto the transfer belt. After R10 was seated in the wheelchair NA-A removed the gloves and wheeled R10 to the sink area. -At 7:59 a.m. NA-A came out of bathroom, without washing hands, and took the bed remote with her right hand and then asked R10 if she needed the sling on her right arm removed, which R10 stated "yes." NA-A went into the bathroom and removed the sling and then NA-A washed her hands. -At 8:51 a.m. NA-A acknowledged she had not removed gloves and washed hands after providing pericare on R10. NA-A stated she was supposed to remove gloves and wash her hands. During an interview on 8/15/18, at 1:26 p.m. the director of nursing stated staff were always supposed to wash their hands before and after cares. She further stated that staff should wash their hands each time after removing soiled gloves.	21385		

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21385	Continued From page 7 R238's admission face sheet dated 1/4/17, indicated diagnoses of Zoster (shingles) without complications. R238's quarterly Minimum Data Set dated 7/11/18, indicated R238 was able to make self understood and was able to understand others and was cognitively intact. Care plan dated 1/16/17, indicated self care deficit in regards to bed mobility, dressing, grooming, feeding, toileting, transfers and locomotion on and off unit which R238 would perform self care activities with assistance and used walker for mobility with limited assist. Care plan further indicated R238 was at risk for pain due to shingles and to monitor pain every shift. During random observations on 8/15/18, at 7:47 a.m. nursing assistant (NA)-B was in R238's room and asked for assistance. Licensed practical nurse (LPN)-A was observed to don a gown and gloves and entered R238's room. R238 had a sign on door for contact precaution. NA-B and LPN-A were observed to use the mechanical stand to transfer R238 from the bathroom to R238's chair in R238's sitting area. LPN-A was observed to remove the gown and gloves, then walked out of R238's contact precaution room to the hallway. LPN-A then took the medication cart to go to another resident's room, take out a cup with medications already set up out of the medication cart drawer, and placed the cup on top of the medication cart. As LPN-A was about to give the medications to another resident surveyor intervened and suggested that LPN-A wash hands or use hand sanitizer. During an interview on 8/15/18, at 7:57 a.m.	21385		

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21385	Continued From page 8 LPN-A confirmed she should have washed hands after leaving a contact precaution room. During an interview on 8/16/18, at 9:29 a.m. the DON indicated she expected staff to remove gloves and PPE (personal protective equipment) and wash hands when leaving contact precaution rooms. The facility Handwashing/Hand Hygiene policy dated June 2015, directed staff to wash their hands or use an alcohol-based hand rub containing at least 62% or soap and water for the following situations: "b. Before and after direct contact with residents; c. Before preparing or handling medications; h. Before moving from a contaminated body site to a clean resident care; j. After contact with blood or body fluids; m. After removing gloves; n. Before and after entering isolation precaution setting..." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could assure policies are up to date, staff trained and a monitoring system developed and implemented to assure appropriate hand hygiene practices are conducted when providing care to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		