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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2Q86

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**

2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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 **04/10/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **178** (L18)

13.Total Certified Beds **178** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 04/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/17/2013 (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
07/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 5/3/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5264

At the time of the standard survey completed February 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On April 10, 2013, the Minnesota Department of Health and, on April 3, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 15, 2013, effective March 27, 2013. Therefore, the remedies outlined in our letter dated March 12, 2013, will not be imposed. See attached CMS-2567B forms for the results of the April 10, 2013 and April 3, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5264 April 17, 2013

Mr. David Shaw, Administrator
Augustana Health Care Center of Apple Valley
14650 Garrett Avenue
Apple Valley, Minnesota 55124

Dear Mr. Shaw:

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 27, 2013 the above facility is certified for:

178 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 178 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.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 17, 2013

Mr. David Shaw, Administrator
Augustana Health Care Center of Apple Valley
14650 Garrett Avenue
Apple Valley, Minnesota 55124

RE: Project Number S5264022

Dear Mr. Shaw:

On March 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 10, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 3, 2013 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 survey, completed on February 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2013, effective March 27, 2013 and therefore remedies outlined in our letter to you dated March 12, 2013, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5264r113.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245264	A. Building B. Wing	4/10/2013

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/22/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/27/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/22/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/22/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/27/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/22/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/21/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/22/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	04/17/13	22580	04/10/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/15/2013			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245264	A. Building B. Wing **01 - MAIN BUILDING 01**	4/3/2013

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/18/2013**	ID Prefix	Correction Completed **03/18/2013**	ID Prefix	Correction Completed **03/22/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0052		LSC K0054		LSC K0056	
ID Prefix	Correction Completed **03/18/2013**	ID Prefix	Correction Completed **03/18/2013**	ID Prefix	Correction Completed **03/18/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0062		LSC K0069		LSC K0144	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	04/17/13	25822	04/03/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/13/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 17, 2013

Mr. David Shaw, Administrator
Augustana Health Care Center of Apple Valley
14650 Garrett Avenue
Apple Valley, Minnesota 55124

Re: Enclosed Reinspection Results - Project Number S5264022

Dear Mr. Shaw:

On April 10, 2013 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 February 15, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5264r113lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00979	A. Building B. Wing	4/10/2013

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **03/27/2013**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **03/22/2013**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **03/22/2013**
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **03/22/2013**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	Correction Completed **03/22/2013**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **03/21/2013**
ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **03/27/2013**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. 2** LSC	Correction Completed **03/22/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	04/17/13	22580	04/10/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/15/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2Q86

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**

2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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) **01/25/2006**

6. DATE OF SURVEY **02/15/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **178** (L18)

13.Total Certified Beds **178** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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 SNF	ICF	IID
	178			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Candace Bolduc, HFE NE II 03/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/04/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/5/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5264

At the time of the standard survey completed February 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed.
See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 4344

March 12, 2013

Mr. David Shaw, Administrator
Augustana Hcc Of Apple Valley
14650 Garrett Avenue
Apple Valley, Minnesota 55124

RE: Project Number S5264022 & H5264044

Dear Mr. Shaw:

On February 15, 2013, 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 actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 15, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5264044 that was found to be unsubstantiated.

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;

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto
Minnesota Department of Health
P.O. BOX 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794

Fax: (651) 201-3790

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 27, 2013, 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 27, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 15, 2013 (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 15, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

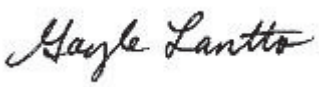
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

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
	245264	A. BUILDING _____ B. WING _____	C 02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. At the time of the standard recertification survey, an investigation of complaint H5264044 was also conducted and was found to be unsubstantiated. POC accepted 3/22/13 Stan Ho RECEIVED MAR 22 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	F 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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 which are in violation of the state statute after the statement, "This Rule 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.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Shaw — TITLE: Administrator — (X6) DATE: 3-22-13

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.

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F 280	Continued From page 1 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan when changes occurred for 1 of 1 resident (R111) reviewed for hospice services. Findings include: R111 was admitted 12/12, diagnoses included Lewy Body dementia, neuropathy, and diabetes. The physician ordered a hospice evaluation and treatment on 12/27/12. On 12/28/12, a hospice nursing note read "admit to hospice services." On 2/13/13, at 8:20 a.m. R111 stated he said he thought someone from a hospice agency came,	F 280	It is the policy of Augustana Health Care Center of Apple Valley to allow residents to participate in care planning and treatment or changes in care or treatment and to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment.	

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F 280	Continued From page 2 but was unsure if it was a nurse or an aide. R111 did not know how long he had received hospice services, or what services were being provided. A nursing assistant (NA)-C on 2/13/13, at 10:21 a.m. did not think R111 was receiving hospice care, and referred the surveyor to the floor nurse. At 10:33 a.m. NA-D stated R111 was receiving hospice care. The aide had seen someone from the agency come after lunch, and thought they had given R111 a bath. NA-D further stated the night shift nurse wrote on the aide assignment sheet if the hospice aide was coming. NA-D was unaware of the days of the week the hospice staff came. The following day at 11:14 a.m. NA-A reported R111 she did not she did not believe the resident was receiving hospice care. The facility nursing assistant (NA) assignment sheet for R111 stated hospice but, it did not indicate the type of services that would be provided by the hospice aide and when those cares would be provided (e.g. bathing). R111's facility care plan dated 12/28/12, noted for advance directives a POLST (Physician Orders for Life-Sustaining Treatment) was completed by hospice and hospice care was indicated as an intervention. No further information was documented regarding the services and disciplines that would be providing services. R111's hospice admission plan of care dated 12/28/12, indicated a skilled nurse would visit the resident 1-2 times per week and social worker 1-3 times per month. No further updates were noted to address hospice aide services, and no notes were located regarding the social worker's	F 280	R111 care plan was updated to include information regarding the types and frequency of services hospice is providing. A calendar was obtained from Hospice agency and placed in R111 chart. For residents who are on hospice that information will be on the NAR assignment sheet. A copy of each hospice patient's calendar will be placed in the schedule book so staff can check it at any time to see when hospice staff visits will occur. Re-education was completed 3/20/13 with nurse managers and social workers regarding importance of coordinating care with outside services such as hospice. An audit will be completed monthly for each resident on hospice to ensure that the care plan contains information regarding the types and frequencies of services provided by hospice x 3 months. Social Services Director or designee responsible for compliance. Audits will be reviewed at quarterly QA committee meeting. Completion date 3/22/13 ✓	

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F 280	Continued From page 3 visits. An interview conducted with a licensed practical nurse (LPN)-A on 2/13/13, at 9:35 a.m. revealed a hospice aide came twice weekly per the medical record. LPN-A further stated thought they usually called ahead with days and times but, the unit nurse manager was calling the agency for verification. At 10:15 a.m. LPN-A stated that the nurse manage reported the hospice agency thought calendars for hospice aide visits were sent after visits were completed, and she thought the hospice agency could mark the days as they visited the resident. The registered nurse manager (RN)-B was interviewed on 2/13/13, at 10:17 a.m. The RN had called the hospice agency regarding the RN visits, but did not inquire about the aide's visits, and did not know when those visits took place. The RN placed a second call to the agency, and was told the aide was scheduled for twice weekly visits on Mondays and Wednesdays. A phone interview was conducted on 2/15/13, at 2:00 p.m. with hospice RN-D. Hospice RN-D stated R111 had a hospice aide visit twice weekly. The RN explained that when a resident was admitted to hospice care and hospice aide services were needed, the agency notified the hospice staffing department of the need for services. Hospice RN-D further stated after the hospice aide received their schedule from the agency, they would typically let the facility know the days they could be expected to visit. The RN said services began for R111, because the resident's family wanted him to receive an extra bath weekly. A few weeks prior, the resident was	F 280		

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F 280	Continued From page 4 not allowing the hospice aide to provide the extra bath, therefore, a change was made to provide companionship visits. Hospice RN-D stated the agency was in the process of changing their documentation, and as of the date of the interview, it would include duplicate notes for all disciplines. A change would include providing a copy of the note for the facility's records. The RN acknowledged the current Hospice Communication Notes were brief and did not comprehensively note the resident's current condition and need for hospice. A facility policy for Care Plans (last revised 12/12), indicated the care plans would be updated and approved at the care conference with the interdisciplinary team (IDT) and others (resident and family) in attendance. Outside services such as dialysis and hospice would include coordination of care and services provided. It was noted that a resident's care plan was constantly changing, and was to be updated routinely on the hard copy of the chart with resident condition changes. A facility policy for Palliative Care Program (review date 1/21/12), indicated the goal was to help devise an individualized palliative plan of care which included a physical, psychological, leisure, and spiritual interventions to support and enhance the residents abilities, choices, and needs during end of life process.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

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F 282	Continued From page 5 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and treatment according to the care plan (CP) for 1 of 2 residents (R30) reviewed for pressure ulcers. Findings include: R30 developed a pressure ulcer (PU) over the left lateral knee, however, the resident's care plan and treatment interventions were not provided timely and consistently to minimize the risk of worsening of the PU when the ulcer was superficial, and the wound was not documented according to policy. R30's care plan (CP) with a review date of 2/4/13, indicated the resident had one Stage 3 PU on the left medial malleous, one Stage 3 on the right medial malleolus, and one Stage 4 on left lateral knee. Interventions directed staff to write progress notes regarding the wounds, update the physician and family monthly, provide the nutritional supplement Arginaid twice daily to promote wound healing, and pressure relief cushion for wheelchair (w/c). "OFFER CHANCE TO LAY DOWN BETWEEN MEALS, KEEP RT [right] FOOT/LEFT FOOT OFF LOADED W/ [with] NO PRESSURE, USING FOAM BOOTS, BLANKET OR PILLOWS. PRESSURE REDUCTION FOAM BOOT TO RIGHT FOOT EVERY NIGHT, CONTINUE TO OFF LOAD LEFT FOOT WHEN IN BED hs [bedtime]. POSITION (L) KNEE OFF BED WITH PILLOWS	F 282	It is the policy of Augustana Health Care Center of Apple Valley to have the services provided by the facility be provided by qualified persons in accordance with each resident's written plan of care. The facility believes that we were providing necessary services to R30 and we respectfully disagree with this deficiency. ZFlo pillow has been discontinued and low air loss mattress is on resident's bed. Care plan and treatment record was clarified regarding expectations. Resident does decline to wear heel boots at times and she often prefers not to wear socks because her feet get too hot. Risk vs benefits of not allowing these interventions reviewed with resident. Wound is not currently infected. When area was discovered on 3/22/12 area on wheelchair was padded immediately; NP and family were notified and a treatment was initiated to this area.	

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F 282	Continued From page 6 (ABOVE & BELOW KNEE) DX: [diagnosis] INFECTED (L) KNEE WOUND, KEEP PRESSURE OFF KNEE AT ALL TIMES, INCLUDES IN BED & HARDWARE OF W/C. DON'T JUST PAD HARDWARE OF W/C, AS THIS DOES NOT PROVIDE PRESSURE RELIEF. AIR MATTRESS, LAMBS WOOL BETWEEN TOES PM." Staff were also directed to follow the turning/repositioning schedule, and "Heel Float Boots, Air Flow mattress. Wound Care--Measure wounds on Right and Left Medial Malleous AND wound on Left lateral knee." On 2/13/13, at 2:00 p.m. observations were conducted of scheduled treatments to R30's PUs by LPN-B. Although a Z-Flo positioning pillow (to support vulnerable areas of the body) was to be used to support the left lateral knee, the LPN placed the Z-Flo positioning pillow under R30's feet, and the Posie boots [specialized footwear] which the resident was to have applied to her feet were on the floor under the resident's dresser. During subsequent observations the resident was not positioned to minimize the risk of pressure to vulnerable areas. For example, on 2/14/13, at 9:30 a.m. R30's feet were wrapped with gauze and her heels were exposed and resting on the foot rest. At 10:15 the resident was wearing the Posie boots, however, her toes were exposed and the right foot was sliding off the foot pedal toward the front wheel of the chair. At 10:25 a nursing assistant (NA)-A was assisted to transfer R30 from the wheelchair to the bed, and the Z-Flo pillow was again incorrectly positioned under both feet (with Posie boots) with the top of the pillow approximately one inch below the wound dressing to the left lateral knee. The following day at day at	F 282	Documentation in the medical record includes a treatment on March 22nd "Place foam dressing to left outer knee and change every 2 days and PRN. Keep pillow under left knee to protect left knee when on side." This treatment is charted off every 2 days until April 11th. On April 12th the NP was notified and a new order written for a new treatment to the left lateral knee to institute the same treatment that was being used on the areas on her ankles. The new treatment is documented on the treatment record to Left Lateral Knee-cleanse W/NS, pat dry, apply Iodosorb gel to wound base thickness of a dime, cover w 4" kling or kerlix. Please use skin prep around wound w/each drsg change. Change 3 X/wk and PRN expect drainage and gel to turn brown to white. This is documented in the treatment record until April 23rd when the NP was again consulted regarding the Left lateral knee wound and a new order was obtained for "Hyrdocolloid to left knee cleanse and change every 3 days and PRN." It is our belief	

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F 282	Continued From page 7 9:00 a.m. the resident was not wearing the Posie boots and both heels were exposed with the right foot was resting against the front right wheel of wheelchair. At 10:00 a.m. R30 was in bed and again the Z-Flo positioning pillow was under both feet approximately two inches below dressing on left lateral leg. A standard pillow had been placed under the resident's left knee and another under the resident's right side. Nursing notes and wound clinic notes revealed the following interventions were recommended, however were not consistently and aggressively being implemented, and the resident's wounds became worse with deadened tissue and infection. On 3/22/12, a nursing note revealed the discover of a PU over the left lateral knee described as purple, not open, and measuring 1.3 x 0.8 centimeters (cm). The cause was identified from the knee "digging into metal leg rest" of the wheelchair (w/c). On 4/23/12, the NP wrote "She also has a new open area on the outer left knee. It appears to be from the hardware on her wheelchair. This area is unstageable and measures 2.5 x 1.8 x 0.2 cm. Occupational therapy was ordered for offloading 100% pressure to left knee from the w/c. On 4/30/12, the NP diagnosed cellulitis (infection) of the left leg and the NP ordered antibiotic therapy. On 5/18/12, the NP ordered an air mattress. The wound clinic nurse documented on 5/21/12, that the PU remained unstageable measuring 4.5 cm by 4.3 cm by 0.8 cm. and directed staff to, "KEEP PRESSURE OFF KNEE AT ALL TIMES"	F 282	that appropriate care and treatment was rendered to R30 and despite our efforts to prevent decline in this wound, it did deteriorate. R30 is very medically compromised and the development of pressure ulcers is believed to be unavoidable. Although the note on April 23rd describes the area as a "new open area on the left outer knee" we feel that the "new" relates to the fact that despite protection and treatment of the area it had opened up rather than just being a "purple" area as initially identified on 3/22/12. The NP that wrote the note is the same NP who had been writing new treatment orders for this area so she was aware that it was present. Re-education on documentation regarding wounds completed with licensed staff on 3/21/13. An audit will be conducted of all residents with pressure ulcers weekly to ensure that care plan interventions are implemented appropriately X 3 months and then 10% of those with pressure ulcers will be audited monthly after that. Each unit manager and/or designee is responsible for compliance. Date of completion 3/27/13. ✓	

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F 282	Continued From page 8 that included the bed and hardware of the w/c. "Please do not just pad the hardware of the wheel chair as this does not provide pressure relief." The NP documented on 6/6/12, that R30 had an air mattress and was seeing an occupational therapist for positioning, however, on 8/10/12, another order was written for an air mattress. On 8/14/12, the NP saw the resident and ordered a Z-Flo positioning pillow for left lateral knee when in bed. The NP also wanted staff to check on status of air mattress and notified the nurses. R30's record showed she was utilizing an air mattress as noted on treatment records for the month of 2/13, progress notes, and the most recent comprehensive assessment dated 2/4/13. On 2/14/13 at 10:50 a.m. RN-A explained R30 had a pressure reduction mattress on the bed ordered 5/8/12, and the resident wore Posie boots on both feet. Because a standard mattress was observed on the bed, the RN and surveyor visualized the mattress, and the RN confirmed it was not the air mattress that had been ordered on two different occasions by the NP. NA-A was interviewed on 2/15/13, at 9:05 a.m. The NA stated R30 needed a special pillow under both legs in bed. RN-A was interviewed on 2/15/13, at 10:50 a.m. and explained that R30 had a pressure reduction mattress on the bed ordered 5/8/12, (not an air mattress) and wore Posie boots on both feet. RN-A confirmed care was not consistently provided for R30 in order to minimize the risk of further development and to promote healing of the PUs.	F 282		

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F 282	Continued From page 9 The facility's Skin Care Program policy (dated 12/12) directed staff as follows: residents who had pressure sores would receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. For residents at risk with skin alterations, staff was to immediately develop a plan of care, request physical and/or occupational therapy assessment/evaluation as needed. Staff was to also assess, measure and document PUs on a weekly basis utilizing the Weekly Wound Flow Sheet scheduled on the care path.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate services between the facility and hospice agency to promote communication and provide appropriate care services for 1 of 1 resident (R111) reviewed for hospice services. Findings include: The facility did not coordinate hospice services for R111 to maintain the resident's highest	F 309		

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F 309	Continued From page 10 practicable level of functioning. R111 was admitted 12/12, diagnoses included Lewy Body dementia, anxiety, depression, neuropathy, hypertension, obstructive hydrocephalus, and diabetes. The physician ordered a hospice evaluation and treatment on 12/27/12. On 12/28/12, a hospice nursing note read "admit to hospice services." On 2/13/13, at 8:20 a.m. R111 was observed seated in a wheelchair at the dining room table. The resident was eating independently and was visiting with tablemates. After breakfast the resident was observed as he was assisted to bed by one staff person. The resident was then interviewed regarding hospice services. He said he thought someone from a hospice agency came, but was unsure if it was a nurse or an aide. R111 did not know how long he had received hospice services, or what services were being provided. A nursing assistant (NA)-C on 2/13/13, at 10:21 a.m. did not think R111 was receiving hospice care, and referred the surveyor to the floor nurse. At 10:33 a.m. NA-D stated R111 was receiving hospice care. The aide had seen someone from the agency come after lunch, and thought they had given R111 a bath. NA-D further stated the night shift nurse wrote on the aide assignment sheet if the hospice aide was coming. NA-D was unaware of the days of the week the hospice staff came. The following day at 11:14 a.m. NA-A reported R111 she did not she did not believe the resident was receiving hospice care. Review of the Hospice Communication Notes	F 309	It is the policy of Augustana Health Care Center of Apple Valley to provide care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and care plan. R111 care plan was updated to include information regarding the types and frequency of services hospice is providing. A calendar was obtained from Hospice agency and placed in R111 chart. For residents who are on hospice that information will be on the NAR assignment sheet. A copy of each hospice patients calendar will be placed in the schedule book so staff can check it at any time to see when hospice staff visits will occur . MD Reviewed R111 medications	

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F 309	Continued From page 11 revealed the following: 1. 12/28/12, hospice admission signed by RN 2. 12/31/12, met the resident and the resident's daughter. The resident was "getting ready for supper." Hospice aide checked "socialization and companionship" 3. 1/2/13, Hospice aide and RN noted will start shower with aide "next Thursday" and "socialization" checked 4. 1/7/13, Resident declined supper, as was sick after lunch. "Socialization" checked and signed by aide and RN 5. 1/11/13, "Disease management" checked and shower was completed--with change in days--signed by aide and RN 6. 1/15/13, the resident ate and drank 75% of his meal, "socialization" was provided, and note signed by aide and RN 7. 1/17/13, "Disease management" was checked and noted the resident had already had a shower. Signed by the RN and aide 8. 1/21/13, "Disease management" by RN 9. 1/22/13, "Socialization" signed by aide and RN 10. 1/24/13, "Socialization" signed by aide and RN 11. 1/29/13, No notes regarding the visit, but signatures by the RN and aide 12. 1/31/13, RN for "disease management" 13. 2/5/13, "Socialization" signed by aide and RN 14. 2/6/13, "Disease management" signed by nurse 15. 2/7/13, Resident not feeling well and had an emesis, "very upset, felt ill when talking" and note signed by aide and RN 16. 2/12/13, Resident "Comfortable, denies any pain. Staff states no concerns--meds [medications] checked." Note signed by aide and RN	F 309	on 3/14/13 to determine if the medications that he is on are still appropriate. Per MD "Please note that R111 medications are reviewed and felt to be appropriate to continue during hospice. Until I hear otherwise from patient or family, please continue medications as prescribed and indicated." Re-education was completed 3/20/13 with nurse managers and social workers regarding importance of coordinating care with outside services such as hospice. An audit will be completed monthly for each resident on hospice to ensure that the care plan contains information regarding the types and frequencies of services provided by hospice x 3 months. Social Services Director or designee responsible for compliance. Audits will be reviewed at quarterly QA committee meeting. Completion date 3/22/13. ✓	

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F 309	Continued From page 12 The facility nursing assistant (NA) assignment sheet for R111 stated hospice but, it did not indicate the type of services that would be provided by the hospice aide and when those cares would be provided (e.g. bathing). R111's facility care plan dated 12/28/12, noted for advance directives a POLST (Physician Orders for Life-Sustaining Treatment) was completed by hospice and hospice care was indicated as an intervention. No further information was documented regarding the services and disciplines that would be providing services. R111's hospice admission plan of care dated 12/28/12, indicated a skilled nurse would visit the resident 1-2 times per week and social worker 1-3 times per month. No further updates were noted to address hospice aide services, and no notes were located regarding the social worker's visits. Although the resident was on hospice, it was unclear whether there was a continued need for the current medication regimen which included three medications for high blood pressure and three medications for diabetes. Medications included: Astelin (seasonal nasal allergies) twice daily, Aricept (dementia) 10 milligrams (mg) daily, Neurontin (seizures/neuropathic pain) 300 mg daily, Glucophage (diabetes) 1000 mg twice daily, Ritalin (central nervous system stimulant) 5 mg daily, Zocor (cholesterol) 20 mg daily, Norvasc (high blood pressure) 5 mg daily, aspirin (heart attack and stroke prevention) 81 mg daily, Tenormin (high blood pressure) 50 mg daily, Glucotrol XL (diabetes)10 mg daily, Lexapro	F 309		

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F 309	Continued From page 13 (antidepressant) 10 mg daily, Zestril (high blood pressure) 40 mg daily, Actos (diabetes) 15 mg daily, and Flomax (prostate) 0.4 mg daily. An interview conducted with a licensed practical nurse (LPN)-A on 2/13/13, at 9:35 a.m. revealed a hospice aide came twice weekly per the medical record. LPN-A further stated thought they usually called ahead with days and times but, the unit nurse manager was calling the agency for verification. At 10:15 a.m. LPN-A stated that the nurse manage reported the hospice agency thought calendars for hospice aide visits were sent after visits were completed, and she thought the hospice agency could mark the days as they visited the resident. The registered nurse manager (RN)-B was interviewed on 2/13/13, at 10:17 a.m. The RN had called the hospice agency regarding the RN visits, but did not inquire about the aide's visits, and did not know when those visits took place. The RN placed a second call to the agency, and was told the aide was scheduled for twice weekly visits on Mondays and Wednesdays. A phone interview was conducted on 2/15/13, at 2:00 p.m. with hospice RN-D. Hospice RN-D stated R111 had a hospice aide visit twice weekly. The RN explained that when a resident was admitted to hospice care and hospice aide services were needed, the agency notified the hospice staffing department of the need for services. Hospice RN-D further stated after the hospice aide received their schedule from the agency, they would typically let the facility know the days they could be expected to visit. The RN said services began for R111, because the	F 309		

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F 309	Continued From page 14 resident's family wanted him to receive an extra bath weekly. A few weeks prior, the resident was not allowing the hospice aide to provide the extra bath, therefore, a change was made to provide companionship visits. Hospice RN-D stated the agency was in the process of changing their documentation, and as of the date of the interview, it would include duplicate notes for all disciplines. A change would include providing a copy of the note for the facility's records. The RN acknowledged the current Hospice Communication Notes were brief and did not comprehensively note the resident's current condition and need for hospice. A facility policy for Care Plans (last revised 12/12), indicated the care plans were completed no later than day 21 of a residents' stay or seven days upon completion of the comprehensive initial Minimum Data Set (MDS) assessment, whichever came first. The final plan would be updated and approved at the care conference with the interdisciplinary team (IDT) and others (resident and family) in attendance. Outside services such as dialysis and hospice would include coordination of care and services provided. It was noted that a resident's care plan was constantly changing, and was to be updated routinely on the hard copy of the chart with resident condition changes. A facility policy for Palliative Care Program (review date 1/21/12), indicated residents who had a palliative care order or who elected hospice would also be referred to the Palliative Care Review Team. The goal of that team was to review each resident on a regular basis, and help devise an individualized palliative plan of care	F 309		

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F 309	Continued From page 15 which included a physical, psychological, leisure, and spiritual interventions to support and enhance the residents abilities, choices, and needs during end of life process. In conjunction with the IDT, they would use a grid as a guide for a specific process for advanced care planning. Key elements were POLST completions, care conferences, roles of therapy, laboratories, medications, and dietary considerations. The grid directed staff to review/revise pain management programs, psychological assessments, and spiritual care assessments.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions were consistently implemented and re-assessed to minimize the risk of development and promote healing of pressure ulcers for 1 of 2 residents in the sample (R30) who were reviewed for pressure ulcers. This resulted in actual harm when the risk of development of pressure ulcers was not minimized and an additional PU with complications developed.	F 314		

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F 314	Continued From page 16 Findings include: R30 developed a pressure ulcer (PU) over the left lateral knee, however, appropriate care and treatment was not provided timely and consistently which resulted in the PU progressing to a Stage 4. In addition, interventions were not provided to prevent PU to the heels and promote healing to the ankles. Standardized PU staging is as follows: o Stage 1 Observable, pressure-related alteration of intact skin, where adjacent may include changes in skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin. o Stage 2 Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. o Stage 3 Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. o Stage 4 Full thickness tissue loss with exposed bone, tendon or muscle. R30's Minimum Data Set (MDS) assessments revealed diagnoses included rheumatoid arthritis and idiopathic peripheral neuropathy and the resident displayed short term memory problems. In addition, the following information regarding PUs was documented: 1) 1/25/12 one Stage 2 and healed PUs, 2) 4/19/12 two Stage 3, 3) 7/11/12 one Stage 4, 4) 10/3/12 one Stage 3 and one Stage 4, and 5) 12/26/12 two Stage 3 (1	F 314	It is the policy of Augustana Health Care Center of Apple Valley to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The facility believes that we were providing necessary services to R30 and we respectfully disagree with the scope and severity of this deficiency and we believe that our practice did not result in actual harm to this resident. ZFlo pillow has been discontinued and low air loss mattress is on resident's bed. Care plan and treatment record was clarified regarding expectations. Resident does decline to wear heel boots at times and she often prefers	

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F 314	Continued From page 17 Stage 3 that worsened) and one Stage 4 PU. The annual MDS dated 10/3/12, triggered for PUs and the Care Area Assessment (CAA) was completed on 10/8/12. Risk factors included the need for extensive assistance of two staff to move sufficiently to relieve pressure, confinement to a bed or chair all or most of the time, the need for a special mattress or seat cushion to reduce or relieve pressure, and the need for a regular turning schedule. The CAA also noted R30 was immobile, incontinent of bowel and bladder, malnourished, and a history of healed PUs, as well as PUs on the inner ankles that were being treated. R30 had an additional risk factor of long term steroid use with Prednisone 5 mgs since 1/24/10. Nursing notes and wound clinic notes revealed the progression of R30's left lateral knee PU was as follows: 1) On 3/22/12, a nursing note revealed the discover of a PU over the left lateral knee described as purple, not open, and measuring 1.3 x 0.8 centimeters (cm). The cause was identified from the knee "digging into metal leg rest" of the wheelchair (w/c). The plan was to pad the w/c. The resident was going to be sent to a wound clinic due to "no improvement with wounds bilateral ankles." The nurse practitioner (NP) then ordered a foam dressing to the left lateral leg that was to be changed every two days and as needed. A pillow was to be kept below the outer knee for protection when the resident was on her left side. 2) On 3/23/12, R30 had an initial consult at the	F 314	not to wear socks because her feet get too hot. Risk vs benefits of not allowing these interventions reviewed with resident. Wound is not currently infected. When area was discovered on 3/22/12 area on wheelchair was padded immediately; NP and family were notified and a treatment was initiated to this area. Documentation in the medical record includes a treatment on March 22nd "Place foam dressing to left outer knee and change every 2 days and PRN. Keep pillow under left knee to protect left knee when on side." This treatment is charted off every 2 days until April 11th. On April 12th the NP was notified and a new order written for a new treatment to the left lateral knee to institute the same treatment that was being used on the areas on her ankles. The new treatment is documented on the treatment record to Left Lateral Knee-cleanse	

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F 314	Continued From page 18 local wound clinic, however, documentation did not show the new PU on the left lateral knee was addressed at that time. The clinical record lacked as assessment of the newly developed PU. 3) On 3/26/12 and 4/5/12, the NP saw the resident, but did not address the knee PU. 4) On 4/9/12 Weekly Wound Status Documentation noted numerous open areas on the resident's ankle, but there was no mention of the knee PU. 5) On 4/12/12, R30 was again seen by the NP. A progress note dated 4/12/12, indicated licensed nursing staff requested the NP to check the left lateral knee area which had been rubbing on the w/c side while R30 was in the w/c and during transfers. The note revealed the w/c had been padded now and staff were using a Hoyer (mechanical) lift for transfers. 6) There was no Weekly Wound Status Documentation for the week of 4/16/12. Two weeks later on 4/23/12, the Weekly Wound Status Documentation included, "She also has a new open area on the outer left knee. It appears to be from the hardware of her wheelchair and is unstageable and measures 2.5 cm's x 1.8 cm's x 0.2 cm's." 7) On 4/23/12, the NP wrote "She also has a new open area on the outer left knee. It appears to be from the hardware on her wheelchair. This area is unstageable and measures 2.5 x 1.8 x 0.2 cm. Occupational therapy was ordered for offloading 100% pressure to left knee from the w/c."	F 314	W/NS, pat dry, apply Iodosorb gel to wound base thickness of a dime, cover w 4" kling or kerlix. Please use skin prep around wound w/each drsg change. Change 3 X/wk and PRN expect drainage and gel to turn brown to white. This is documented in the treatment record until April 23rd when the NP was again consulted regarding the Left lateral knee wound and a new order was obtained for "Hyrdocolloid to left knee cleanse and change every 3 days and PRN." It is our belief that appropriate care and treatment was rendered to R30 and despite our efforts to prevent decline in this wound, it did deteriorate. We maintain that we did not cause harm to R30. R30 is very medically compromised and the development of pressure ulcers is believed to be unavoidable. Although the note on April 23rd describes the area as a "new open area on the left outer knee" we feel that the "new" relates to the fact that despite protection and treatment of the area it had opened	

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F 314	Continued From page 19 Clinical evidence shows if a PU fails to show progression in healing within the first two to four weeks, the PU (including potential complications) and the resident's overall clinical condition should be reassessed, including determining whether to continue or modify interventions. Possible avoidable negative outcomes may include permanent tissue damage increasing the potential for serious complications, with the tissue closest to the bone potentially undergoing necrosis (death). R30 had risk factors due to impaired circulation to the tissue from the use of medical devices, as well as pressure on legs due to contractures, with the need for special attention to effectively reduce pressure on a bony prominence. 8) On 4/30/12, the staff notified the NP of increased redness, warmth, and odor around the knee wound. The NP diagnosed cellulitis (infection) of the left leg and the NP ordered antibiotic therapy. The NP directed the resident's left knee be positioned off the bed with a pillow above and below the knee. 9) On 5/7/12, R30 was again seen at the wound clinic, and the NP noted the PU was "unstageable" (could not be visualized in order to stage from necrotic tissue), and measured 4 x 3 x 0.4 cm. (the latter measurement indicating tunneling, or a passageway of tissue destruction under the skin surface) and the surrounding skin that was purple was now an open area and part of the wound itself. 10) On 5/18/12, the NP ordered an air mattress. 11) On 5/21/12, the wound clinic nurse	F 314	up rather than just being a "purple" area as initially identified on 3/22/12. The NP that wrote the note is the same NP who had been writing new treatment orders for this area so she was aware that it was present. Body audits (Skin checks) were completed by unit managers on all LTC residents the week of March 18th to ensure that there are no areas of concern that are not currently being addressed. Re-education on documentation regarding wounds completed with licensed staff on 3/21/13. An audit will be conducted of all residents with pressure ulcers weekly to ensure weekly measurements have been completed X 3 months. Results of these audits will be reviewed by the QA committee. Each unit manager and/or designee is responsible for compliance. Completion date: 3/22/13 ✓	

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F 314	Continued From page 20 documented the PU remained unstageable measuring 4.5 cm by 4.3 cm by 0.8 cm. Although it had been two months since the PU was first discovered, the staff continued with the same intervention and the wound became progressively worse. The wound nurse directed staff to, "KEEP PRESSURE OFF KNEE AT ALL TIMES" that included the bed and hardware of the w/c. "Please do not just pad the hardware of the wheel chair as this does not provide pressure relief." 12) On 6/6/12, the NP progress note indicated R30 had an air mattress and was seeing an occupational therapist for positioning. 13) On 6/4/12, wound clinic consult documentation indicated the left lateral knee was debrided (removal of dead tissue to facilitate the healing process) to a stage 4 PU. The wound was cleaned down to the muscle, and measured 5.3 x 3.3 x 0.8 cm. 14) On 8/10/12, another order was written for an air mattress. 15) On 8/14/12, the NP saw the resident and ordered a Z-Flo positioning pillow for left lateral knee when in bed. The NP also wanted staff to check on status of air mattress and notified the nurses. 16) On 9/10/12, the wound clinic noted the wound knee measured 6.3 x 3.7 x 0.5, which had increased in size. 17) On 11/15/12, the wound clinic noted the wound was 8.3 x 3.3 x 0.5 and the superior edge was brown in color with moderate serous	F 314		

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F 314	Continued From page 21 drainage, and was essentially unchanged in 12/12. 18) On 1/10/13 the wound was noted as "slightly smaller than last month. 19) R30's record showed she was utilizing an air mattress as noted on treatment records for the month of 2/13, progress notes, and in the most recent comprehensive assessment dated 2/4/13. 20) R30's care plan (CP) with a review date of 2/4/13, indicated the resident had one Stage 3 PU on the left medial malleous, one Stage 3 on the right medial malleolus, and one Stage 4 on left lateral knee. Interventions directed staff to write progress notes regarding the wounds, update the physician and family monthly, provide the nutritional supplement Arginaid twice daily to promote wound healing, and pressure relief cushion for wheelchair (w/c). "OFFER CHANCE TO LAY DOWN BETWEEN MEALS, KEEP RT [right] FOOT/LEFT FOOT OFF LOADED W/ [with] NO PRESSURE, USING FOAM BOOTS, BLANKET OR PILLOWS. PRESSURE REDUCTION FOAM BOOT TO RIGHT FOOT EVERY NIGHT, CONTINUE TO OFF LOAD LEFT FOOT WHEN IN BED hs [bedtime]. POSITION (L) KNEE OFF BED WITH PILLOWS (ABOVE & BELOW KNEE) DX: [diagnosis] INFECTED (L) KNEE WOUND, KEEP PRESSURE OFF KNEE AT ALL TIMES, INCLUDES IN BED & HARDWARE OF W/C. DON'T JUST PAD HARDWARE OF W/C, AS THIS DOES NOT PROVIDE PRESSURE RELIEF. AIR MATTRESS, LAMBS WOOL BETWEEN TOES PM." Staff were also directed to follow the turning/repositioning schedule, and	F 314		

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F 314	Continued From page 22 "Heel Float Boots, Air Flow mattress. Wound Care--Measure wounds on Right and Left Medial Malleous AND wound on Left lateral knee." 21) R30's tissue tolerance assessments (testing to determine the skin's ability to withstand pressure) documented 2/14/13, was a sitting evaluation and was completed by a registered nurse (RN) noted the resident's skin was able to withstand 1.5 hours of pressure. Although the RN did not proceed to the next interval of testing, the documentation noted R30 tolerated repositioning every two hours. For lying, the licensed practical nurse (LPN) who completed the assessment, did not document the purpose of the testing to determine how R30's body responded to pressure. The LPN instead documented observations of wound dressings and noted that the rest of R30's skin was clean and intact. 22) On 2/7/13, the wound clinic nurse described the left lateral knee wound as Stage 4 and measured 8.0 x 2.5 x 0.2 cm and tapering to 1 cm with serous drainage and the left medial malleous measuring 1.9 x 2.2 cm with a small amount of serous drainage. It was also noted as "slightly smaller than the previous month--uses Z-Flo positioning pillow." The wounds to the ankles were described as Stage 3 with the medial malloelar ulcer described as clean and red, "unchanged" measuring 2.2 x 2.3 x 3.0 cm. On 2/13/13, at 2:00 p.m. observations were conducted of scheduled treatments to R30's PUs by LPN-B. The left lateral knee wound was open, however, the wound did appear clean. Orders were for wound care to the ankles daily, and three times weekly to the knee. Wound care specific to	F 314		

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F 314	Continued From page 23 the knee read that the left knee was to be positioned off the bed every shift, with wound care including: Cleanse with wound cleanser, pat dry, cover wound base with Aquacel AG [wound dressing] and secure with 5 x 5 Allevyn adhesive ("ok to change to Algicell AG until Aquacell comes in"), apply Silvadene [ointment] to wound daily and cover with non-stick dressing, Z-Flo positioning pillow (to support vulnerable areas of the body) to left lateral knee. During the observation, however, the LPN placed the Z-Flo positioning pillow under R30's feet, and the Posie boots [specialized footwear] which were to be applied to the resident's feet were on the floor under the resident's dresser. The resident was leaning to the left, and her knees were contracted to a 90 degree angle and were approximately an inch from touching the standard mattress, with a pillow placed under the left side of the resident's trunk. During subsequent observations the resident was not positioned to minimize the risk of pressure to vulnerable areas. For example, on 2/14/13, at 9:30 a.m. R30's feet were wrapped with gauze and her heels were exposed and resting on the foot rest. At 10:15 the resident was wearing the Posie boots, however, her toes were exposed and the right foot was sliding off the foot pedal toward the front wheel of the chair. At 10:25 a nursing assistant (NA)-A was assisted to transfer R30 from the wheelchair to the bed, and the Z-Flo pillow was again incorrectly positioned under both feet (with Posie boots) with the top of the pillow approximately one inch below the wound dressing to the left lateral knee. The following day at 9:00 a.m. the resident was not wearing the Posie boots and both heels were exposed with the right	F 314		

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F 314	Continued From page 24 foot resting against the front right wheel of wheelchair. At 10:00 a.m. R30 was in bed and again the Z-Flo positioning pillow was under both feet approximately two inches below dressing on left lateral leg. A standard pillow had been placed under the resident's left knee and another under the resident's right side. On 2/14/13 at 10:50 a.m. RN-A explained R30 had a pressure reduction mattress on the bed ordered 5/8/12, and the resident wore Posie boots on both feet. In addition, the resident was turned and repositioned every two hours according to her tissue tolerance assessment. Because a standard mattress was observed on the bed, the RN and surveyor visualized the mattress, and the RN confirmed it was not the air mattress that had been ordered on two different occasions by the NP. NA-A was interviewed on 2/15/13, at 9:05 a.m. The NA stated R30 needed a special pillow under both legs in bed, and was repositioned every two hours. The NAs were to notify the nurse if the resident's wounds were uncovered or leaking. RN-A was interviewed on 2/15/13, at 10:50 a.m. and explained that R30 had a pressure reduction mattress on the bed ordered 5/8/12, (not an air mattress) and wore Posie boots on both feet. RN-A stated R30 was turned and repositioned every two hours according to the tissue tolerance assessment. RN-A confirmed care was not consistently provided for R30 in order to minimize the risk of further development and to promote healing of the PUs. The facility's Skin Care Program policy (dated	F 314		

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F 314	Continued From page 25 12/12) directed staff as follows: residents who had pressure sores would receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. For residents at risk with skin alterations, staff was to immediately develop a plan of care, request physical and/or occupational therapy assessment/evaluation as needed. Staff was to also assess, measure and document PUs on a weekly basis utilizing the Weekly Wound Flow Sheet scheduled on the care path.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify diagnoses for 1 of 10 residents (R111) reviewed for unnecessary medications, and to monitor for potential side effects of antipsychotic medications for 2 of 4 residents (R16, R329) in the sample who were prescribed antipsychotic medication. Findings include: R111 was admitted 12/27/12, with diagnoses including Lewy Body dementia, anxiety, depression, neuropathy, hypertension, obstructive hydrocephalus, and diabetes. The day after the resident's admission to the facility he was admitted to hospice care. Although the resident had multiple medications, diagnoses to support the use of those medications ordered in the residents' admission orders, hospital records reviewed, as well as facility's electronic and paper medical records. R111's medication regimen included three medications for high blood pressure and three medications for diabetes. Medications included: Astelin (seasonal nasal allergies) twice daily, Aricept (dementia) 10 milligrams (mg) daily, Neurontin (seizures/neuropathic pain) 300 mg daily, Glucophage (diabetes) 1000 mg twice daily, Ritalin (central nervous system stimulant) 5 mg daily, Zocor (cholesterol) 20 mg daily, Norvasc (high blood pressure) 5 mg daily, aspirin (heart attack and stroke prevention) 81 mg daily, Tenormin (high blood pressure) 50 mg daily,	F 329	It is the policy of Augustana Health Care Center of Apple Valley to ensure that each resident's drug regimen is free from unnecessary drugs. Diagnosis have been added to R111 medications. An audit of all resident medications has been completed and any missing diagnosis have been added. Health Information Staff were re-educated on the importance of making sure diagnosis are present with all medications on 3/21/13. Side effect monitoring that was missing for R 16 and R 329 was completed on 2/26/13. AIMS monitoring will no longer be completed by pharmacy staff and facility staff will be responsible for the tracking and completion of this monitoring. Side effect monitoring was added to R 16 care plan and all care plans for residents on psychotropic medications were audited to ensure that side effect monitoring is included on the care plan. A random audit of 10% of each units	

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F 329	Continued From page 27 Glucotrol XL (diabetes)10 mg daily, Lexapro (antidepressant) 10 mg daily, Zestril (high blood pressure) 40 mg daily, Actos (diabetes) 15 mg daily, and Flomax (prostate) 0.4 mg daily. An interview conducted with medical records staff (MR)-A on 2/15/13, at 4:00 p.m. revealed the staff was unable to locate physician orders with diagnoses for current medications. MR-A stated the facility should have called the physician or nurse practitioner for diagnoses for the medication uses upon admission. MR-A stated R111 utilized an outside physician who did not make visits at the facility. An interview conducted with nurse manager registered nurse (RN)-B on 2/15/13, at 4:05 p.m. confirmed R111's current medications did not include diagnoses. Nurse manager RN-B further indicated diagnoses for R111's medications should have been completed upon admission to the facility 12/27/12. RN-B stated the Ritalin mediation was ordered for "apathy" and the nurse planned to contact R111's physician for clarification of all medications and corresponding diagnoses. R16 received Abilify 30 mg daily (antipsychotic medication) for bipolar disorder since 4/20/10. A pharmacy review dated 5/8/12, referenced a physician review of clinical contradictions for psychotropic medication reduction. A psychiatrist progress note dated 2/5/13, indicated R16 was stable and had no symptoms of psychosis/mania, depression, or anxiety and tolerated medications well. Although monitoring for tardive dyskinesia (TD–a potential side effect resulting in involuntary, repetitive body movements) is	F 329	charts will be completed monthly to ensure all medications have diagnosis listed. A random audit of 50% of residents house wide who are taking psychotropic medications will be completed monthly to ensure that appropriate side effect monitoring is scheduled and completed. Results will be taken to QA committee for review and recommendations. Responsible person: Each unit manager and/or designee. Completion date: 3/27/13 ✓	

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F 329	Continued From page 28 recommended every six months, there had been no monitoring for TD since 5/31/12. R16's care plan dated 2/11/13, indicated the resident had a potential for alteration in behaviors related to bipolar, schizoaffective, depressive disorder, altered mental status, and insomnia. "No behaviors noted at this time. Takes psychotropic medication are effective." The plan did not include the need for side effect monitoring, including for TD. RN-B explained on 2/15/13, at 2:30 p.m. that it was facility policy that the consulting pharmacist conduct TD assessments every six months. RN-B then contacted the pharmacy consultant who completed the TD assessment, but was unable to provide any documentation an assessment had been completed for R16 since 5/3/12. R329 received the antipsychotic medication Seroquel 25 mg twice daily for psychosis, paranoia, and hallucinations since 1/10/13. There was no tardive dyskinesia (TD) (a) monitoring within the first 30 days of the initiation of the medication. A pharmacy recommendation dated 1/14/13, addressed possibly discontinuing the Seroquel for paranoid delusions related to the recent addition of Remeron which could have contributed to delusions, as well as Tamiflu (to minimize flu symptoms) which could have contributed to R329's hallucinations. A subsequent physician's progress note for R329 dated 2/6/13, indicated "Alzheimers disease, no treatment...Psychosis, not hallucinating anymore. Current treatment is	F 329		

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F 329	Continued From page 29 effective. Decrease of Seroquel may cause emotional harm. No change to tx (treatment)." R329's care plan dated 2/7/13, indicated the resident had been physically and verbally abusive to other residents, and also wandered and rejected care. The resident had short and long term memory loss, and although displayed tearfulness and crying, had minimal signs of depression and was able to be redirected. "Takes antipsychotic and antidepressant medication." The plan lacked side effect monitoring, including for TD. The facility's policy and procedure for Tardive Dyskinesia Monitoring (policy review dated 11/12), indicated "Tardive Dyskinesia monitoring will be performed utilizing the DISCUS [Dyskinesia Identification System Condensed User Scale] assessment tool. These assessments will be completed according to the following schedule: 1) Within 30 days from the time a medication is started...." A registered nurse manager (RN)-B was unable to locate TD monitoring for R329 on 2/15/13, at 5:00 p.m. and verified the resident's care plan did not address monitoring for potential medication side effects.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain 2 of 3 nourishment refrigerators in a sanitary manner on the first and second floors, having the potential to affect 28 of 167 residents who received nourishments. Findings include: On 2/13/13, between 10:30 and 11:30 a.m. the first and second floor medication rooms and therapeutic recreation (TR) room refrigerators had sticky substances of tan, pink, and brown colored spills on the shelving throughout. The first floor medication room refrigerator had an inside door shelf taped to hold the cartons in place preventing a cleanable surface. There was also an open unsealed supplement can on the shelf. Furthermore, all three refrigerators had six ounce containers of unmarked, undated substances designated with a P (17 containers) or AS (8 containers), and then a single number such as 5, 8, or 10. There were also two containers with the numbers 211 and 1 container had the number 216. Nineteen containers of Protein Plus 2 Protein energy shake were not dated when thawed or opened. During an interview on 2/13/13, at 11:30 a.m. the registered nurses (RN)-A RN-B and RN-C verified the P probably meant pudding and the AS	F 371	It is the policy of Augustana Health care Center of Apple Valley to Store, prepare, distribute and serve food under sanitary conditions. Medication room refrigerators were cleaned immediately. Nursing staff will clean medication room refrigerators weekly and as needed for spills. Nurses have been re-educated on dating the Protein Plus 2 when it is opened and that the Protein Plus 2 must be discarded within 48 hours after opening. Night shift nurses will check expiration dates of pudding and applesauce in med room refrigerators weekly when they are cleaning it. Unit managers will audit cleanliness of medication refrigerators every 1 week X 3 months. Responsible person: Unit managers/designee. Dietary Director removed	

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F 371	Continued From page 31 meant applesauce. The numbers they thought could have been a date but were unsure. RN-A stated "The Protein Plus is good for seven days if open and it is good for 14 days from the thaw date." RN-A verified there was no date on the containers for a thaw date or for an open date. When interviewed on 2/14/13, at 1:30 p.m. the dietary director (DD) confirmed the pudding and applesauce were designated with letters but agreed the labeling needed to be clearer for staff. The DD verified the facility did not have a system for dating the Protein Plus when thawed or opened but said one would be implemented immediately. On 1/14/13, at 2:00 p.m. the director of housekeeping and the director of therapeutic recreation both agreed they did not know who was responsible to defrost and clean the TR refrigerator. The refrigerator was being utilized for resident activities and employee lunches, however, employee lunches should have been stored separately from residents' food. The facility policy and procedure Dietary Food Service Requisition Form dated 2/01 read, Dietary to portion pudding and or apple sauce. A=applesauce and P=pudding. Date item was packaged will be indicated.	F 371	unmarked/undated applesauce and pudding from the med room refrigerators and individual containers of those items are being provided to nursing staff for residents. Dietary staff is dating Protein Plus 2 supplement with a date thawed prior to bringing it to the nursing stations. Responsible person: Dietary Director. TR Director will clean TR room refrigerator weekly and will defrost it as needed. TR employees have been educated that they can not keep their personal lunches in the TR refrigerator. Responsible person: TR Director. Completion date: 3/22/13 ✓	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		

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F 428	Continued From page 32 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review, and interview the consultant pharmacist failed to identify diagnoses for ordered medications for 1 of 10 residents (R111) reviewed for unnecessary medications. Findings include: The consultant pharmacist did not identify and report the lack of medical diagnoses for R111's ordered medications. Pharmacy review notes dated 1/16/13, stated "medication regimen review completed. No irregularities noted." R111 was admitted 12/27/12, with diagnoses including Lewy Body dementia, anxiety, depression, neuropathy, hypertension, obstructive hydrocephalus, and diabetes. The day after the resident's admission to the facility he was admitted to hospice care. Although the resident had multiple medications, diagnoses to support the use of those medications ordered in the residents' admission orders, hospital records reviewed, as well as facility's electronic and paper medical records. R111's medication regimen included three medications for high blood pressure and three medications for diabetes. Medications included: Astelin (seasonal nasal allergies) twice daily,	F 428	It is the policy of Augustana Health Care Center of Apple Valley to ensure that each resident's drug regimen is reviewed at least monthly by a licensed pharmacist and that any irregularities are acted upon. Diagnosis have been added to R111 medications. An audit of all resident medications has been completed and any missing diagnosis were added. Auditing of medications for appropriate diagnosis will be completed with the monthly drug review by the consultant pharmacist and the follow up recommendations results will be reviewed at QA for any resulting recommendations needed. Results will be taken to QA committee for review and recommendations. Responsible person: Consultant Pharmacist and DON Completion date 3/21/13 ✓	

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	245264	A. BUILDING _____ B. WING _____	C 02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 33 Aricept (dementia) 10 milligrams (mg) daily, Neurontin (seizures/neuropathic pain) 300 mg daily, Glucophage (diabetes) 1000 mg twice daily, Ritalin (central nervous system stimulant) 5 mg daily, Zocor (cholesterol) 20 mg daily, Norvasc (high blood pressure) 5 mg daily, aspirin (heart attack and stroke prevention) 81 mg daily, Tenormin (high blood pressure) 50 mg daily, Glucotrol XL (diabetes)10 mg daily, Lexapro (antidepressant) 10 mg daily, Zestril (high blood pressure) 40 mg daily, Actos (diabetes) 15 mg daily, and Flomax (prostate) 0.4 mg daily. An interview conducted with medical records staff (MR)-A on 2/15/13, at 4:00 p.m. revealed the staff was unable to locate physician orders with diagnoses for current medications. MR-A stated the facility should have called the physician or nurse practitioner for diagnoses for the medication uses upon admission. MR-A stated R111 utilized an outside physician who did not make visits at the facility. An interview conducted with nurse manager registered nurse (RN)-B on 2/15/13, at 4:05 p.m. confirmed R111's current medications did not include diagnoses. Nurse manager RN-B further indicated diagnoses for R111's medications should have been completed upon admission to the facility 12/27/12. RN-B stated the Ritalin mediation was ordered for "apathy" and the nurse planned to contact R111's physician for clarification of all medications and corresponding diagnoses.	F 428		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		

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F 465	Continued From page 34 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to ensure 2 of 3 medication rooms (first and second floors) and the therapeutic recreation floor surfaces were clean and safely maintained. This had the potential to affect approximately 58 of 167 residents residing on the first and second floor units. Findings include: Floor surfaces were not clean in the medication rooms on first and second floors, and the therapeutic recreation (TR) room. An environmental tour conducted on 2/13/13 between 10:30 and 12:30 p.m. with the director of maintenance was completed. The first and second unit medication rooms and the TR room floors had a large build up of dust, sand and paper particles. The first unit medication room had a new sink installed where sections were cut out in the sheet rock "two days ago" according to the director of maintenance. A large area of powdery substance from cutting sheet rock remained on the floor in the medication room. The second floor medication room and the TR room had large shelving units used for storage that did not allow for clearance for cleaning under the shelving. The director of maintenance acknowledged when	F 465	It is the policy of Augustana Health Care Center of Apple Valley to provide a safe, functional, sanitary, and comfortable environment for residents, staff and public. Shelving units in 2nd and 3rd floor medication rooms were replaced and TR shelving unit was raised to allow cleaning underneath it. Housekeepers were re-educated on importance of cleaning medication rooms on 3/21/13. Housekeeping will be responsible for finding licensed nurse to be able to have access to the medication room for daily cleaning. Audit will be done twice a month for 3 months , then monthly thereafter. Director of Environmental Services / designee will be responsible for audits. Therapeutic Recreation Room Floors will be cleaned 3x a week and an audit will be done once a month then quarterly thereafter by Director of Environmental services. Environmental services Director is responsible. Completion date: 3/22/13 ✓	

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F 465	Continued From page 35 interviewed on 2/13/13, at 12:08 p.m. the first floor medication room sink was installed two days prior and the sheet rock powder had not been cleaned up. When interviewed on 2/13/13, at 1:00 p.m. the first and second floor housekeeper (H)-A and H-B both revealed they had so much to do each day, that medication rooms were left until the end of the day in case time ran out to finish their other work. H-A and H-B stated they needed a nurse to open the locked door of the medications rooms. H-A and H-B stated they had been told not to move anything in the medications rooms so they just cleaned the center of the floor. Both housekeepers acknowledged they were unable to clean the medication rooms the previous day, and had not had an opportunity to clean them the day of the tour. The director of housekeeping was interviewed on 2/14/13, at 2:00 p.m. and verified the flooring in the therapeutic recreation room was in need of cleaning because of a build up of sand and paper particles. Cleaning procedures for medication and TR room were requested but not received by the time of the exit conference.	F 465		

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

F5264021

PRINTED: 03/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Augustana Health Care Center of Apple Valley, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok PB 3-27-13 RECEIVED MAR 22 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 3-27-13
EXIT: 2-15-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Shaw
TITLE: Administrator
(X6) DATE: 3-22-13

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.

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Augustana Health Care Center of Apple Valley is a 3-story building with a full basement. The building was constructed in 1983, and was determined to be of Type II(222) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility chooses to have battery operated single station smoke alarms in all resident rooms. The facility has a licensed capacity of 178 beds and had a census of 165 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Section 2-3.5.1. The deficient practice could affect 50 out of 165 residents. Findings include: On facility tour between 10:55 AM and 2:25 PM on 02/13/2013, based on observation the following was found: 1. The following smoke detectors are located with-in 3 feet of of air supply/return vents: a. 3rd floor - in corridor by resident room # 334	K 052		

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K 052	Continued From page 3 b. Basement - in corridor by main storage room NOTE: the entire facility needs to be checked for this deficiency This deficient practice was confirmed by the Facility Maintenance Director (RC) at the time of discovery.	K 052	Smoke detectors in areas of concern were Relocated to correct this deficiency On March 18, 2013	3/18/13
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1 and 7-5.2.2. The deficient practice could affect all 165 residents. Findings include: On facility tour between 10:55 AM and 2:25 PM on 02/13/2013, the review of the annual fire alarm system inspection / test report and the following was found: 1. The annual was not completed with-in a 12 month period. The report from Electric Scientific indicated the 2012 was completed on 11/08/2012 and 2011 was completed on 11/02/2011. 2. Not all the information was provided on the	K 054	We made contact with Electric Scientific company and asked them to Schedule the annual inspections within The correct yearly dates so we will comply Within the window of 12 months, we also Made note of the next inspection due date in Our records to prevent this from going over The 12 month window of inspection.	3/18/13

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K 054	Continued From page 4 annual report form dated 11/08/2012 These deficient practices were confirmed by the Facility Maintenance Director (RC) at the time of discovery.	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7 and 1999 NFPA 13, 5-13.6. The deficient practice could affect all 165 residents. FINDINGS INCLUDE: On facility tour between 10:55 AM and 2:25 PM on 02/13/2013, observation revealed that the	K 056		

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K 056	Continued From page 5 hydraulic elevator pit does not have fire sprinkler protection. This deficient practice was confirmed by the Facility Maintenance Director (RC) at the time of discovery.	K 056	We have contacted Viking sprinkler To install new piping and sprinkler Heads in Elevator pit areas, work will Be completed on 3/22/13	3/22/13
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-1, 2-2.1.1 and 5-3.2.1. This deficient practice could affect all 165 residents. Findings include: On facility tour between 10:55 AM and 2:25 PM on 02/13/2013, the review of the annual fire sprinkler inspection report from Viking Fire Protection revealed that the following was found: 1. Annual inspection was not completed in a 12 month period. 2011 was done on 07/07/2011 and 2012 was done on 07/31/2012	K 062	Procedures have been put in place to Make certain that Viking sprinkler tests Our sprinklers according to required dates At a 12 month interval Per life safety code.	3/18/13

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K 062	Continued From page 6 2. The 10 minute weekly fire pump run test was missed on the following dates: 1/21 and 1/7/2013, 4/2, 4/23, 5/21, 6/28, 7/23, 8/13, 9/17, 10/8, 11/19 and 12/17/2012 3. Following areas have corroded fire sprinkler heads a. Basement - main storage room b. Basement - pool area locker / showers / office rooms These deficient practices were confirmed by the Facility Maintenance Director (RC) at the time of discovery.	K 062	Fire pump test have been Put into a calendar data base to insure They are tested every week for ten minutes Fire sprinkler heads will be replaced with New ones by Viking sprinkler	3/18/13 3/22/13
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not maintained in accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 8.2.. This deficient practice could affect all 165 residents. Findings include: On facility tour between 10:55 AM and 2:25 PM on 02/13/2013, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months (02/12/2012 and 01/02/2013). This deficient practice was confirmed by the	K 069		

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K 069	Continued From page 7 Facility Maintenance Director (RC) at the time of discovery.	K 069	Kitchen hood inspection will be done every Six Months, the correction will	3/18/13
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 165 residents. Findings include: On facility tour between 10:55 AM and 2:25 PM on 02/13/2013, the documentation review of the weekly inspection logs (February 2012 to February 2013) for the diesel emergency generator revealed that a weekly operational inspections were missed for the weeks of 1/18/2013, 2/20, 4/2, 4/23, 5/21, 6/18, 7/23, 8/13, 10/1, 10/22, 11/19 and 12/19/2012 . This deficient practice was confirmed by the Facility Maintenance Director (RC) at the time of	K 144	Be achieved by putting the Calendar dates For this inspection in our calendar	

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K 144	Continued From page 8 discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	The generator systems will be run every Monday During the Year to eliminate Confusion and to comply with all life Safety codes. NOTE: All areas that we received K tags for Non compliant Dates and times Of inspections or tests will be Addressed with improved Calendars and outlook Data bases to back up the calendar Dates With a computer Reminder system, having multiple ways Of keeping track and reminding us Will assure compliance on our part, and Make certain All critical tests and inspections are done according to All life safety codes.	3/18/13

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 4344

March 12, 2013

Mr. David Shaw, Administrator
Augustana Hcc Of Apple Valley
14650 Garrett Avenue
Apple Valley, Minnesota 55124

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5264022 & H5264044

Dear Mr. Shaw:

The above facility was surveyed on February 11, 2013 through February 15, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5264044 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule

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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. BOX 64900, St. Paul, Minnesota 55164-0900. 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 me.

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,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

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
	00979	A. BUILDING: _____ B. WING _____	C 02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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) COMPLETE DATE
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: On February 11th through February 15th 2013, surveyors of this Department's staff visited the above provider and the following correction orders are issued. At the time of the survey, an investigation of complaint H5264044 was also conducted and was found to be unsubstantiated.	2 000	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.	

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2 000	Continued From page 1 When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by:	2 565		

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2 565	Continued From page 2 Based on observation, interview, and document review, the facility failed to provide care and treatment according to the care plan (CP) for 1 of 2 residents (R30) reviewed for pressure ulcers. Findings include: R30 developed a pressure ulcer (PU) over the left lateral knee, however, the resident's care plan and treatment interventions were not provided timely and consistently to minimize the risk of worsening of the PU when the ulcer was superficial, and the wound was not documented according to policy. R30's care plan (CP) with a review date of 2/4/13, indicated the resident had one Stage 3 PU on the left medial malleous, one Stage 3 on the right medial malleolus, and one Stage 4 on left lateral knee. Interventions directed staff to write progress notes regarding the wounds, update the physician and family monthly, provide the nutritional supplement Arginaid twice daily to promote wound healing, and pressure relief cushion for wheelchair (w/c). "OFFER CHANCE TO LAY DOWN BETWEEN MEALS, KEEP RT [right] FOOT/LEFT FOOT OFF LOADED W/ [with] NO PRESSURE, USING FOAM BOOTS, BLANKET OR PILLOWS. PRESSURE REDUCTION FOAM BOOT TO RIGHT FOOT EVERY NIGHT, CONTINUE TO OFF LOAD LEFT FOOT WHEN IN BED hs [bedtime]. POSITION (L) KNEE OFF BED WITH PILLOWS (ABOVE & BELOW KNEE) DX: [diagnosis] INFECTED (L) KNEE WOUND, KEEP PRESSURE OFF KNEE AT ALL TIMES, INCLUDES IN BED & HARDWARE OF W/C. DON'T JUST PAD HARDWARE OF W/C, AS THIS DOES NOT PROVIDE PRESSURE RELIEF. AIR MATTRESS, LAMBS WOOL	2 565		

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2 565	Continued From page 3 BETWEEN TOES PM." Staff were also directed to follow the turning/repositioning schedule, and "Heel Float Boots, Air Flow mattress. Wound Care--Measure wounds on Right and Left Medial Malleous AND wound on Left lateral knee." On 2/13/13, at 2:00 p.m. observations were conducted of scheduled treatments to R30's PUs by LPN-B. Although a Z-Flo positioning pillow (to support vulnerable areas of the body) was to be used to support the left lateral knee, the LPN placed the Z-Flo positioning pillow under R30's feet, and the Posie boots [specialized footwear] which the resident was to have applied to her feet were on the floor under the resident's dresser. During subsequent observations the resident was not positioned to minimize the risk of pressure to vulnerable areas. For example, on 2/14/13, at 9:30 a.m. R30's feet were wrapped with gauze and her heels were exposed and resting on the foot rest. At 10:15 the resident was wearing the Posie boots, however, her toes were exposed and the right foot was sliding off the foot pedal toward the front wheel of the chair. At 10:25 a nursing assistant (NA)-A was assisted to transfer R30 from the wheelchair to the bed, and the Z-Flo pillow was again incorrectly positioned under both feet (with Posie boots) with the top of the pillow approximately one inch below the wound dressing to the left lateral knee. The following day at day at 9:00 a.m. the resident was not wearing the Posie boots and both heels were exposed with the right foot was resting against the front right wheel of wheelchair. At 10:00 a.m. R30 was in bed and again the Z-Flo positioning pillow was under both feet approximately two inches below dressing on left lateral leg. A standard pillow had been placed under the resident's left knee and another under the resident's right side.	2 565		

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2 565	Continued From page 4 Nursing notes and wound clinic notes revealed the following interventions were recommended, however were not consistently and aggressively being implemented, and the resident's wounds became worse with deadened tissue and infection. On 3/22/12, a nursing note revealed the discover of a PU over the left lateral knee described as purple, not open, and measuring 1.3 x 0.8 centimeters (cm). The cause was identified from the knee "digging into metal leg rest" of the wheelchair (w/c). On 4/23/12, the NP wrote "She also has a new open area on the outer left knee. It appears to be from the hardware on her wheelchair. This area is unstageable and measures 2.5 x 1.8 x 0.2 cm. Occupational therapy was ordered for offloading 100% pressure to left knee from the w/c. On 4/30/12, the NP diagnosed cellulitis (infection) of the left leg and the NP ordered antibiotic therapy. On 5/18/12, the NP ordered an air mattress. The wound clinic nurse documented on 5/21/12, that the PU remained unstageable measuring 4.5 cm by 4.3 cm by 0.8 cm. and directed staff to, "KEEP PRESSURE OFF KNEE AT ALL TIMES" that included the bed and hardware of the w/c. "Please do not just pad the hardware of the wheel chair as this does not provide pressure relief." The NP documented on 6/6/12, that R30 had an air mattress and was seeing an occupational therapist for positioning, however, on 8/10/12, another order was written for an air mattress. On 8/14/12, the NP saw the resident and ordered a Z-Flo positioning pillow for left lateral knee when in bed. The NP also wanted staff to check on	2 565		

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2 565	Continued From page 5 status of air mattress and notified the nurses. R30's record showed she was utilizing an air mattress as noted on treatment records for the month of 2/13, progress notes, and the most recent comprehensive assessment dated 2/4/13. On 2/14/13 at 10:50 a.m. RN-A explained R30 had a pressure reduction mattress on the bed ordered 5/8/12, and the resident wore Posie boots on both feet. Because a standard mattress was observed on the bed, the RN and surveyor visualized the mattress, and the RN confirmed it was not the air mattress that had been ordered on two different occasions by the NP. NA-A was interviewed on 2/15/13, at 9:05 a.m. The NA stated R30 needed a special pillow under both legs in bed. RN-A was interviewed on 2/15/13, at 10:50 a.m. and explained that R30 had a pressure reduction mattress on the bed ordered 5/8/12, (not an air mattress) and wore Posie boots on both feet. RN-A confirmed care was not consistently provided for R30 in order to minimize the risk of further development and to promote healing of the PUs. The facility's Skin Care Program policy (dated 12/12) directed staff as follows: residents who had pressure sores would receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. For residents at risk with skin alterations, staff was to immediately develop a plan of care, request physical and/or occupational therapy assessment/evaluation as needed. Staff was to also assess, measure and document PUs on a weekly basis utilizing the Weekly Wound Flow Sheet scheduled on the care path.	2 565		

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2 565	Continued From page 6 SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to ensure all care plans inteventions are followed according to individualized needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan when changes occurred for 1 of 1 resident (R111) reviewed for hospice services. Findings include: R111 was admitted 12/12, diagnoses included Lewy Body dementia, neuropathy, and diabetes.	2 570		

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2 570	Continued From page 7 The physician ordered a hospice evaluation and treatment on 12/27/12. On 12/28/12, a hospice nursing note read "admit to hospice services." On 2/13/13, at 8:20 a.m. R111 stated he said he thought someone from a hospice agency came, but was unsure if it was a nurse or an aide. R111 did not know how long he had received hospice services, or what services were being provided. A nursing assistant (NA)-C on 2/13/13, at 10:21 a.m. did not think R111 was receiving hospice care, and referred the surveyor to the floor nurse. At 10:33 a.m. NA-D stated R111 was receiving hospice care. The aide had seen someone from the agency come after lunch, and thought they had given R111 a bath. NA-D further stated the night shift nurse wrote on the aide assignment sheet if the hospice aide was coming. NA-D was unaware of the days of the week the hospice staff came. The following day at 11:14 a.m. NA-A reported R111 she did not she did not believe the resident was receiving hospice care. The facility nursing assistant (NA) assignment sheet for R111 stated hospice but, it did not indicate the type of services that would be provided by the hospice aide and when those cares would be provided (e.g. bathing). R111's facility care plan dated 12/28/12, noted for advance directives a POLST (Physician Orders for Life-Sustaining Treatment) was completed by hospice and hospice care was indicated as an intervention. No further information was documented regarding the services and disciplines that would be providing services. R111's hospice admission plan of care dated 12/28/12, indicated a skilled nurse would visit the	2 570		

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2 570	Continued From page 8 resident 1-2 times per week and social worker 1-3 times per month. No further updates were noted to address hospice aide services, and no notes were located regarding the social worker's visits. An interview conducted with a licensed practical nurse (LPN)-A on 2/13/13, at 9:35 a.m. revealed a hospice aide came twice weekly per the medical record. LPN-A further stated thought they usually called ahead with days and times but, the unit nurse manager was calling the agency for verification. At 10:15 a.m. LPN-A stated that the nurse manage reported the hospice agency thought calendars for hospice aide visits were sent after visits were completed, and she thought the hospice agency could mark the days as they visited the resident. The registered nurse manager (RN)-B was interviewed on 2/13/13, at 10:17 a.m. The RN had called the hospice agency regarding the RN visits, but did not inquire about the aide's visits, and did not know when those visits took place. The RN placed a second call to the agency, and was told the aide was scheduled for twice weekly visits on Mondays and Wednesdays. A phone interview was conducted on 2/15/13, at 2:00 p.m. with hospice RN-D. Hospice RN-D stated R111 had a hospice aide visit twice weekly. The RN explained that when a resident was admitted to hospice care and hospice aide services were needed, the agency notified the hospice staffing department of the need for services. Hospice RN-D further stated after the hospice aide received their schedule from the agency, they would typically let the facility know the days they could be expected to visit. The RN said services began for R111, because the	2 570		

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2 570	Continued From page 9 resident's family wanted him to receive an extra bath weekly. A few weeks prior, the resident was not allowing the hospice aide to provide the extra bath, therefore, a change was made to provide companionship visits. Hospice RN-D stated the agency was in the process of changing their documentation, and as of the date of the interview, it would include duplicate notes for all disciplines. A change would include providing a copy of the note for the facility's records. The RN acknowledged the current Hospice Communication Notes were brief and did not comprehensively note the resident's current condition and need for hospice. A facility policy for Care Plans (last revised 12/12), indicated the care plans would be updated and approved at the care conference with the interdisciplinary team (IDT) and others (resident and family) in attendance. Outside services such as dialysis and hospice would include coordination of care and services provided. It was noted that a resident's care plan was constantly changing, and was to be updated routinely on the hard copy of the chart with resident condition changes. A facility policy for Palliative Care Program (review date 1/21/12), indicated the goal was to help devise an individualized palliative plan of care which included a physical, psychological, leisure, and spiritual interventions to support and enhance the residents abilities, choices, and needs during end of life process. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to ensure all care plans are reviewed and revised as necessary. A monitoring program could be established in order to assure ongoing	2 570		

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2 570	Continued From page 10 and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate services between the facility and hospice agency to promote communication and provide appropriate care services for 1 of 1 resident (R111) reviewed for hospice services. Findings include: The facility did not coordinate hospice services for R111 to maintain the resident's highest practicable level of functioning. R111 was admitted 12/12, diagnoses included	2 830		

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2 830	Continued From page 11 Lewy Body dementia, anxiety, depression, neuropathy, hypertension, obstructive hydrocephalus, and diabetes. The physician ordered a hospice evaluation and treatment on 12/27/12. On 12/28/12, a hospice nursing note read "admit to hospice services." On 2/13/13, at 8:20 a.m. R111 was observed seated in a wheelchair at the dining room table. The resident was eating independently and was visiting with tablemates. After breakfast the resident was observed as he was assisted to bed by one staff person. The resident was then interviewed regarding hospice services. He said he thought someone from a hospice agency came, but was unsure if it was a nurse or an aide. R111 did not know how long he had received hospice services, or what services were being provided. A nursing assistant (NA)-C on 2/13/13, at 10:21 a.m. did not think R111 was receiving hospice care, and referred the surveyor to the floor nurse. At 10:33 a.m. NA-D stated R111 was receiving hospice care. The aide had seen someone from the agency come after lunch, and thought they had given R111 a bath. NA-D further stated the night shift nurse wrote on the aide assignment sheet if the hospice aide was coming. NA-D was unaware of the days of the week the hospice staff came. The following day at 11:14 a.m. NA-A reported R111 she did not she did not believe the resident was receiving hospice care. Review of the Hospice Communication Notes revealed the following: 1. 12/28/12, hospice admission signed by RN 2. 12/31/12, met the resident and the resident's daughter. The resident was "getting ready for supper." Hospice aide checked "socialization and	2 830		

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2 830	Continued From page 12 companionship" 3. 1/2/13, Hospice aide and RN noted will start shower with aide "next Thursday" and "socialization" checked 4. 1/7/13, Resident declined supper, as was sick after lunch. "Socialization" checked and signed by aide and RN 5. 1/11/13, "Disease management" checked and shower was completed--with change in days--signed by aide and RN 6. 1/15/13, the resident ate and drank 75% of his meal, "socialization" was provided, and note signed by aide and RN 7. 1/17/13, "Disease management" was checked and noted the resident had already had a shower. Signed by the RN and aide 8. 1/21/13, "Disease management" by RN 9. 1/22/13, "Socialization" signed by aide and RN 10. 1/24/13, "Socialization" signed by aide and RN 11. 1/29/13, No notes regarding the visit, but signatures by the RN and aide 12. 1/31/13, RN for "disease management" 13. 2/5/13, "Socialization" signed by aide and RN 14. 2/6/13, "Disease management" signed by nurse 15. 2/7/13, Resident not feeling well and had an emesis, "very upset, felt ill when talking" and note signed by aide and RN 16. 2/12/13, Resident "Comfortable, denies any pain. Staff states no concerns--meds [medications] checked." Note signed by aide and RN The facility nursing assistant (NA) assignment sheet for R111 stated hospice but, it did not indicate the type of services that would be provided by the hospice aide and when those cares would be provided (e.g. bathing).	2 830		

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2 830	Continued From page 13 R111's facility care plan dated 12/28/12, noted for advance directives a POLST (Physician Orders for Life-Sustaining Treatment) was completed by hospice and hospice care was indicated as an intervention. No further information was documented regarding the services and disciplines that would be providing services. R111's hospice admission plan of care dated 12/28/12, indicated a skilled nurse would visit the resident 1-2 times per week and social worker 1-3 times per month. No further updates were noted to address hospice aide services, and no notes were located regarding the social worker's visits. Although the resident was on hospice, it was unclear whether there was a continued need for the current medication regimen which included three medications for high blood pressure and three medications for diabetes. Medications included: Astelin (seasonal nasal allergies) twice daily, Aricept (dementia) 10 milligrams (mg) daily, Neurontin (seizures/neuropathic pain) 300 mg daily, Glucophage (diabetes) 1000 mg twice daily, Ritalin (central nervous system stimulant) 5 mg daily, Zocor (cholesterol) 20 mg daily, Norvasc (high blood pressure) 5 mg daily, aspirin (heart attack and stroke prevention) 81 mg daily, Tenormin (high blood pressure) 50 mg daily, Glucotrol XL (diabetes)10 mg daily, Lexapro (antidepressant) 10 mg daily, Zestril (high blood pressure) 40 mg daily, Actos (diabetes) 15 mg daily, and Flomax (prostate) 0.4 mg daily. An interview conducted with a licensed practical nurse (LPN)-A on 2/13/13, at 9:35 a.m. revealed a hospice aide came twice weekly per the medical record. LPN-A further stated thought they usually called ahead with days and times	2 830		

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2 830	Continued From page 14 but, the unit nurse manager was calling the agency for verification. At 10:15 a.m. LPN-A stated that the nurse manage reported the hospice agency thought calendars for hospice aide visits were sent after visits were completed, and she thought the hospice agency could mark the days as they visited the resident. The registered nurse manager (RN)-B was interviewed on 2/13/13, at 10:17 a.m. The RN had called the hospice agency regarding the RN visits, but did not inquire about the aide's visits, and did not know when those visits took place. The RN placed a second call to the agency, and was told the aide was scheduled for twice weekly visits on Mondays and Wednesdays. A phone interview was conducted on 2/15/13, at 2:00 p.m. with hospice RN-D. Hospice RN-D stated R111 had a hospice aide visit twice weekly. The RN explained that when a resident was admitted to hospice care and hospice aide services were needed, the agency notified the hospice staffing department of the need for services. Hospice RN-D further stated after the hospice aide received their schedule from the agency, they would typically let the facility know the days they could be expected to visit. The RN said services began for R111, because the resident's family wanted him to receive an extra bath weekly. A few weeks prior, the resident was not allowing the hospice aide to provide the extra bath, therefore, a change was made to provide companionship visits. Hospice RN-D stated the agency was in the process of changing their documentation, and as of the date of the interview, it would include duplicate notes for all disciplines. A change would include providing a copy of the note for the facility's records. The RN acknowledged the current Hospice	2 830		

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2 830	Continued From page 15 Communication Notes were brief and did not comprehensively note the resident's current condition and need for hospice. A facility policy for Care Plans (last revised 12/12), indicated the care plans were completed no later than day 21 of a residents' stay or seven days upon completion of the comprehensive initial Minimum Data Set (MDS) assessment, whichever came first. The final plan would be updated and approved at the care conference with the interdisciplinary team (IDT) and others (resident and family) in attendance. Outside services such as dialysis and hospice would include coordination of care and services provided. It was noted that a resident's care plan was constantly changing, and was to be updated routinely on the hard copy of the chart with resident condition changes. A facility policy for Palliative Care Program (review date 1/21/12), indicated residents who had a palliative care order or who elected hospice would also be referred to the Palliative Care Review Team. The goal of that team was to review each resident on a regular basis, and help devise an individualized palliative plan of care which included a physical, psychological, leisure, and spiritual interventions to support and enhance the residents abilities, choices, and needs during end of life process. In conjunction with the IDT, they would use a grid as a guide for a specific process for advanced care planning. Key elements were POLST completions, care conferences, roles of therapy, laboratories, medications, and dietary considerations. The grid directed staff to review/revise pain management programs, psychological assessments, and spiritual care assessments.	2 830		

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2 830	Continued From page 16 SUGGESTED PERIOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents on hospice care receive individualized coordination of services. The director of nursing or designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions were consistently implemented and re-assessed to minimize the risk of development and promote	2 900		

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2 900	Continued From page 17 healing of pressure ulcers for 1 of 2 residents in the sample (R30) who were reviewed for pressure ulcers. This resulted in actual harm when the risk of development of pressure ulcers was not minimized and an additional PU with complications developed. Findings include: R30 developed a pressure ulcer (PU) over the left lateral knee, however, appropriate care and treatment was not provided timely and consistently which resulted in the PU progressing to a Stage 4. In addition, interventions were not provided to prevent PU to the heels and promote healing to the ankles. Standardized PU staging is as follows: o Stage 1 Observable, pressure-related alteration of intact skin, where adjacent may include changes in skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin. o Stage 2 Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. o Stage 3 Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. o Stage 4 Full thickness tissue loss with exposed bone, tendon or muscle. R30's Minimum Data Set (MDS) assessments revealed diagnoses included rheumatoid arthritis and idiopathic peripheral neuropathy and the resident displayed short term memory problems. In addition, the following information regarding	2 900		

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2 900	Continued From page 18 PUs was documented: 1) 1/25/12 one Stage 2 and healed PUs, 2) 4/19/12 two Stage 3, 3) 7/11/12 one Stage 4, 4) 10/3/12 one Stage 3 and one Stage 4, and 5) 12/26/12 two Stage 3 (1 Stage 3 that worsened) and one Stage 4 PU. The annual MDS dated 10/3/12, triggered for PUs and the Care Area Assessment (CAA) was completed on 10/8/12. Risk factors included the need for extensive assistance of two staff to move sufficiently to relieve pressure, confinement to a bed or chair all or most of the time, the need for a special mattress or seat cushion to reduce or relieve pressure, and the need for a regular turning schedule. The CAA also noted R30 was immobile, incontinent of bowel and bladder, malnourished, and a history of healed PUs, as well as PUs on the inner ankles that were being treated. R30 had an additional risk factor of long term steroid use with Prednisone 5 mgs since 1/24/10. Nursing notes and wound clinic notes revealed the progression of R30's left lateral knee PU was as follows: 1) On 3/22/12, a nursing note revealed the discover of a PU over the left lateral knee described as purple, not open, and measuring 1.3 x 0.8 centimeters (cm). The cause was identified from the knee "digging into metal leg rest" of the wheelchair (w/c). The plan was to pad the w/c. The resident was going to be sent to a wound clinic due to "no improvement with wounds bilateral ankles." The nurse practitioner (NP) then ordered a foam dressing to the left lateral leg that was to be changed every two days and as needed. A pillow was to be kept below the outer knee for protection when the resident was on her left side.	2 900		

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2 900	Continued From page 19 2) On 3/23/12, R30 had an initial consult at the local wound clinic, however, documentation did not show the new PU on the left lateral knee was addressed at that time. The clinical record lacked as assessment of the newly developed PU. 3) On 3/26/12 and 4/5/12, the NP saw the resident, but did not address the knee PU. 4) On 4/9/12 Weekly Wound Status Documentation noted numerous open areas on the resident's ankle, but there was no mention of the knee PU. 5) On 4/12/12, R30 was again seen by the NP. A progress note dated 4/12/12, indicated licensed nursing staff requested the NP to check the left lateral knee area which had been rubbing on the w/c side while R30 was in the w/c and during transfers. The note revealed the w/c had been padded now and staff were using a Hoyer (mechanical) lift for transfers. 6) There was no Weekly Wound Status Documentation for the week of 4/16/12. Two weeks later on 4/23/12, the Weekly Wound Status Documentation included, "She also has a new open area on the outer left knee. It appears to be from the hardware of her wheelchair and is unstageable and measures 2.5 cm's x 1.8 cm's x 0.2 cm's." 7) On 4/23/12, the NP wrote "She also has a new open area on the outer left knee. It appears to be from the hardware on her wheelchair. This area is unstageable and measures 2.5 x 1.8 x 0.2 cm. Occupational therapy was ordered for offloading 100% pressure to left knee from the w/c."	2 900		

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2 900	Continued From page 20 Clinical evidence shows if a PU fails to show progression in healing within the first two to four weeks, the PU (including potential complications) and the resident's overall clinical condition should be reassessed, including determining whether to continue or modify interventions. Possible avoidable negative outcomes may include permanent tissue damage increasing the potential for serious complications, with the tissue closest to the bone potentially undergoing necrosis (death). R30 had risk factors due to impaired circulation to the tissue from the use of medical devices, as well as pressure on legs due to contractures, with the need for special attention to effectively reduce pressure on a bony prominence. 8) On 4/30/12, the staff notified the NP of increased redness, warmth, and odor around the knee wound. The NP diagnosed cellulitis (infection) of the left leg and the NP ordered antibiotic therapy. The NP directed the resident's left knee be positioned off the bed with a pillow above and below the knee. 9) On 5/7/12, R30 was again seen at the wound clinic, and the NP noted the PU was "unstageable" (could not be visualized in order to stage from necrotic tissue), and measured 4 x 3 x 0.4 cm. (the latter measurement indicating tunneling, or a passageway of tissue destruction under the skin surface) and the surrounding skin that was purple was now an open area and part of the wound itself. 10) On 5/18/12, the NP ordered an air mattress. 11) On 5/21/12, the wound clinic nurse documented the PU remained unstageable measuring 4.5 cm by 4.3 cm by 0.8 cm. Although	2 900		

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2 900	Continued From page 21 it had been two months since the PU was first discovered, the staff continued with the same intervention and the wound became progressively worse. The wound nurse directed staff to, "KEEP PRESSURE OFF KNEE AT ALL TIMES" that included the bed and hardware of the w/c. "Please do not just pad the hardware of the wheel chair as this does not provide pressure relief." 12) On 6/6/12, the NP progress note indicated R30 had an air mattress and was seeing an occupational therapist for positioning. 13) On 6/4/12, wound clinic consult documentation indicated the left lateral knee was debrided (removal of dead tissue to facilitate the healing process) to a stage 4 PU. The wound was cleaned down to the muscle, and measured 5.3 x 3.3 x 0.8 cm. 14) On 8/10/12, another order was written for an air mattress. 15) On 8/14/12, the NP saw the resident and ordered a Z-Flo positioning pillow for left lateral knee when in bed. The NP also wanted staff to check on status of air mattress and notified the nurses. 16) On 9/10/12, the wound clinic noted the wound knee measured 6.3 x 3.7 x 0.5, which had increased in size. 17) On 11/15/12, the wound clinic noted the wound was 8.3 x 3.3 x 0.5 and the superior edge was brown in color with moderate serous drainage, and was essentially unchanged in 12/12. 18) On 1/10/13 the wound was noted as "slightly	2 900		

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2 900	Continued From page 22 smaller than last month. 19) R30's record showed she was utilizing an air mattress as noted on treatment records for the month of 2/13, progress notes, and in the most recent comprehensive assessment dated 2/4/13. 20) R30's care plan (CP) with a review date of 2/4/13, indicated the resident had one Stage 3 PU on the left medial malleous, one Stage 3 on the right medial malleolus, and one Stage 4 on left lateral knee. Interventions directed staff to write progress notes regarding the wounds, update the physician and family monthly, provide the nutritional supplement Arginaid twice daily to promote wound healing, and pressure relief cushion for wheelchair (w/c). "OFFER CHANCE TO LAY DOWN BETWEEN MEALS, KEEP RT [right] FOOT/LEFT FOOT OFF LOADED W/ [with] NO PRESSURE, USING FOAM BOOTS, BLANKET OR PILLOWS. PRESSURE REDUCTION FOAM BOOT TO RIGHT FOOT EVERY NIGHT, CONTINUE TO OFF LOAD LEFT FOOT WHEN IN BED hs [bedtime]. POSITION (L) KNEE OFF BED WITH PILLOWS (ABOVE & BELOW KNEE) DX: [diagnosis] INFECTED (L) KNEE WOUND, KEEP PRESSURE OFF KNEE AT ALL TIMES, INCLUDES IN BED & HARDWARE OF W/C. DON'T JUST PAD HARDWARE OF W/C, AS THIS DOES NOT PROVIDE PRESSURE RELIEF. AIR MATTRESS, LAMBS WOOL BETWEEN TOES PM." Staff were also directed to follow the turning/repositioning schedule, and "Heel Float Boots, Air Flow mattress. Wound Care--Measure wounds on Right and Left Medial Malleous AND wound on Left lateral knee." 21) R30's tissue tolerance assessments (testing to determine the skin's ability to withstand	2 900		

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2 900	Continued From page 23 pressure) documented 2/14/13, was a sitting evaluation and was completed by a registered nurse (RN) noted the resident's skin was able to withstand 1.5 hours of pressure. Although the RN did not proceed to the next interval of testing, the documentation noted R30 tolerated repositioning every two hours. For lying, the licensed practical nurse (LPN) who completed the assessment, did not document the purpose of the testing to determine how R30's body responded to pressure. The LPN instead documented observations of wound dressings and noted that the rest of R30's skin was clean and intact. 22) On 2/7/13, the wound clinic nurse described the left lateral knee wound as Stage 4 and measured 8.0 x 2.5 x 0.2 cm and tapering to 1 cm with serous drainage and the left medial malleous measuring 1.9 x 2.2 cm with a small amount of serous drainage. It was also noted as "slightly smaller than the previous month--uses Z-Flo positioning pillow." The wounds to the ankles were described as Stage 3 with the medial malloelar ulcer described as clean and red, "unchanged" measuring 2.2 x 2.3 x 3.0 cm. On 2/13/13, at 2:00 p.m. observations were conducted of scheduled treatments to R30's PUs by LPN-B. The left lateral knee wound was open, however, the wound did appear clean. Orders were for wound care to the ankles daily, and three times weekly to the knee. Wound care specific to the knee read that the left knee was to be positioned off the bed every shift, with wound care including: Cleanse with wound cleanser, pat dry, cover wound base with Aquacel AG [wound dressing] and secure with 5 x 5 Allevyn adhesive ("ok to change to Algicell AG until Aquacell comes in"), apply Silvadene [ointment] to wound daily and cover with non-stick dressing, Z-Flo	2 900		

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2 900	Continued From page 24 positioning pillow (to support vulnerable areas of the body) to left lateral knee. During the observation, however, the LPN placed the Z-Flo positioning pillow under R30's feet, and the Posie boots [specialized footwear] which were to be applied to the resident's feet were on the floor under the resident's dresser. The resident was leaning to the left, and her knees were contracted to a 90 degree angle and were approximately an inch from touching the standard mattress, with a pillow placed under the left side of the resident's trunk. During subsequent observations the resident was not positioned to minimize the risk of pressure to vulnerable areas. For example, on 2/14/13, at 9:30 a.m. R30's feet were wrapped with gauze and her heels were exposed and resting on the foot rest. At 10:15 the resident was wearing the Posie boots, however, her toes were exposed and the right foot was sliding off the foot pedal toward the front wheel of the chair. At 10:25 a nursing assistant (NA)-A was assisted to transfer R30 from the wheelchair to the bed, and the Z-Flo pillow was again incorrectly positioned under both feet (with Posie boots) with the top of the pillow approximately one inch below the wound dressing to the left lateral knee. The following day at 9:00 a.m. the resident was not wearing the Posie boots and both heels were exposed with the right foot resting against the front right wheel of wheelchair. At 10:00 a.m. R30 was in bed and again the Z-Flo positioning pillow was under both feet approximately two inches below dressing on left lateral leg. A standard pillow had been placed under the resident's left knee and another under the resident's right side. On 2/14/13 at 10:50 a.m. RN-A explained R30 had a pressure reduction mattress on the bed	2 900		

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2 900	Continued From page 25 ordered 5/8/12, and the resident wore Posie boots on both feet. In addition, the resident was turned and repositioned every two hours according to her tissue tolerance assessment. Because a standard mattress was observed on the bed, the RN and surveyor visualized the mattress, and the RN confirmed it was not the air mattress that had been ordered on two different occasions by the NP. NA-A was interviewed on 2/15/13, at 9:05 a.m. The NA stated R30 needed a special pillow under both legs in bed, and was repositioned every two hours. The NAs were to notify the nurse if the resident's wounds were uncovered or leaking. RN-A was interviewed on 2/15/13, at 10:50 a.m. and explained that R30 had a pressure reduction mattress on the bed ordered 5/8/12, (not an air mattress) and wore Posie boots on both feet. RN-A stated R30 was turned and repositioned every two hours according to the tissue tolerance assessment. RN-A confirmed care was not consistently provided for R30 in order to minimize the risk of further development and to promote healing of the PUs. The facility's Skin Care Program policy (dated 12/12) directed staff as follows: residents who had pressure sores would receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. For residents at risk with skin alterations, staff was to immediately develop a plan of care, request physical and/or occupational therapy assessment/evaluation as needed. Staff was to also assess, measure and document PUs on a weekly basis utilizing the Weekly Wound Flow Sheet scheduled on the care path.	2 900		

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2 900	Continued From page 26 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain 2 of 3 nourishment refrigerators in a sanitary manner on the first and second floors, having the potential to affect 28 of 167 residents who received nourishments. Findings include: On 2/13/13, between 10:30 and 11:30 a.m. the first and second floor medication rooms and therapeutic recreation (TR) room refrigerators had sticky substances of tan, pink, and brown colored spills on the shelving throughout. The first floor medication room refrigerator had an inside door shelf taped to hold the cartons in place preventing a cleanable surface. There was also an open unsealed supplement can on the shelf. Furthermore, all three refrigerators had six ounce	21015		

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21015	Continued From page 27 containers of unmarked, undated substances designated with a P (17 containers) or AS (8 containers), and then a single number such as 5, 8, or 10. There were also two containers with the numbers 211 and 1 container had the number 216. Nineteen containers of Protein Plus 2 Protein energy shake were not dated when thawed or opened. During an interview on 2/13/13, at 11:30 a.m. the registered nurses (RN)-A RN-B and RN-C verified the P probably meant pudding and the AS meant applesauce. The numbers they thought could have been a date but were unsure. RN-A stated "The Protein Plus is good for seven days if open and it is good for 14 days from the thaw date." RN-A verified there was no date on the containers for a thaw date or for an open date. When interviewed on 2/14/13, at 1:30 p.m. the dietary director (DD) confirmed the pudding and applesauce were designated with letters but agreed the labeling needed to be clearer for staff. The DD verified the facility did not have a system for dating the Protein Plus when thawed or opened but said one would be implemented immediately. On 1/14/13, at 2:00 p.m. the director of housekeeping and the director of therapeutic recreation both agreed they did not know who was responsible to defrost and clean the TR refrigerator. The refrigerator was being utilized for resident activities and employee lunches, however, employee lunches should have been stored separately from residents' food. The facility policy and procedure Dietary Food Service Requisition Form dated 2/01 read, Dietary to portion pudding and or apple sauce.	21015		

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21015	Continued From page 28 A=applesauce and P=pudding. Date item was packaged will be indicated. SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietitian could review and revise food service policies and procedures to assure that food is stored and served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21015		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the	21530		

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21530	Continued From page 29 pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on document review, and interview the consultant pharmacist failed to identify diagnoses for ordered medications for 1 of 10 residents (R111) reviewed for unnecessary medications. Findings include: The consultant pharmacist did not identify and report the lack of medical diagnoses for R111's ordered medications. Pharmacy review notes dated 1/16/13, stated "medication regimen review completed. No irregularities noted." R111 was admitted 12/27/12, with diagnoses including Lewy Body dementia, anxiety, depression, neuropathy, hypertension, obstructive hydrocephalus, and diabetes. The day after the resident's admission to the facility he was admitted to hospice care. Although the resident had multiple medications, diagnoses to support the use of those medications ordered in the residents' admission orders, hospital records	21530		

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21530	Continued From page 30 reviewed, as well as facility's electronic and paper medical records. R111's medication regimen included three medications for high blood pressure and three medications for diabetes. Medications included: Astelin (seasonal nasal allergies) twice daily, Aricept (dementia) 10 milligrams (mg) daily, Neurontin (seizures/neuropathic pain) 300 mg daily, Glucophage (diabetes) 1000 mg twice daily, Ritalin (central nervous system stimulant) 5 mg daily, Zocor (cholesterol) 20 mg daily, Norvasc (high blood pressure) 5 mg daily, aspirin (heart attack and stroke prevention) 81 mg daily, Tenormin (high blood pressure) 50 mg daily, Glucotrol XL (diabetes)10 mg daily, Lexapro (antidepressant) 10 mg daily, Zestril (high blood pressure) 40 mg daily, Actos (diabetes) 15 mg daily, and Flomax (prostate) 0.4 mg daily. An interview conducted with medical records staff (MR)-A on 2/15/13, at 4:00 p.m. revealed the staff was unable to locate physician orders with diagnoses for current medications. MR-A stated the facility should have called the physician or nurse practitioner for diagnoses for the medication uses upon admission. MR-A stated R111 utilized an outside physician who did not make visits at the facility. An interview conducted with nurse manager registered nurse (RN)-B on 2/15/13, at 4:05 p.m. confirmed R111's current medications did not include diagnoses. Nurse manager RN-B further indicated diagnoses for R111's medications should have been completed upon admission to the facility 12/27/12. RN-B stated the Ritalin mediation was ordered for "apathy" and the nurse planned to contact R111's physician for clarification of all medications and corresponding	21530		

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21530	Continued From page 31 diagnoses. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		

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21540	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify diagnoses for 1 of 10 residents (R111) reviewed for unnecessary medications, and to monitor for potential side effects of antipsychotic medications for 2 of 4 residents (R16, R329) in the sample who were prescribed antipsychotic medication. Findings include: R111 was admitted 12/27/12, with diagnoses including Lewy Body dementia, anxiety, depression, neuropathy, hypertension, obstructive hydrocephalus, and diabetes. The day after the resident's admission to the facility he was admitted to hospice care. Although the resident had multiple medications, diagnoses to support the use of those medications ordered in the residents' admission orders, hospital records reviewed, as well as facility's electronic and paper medical records. R111's medication regimen included three medications for high blood pressure and three medications for diabetes. Medications included: Astelin (seasonal nasal allergies) twice daily, Aricept (dementia) 10 milligrams (mg) daily, Neurontin (seizures/neuropathic pain) 300 mg daily, Glucophage (diabetes) 1000 mg twice daily, Ritalin (central nervous system stimulant) 5 mg daily, Zocor (cholesterol) 20 mg daily, Norvasc (high blood pressure) 5 mg daily, aspirin (heart attack and stroke prevention) 81 mg daily, Tenormin (high blood pressure) 50 mg daily, Glucotrol XL (diabetes)10 mg daily, Lexapro (antidepressant) 10 mg daily, Zestril (high blood	21540		

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21540	Continued From page 33 pressure) 40 mg daily, Actos (diabetes) 15 mg daily, and Flomax (prostate) 0.4 mg daily. An interview conducted with medical records staff (MR)-A on 2/15/13, at 4:00 p.m. revealed the staff was unable to locate physician orders with diagnoses for current medications. MR-A stated the facility should have called the physician or nurse practitioner for diagnoses for the medication uses upon admission. MR-A stated R111 utilized an outside physician who did not make visits at the facility. An interview conducted with nurse manager registered nurse (RN)-B on 2/15/13, at 4:05 p.m. confirmed R111's current medications did not include diagnoses. Nurse manager RN-B further indicated diagnoses for R111's medications should have been completed upon admission to the facility 12/27/12. RN-B stated the Ritalin mediation was ordered for "apathy" and the nurse planned to contact R111's physician for clarification of all medications and corresponding diagnoses. R16 received Abilify 30 mg daily (antipsychotic medication) for bipolar disorder since 4/20/10. A pharmacy review dated 5/8/12, referenced a physician review of clinical contradictions for psychotropic medication reduction. A psychiatrist progress note dated 2/5/13, indicated R16 was stable and had no symptoms of psychosis/mania, depression, or anxiety and tolerated medications well. Although monitoring for tardive dyskinesia (TD--a potential side effect resulting in involuntary, repetitive body movements) is recommended every six months, there had been no monitoring for TD since 5/31/12. R16's care plan dated 2/11/13, indicated the	21540		

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21540	Continued From page 34 resident had a potential for alteration in behaviors related to bipolar, schizoaffective, depressive disorder, altered mental status, and insomnia. "No behaviors noted at this time. Takes psychotropic medication are effective." The plan did not include the need for side effect monitoring, including for TD. RN-B explained on 2/15/13, at 2:30 p.m. that it was facility policy that the consulting pharmacist conduct TD assessments every six months. RN-B then contacted the pharmacy consultant who completed the TD assessment, but was unable to provide any documentation an assessment had been completed for R16 since 5/3/12. R329 received the antipsychotic medication Seroquel 25 mg twice daily for psychosis, paranoia, and hallucinations since 1/10/13. There was no tardive dyskinesia (TD) (a) monitoring within the first 30 days of the initiation of the medication. A pharmacy recommendation dated 1/14/13, addressed possibly discontinuing the Seroquel for paranoid delusions related to the recent addition of Remeron which could have contributed to delusions, as well as Tamiflu (to minimize flu symptoms) which could have contributed to R329's hallucinations. A subsequent physician's progress note for R329 dated 2/6/13, indicated "Alzheimers disease, no treatment...Psychosis, not hallucinating anymore. Current treatment is effective. Decrease of Seroquel may cause emotional harm. No change to tx (treatment)." R329's care plan dated 2/7/13, indicated the resident had been physically and verbally abusive	21540		

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21540	Continued From page 35 to other residents, and also wandered and rejected care. The resident had short and long term memory loss, and although displayed tearfulness and crying, had minimal signs of depression and was able to be redirected. "Takes antipsychotic and antidepressant medication." The plan lacked side effect monitoring, including for TD. The facility's policy and procedure for Tardive Dyskinesia Monitoring (policy review dated 11/12), indicated "Tardive Dyskinesia monitoring will be performed utilizing the DISCUS [Dyskinesia Identification System Condensed User Scale] assessment tool. These assessments will be completed according to the following schedule: 1) Within 30 days from the time a medication is started...." A registered nurse manager (RN)-B was unable to locate TD monitoring for R329 on 2/15/13, at 5:00 p.m. and verified the resident's care plan did not address monitoring for potential medication side effects. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could review the need for medication monitoring with the licensed staff including the State and federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects and had the appropriate diagnoses. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		

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21685	Continued From page 36	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and interview, the facility failed to ensure 2 of 3 medication rooms (first and second floors) and the therapeutic recreation floor surfaces were clean and safely maintained. This had the potential to affect approximately 58 of 167 residents residing on the first and second floor units. Findings include: Floor surfaces were not clean in the medication rooms on first and second floors, and the therapeutic recreation (TR) room. An environmental tour conducted on 2/13/13 between 10:30 and 12:30 p.m. with the director of maintenance was completed. The first and second unit medication rooms and the TR room floors had a large build up of dust, sand and paper particles. The first unit medication room had a new sink installed where sections were cut out in the sheet rock "two days ago" according to the director of maintenance. A large area of powdery substance from cutting sheet rock remained on the floor in the medication room. The second floor medication room and the TR	21685		

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21685	Continued From page 37 room had large shelving units used for storage that did not allow for clearance for cleaning under the shelving. The director of maintenance acknowledged when interviewed on 2/13/13, at 12:08 p.m. the first floor medication room sink was installed two days prior and the sheet rock powder had not been cleaned up. When interviewed on 2/13/13, at 1:00 p.m. the first and second floor housekeeper (H)-A and H-B both revealed they had so much to do each day, that medication rooms were left until the end of the day in case time ran out to finish their other work. H-A and H-B stated they needed a nurse to open the locked door of the medications rooms. H-A and H-B stated they had been told not to move anything in the medications rooms so they just cleaned the center of the floor. Both housekeepers acknowledged they were unable to clean the medication rooms the previous day, and had not had an opportunity to clean them the day of the tour. The director of housekeeping was interviewed on 2/14/13, at 2:00 p.m. and verified the flooring in the therapeutic recreation room was in need of cleaning because of a build up of sand and paper particles. Cleaning procedures for medication and TR room were requested but not received by the time of the exit conference. SUGGESTED METHOD OF CORRECTION: The director of maintenance or designee could develop and implement policies and procedures to ensure the nursing home was maintained in a safe, clean, functional, comfortable and home-like	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21685	Continued From page 38 manner. Ongoing maintenance, monitoring and record keeping to ensure the environment, including resident rooms, medication rooms, therapeutic recreation rooms and equipment are well maintained. Develop a system to audit the environment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		