DEPARTMENT OF HEAL	TH AND HUMAN	SERVICES			CENTERS FOR ME	DICARE & MEDICAID SERVICES
	MEDIO	CARE/MEDICA	ID CERTIFIC	CATION A	AND TRANSMITTAL	ID: 65E8
	PART I	- TO BE COM	PLETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00255
1. MEDICARE/MEDICAID PROVID (L1) 245289	DER NO.		DDRESS OF FACI IAL GARDENS		SING & REHABILITATION	4. TYPE OF ACTION: <u>7</u> (L8)
2.STATE VENDOR OR MEDICAID	NO.	(L4) 3245 VERA	CRUZ AVENU	E NORTH		1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 604140000		(L5) CRYSTAL	, MN		(L6) 55422	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/S	UPPLIER CATEGO	RY	<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Full Survey Arter Complaint
6. DATE OF SURVEY 03	3/31/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
0 Unaccredited 1 TJC 2 AOA 3 Othe		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILIT	Y IS CERTIFIED AS	S:		
From (a):		X A. In Compl			And/Or Approved Waivers Of The	Following Requirements:
To (b) :			Requirements nce Based On:		2. Technical Personnel	6. Scope of Services Limit
					3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	115 (L18)	1.	Acceptable POC		4. 7-Day RN (Rural SNF)	—
13.Total Certified Beds	115 (L17)	B. Not in C	ompliance with Prog	ram	5. Life Safety Code	9. Beds/Room
			s and/or Applied Wa		* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKE	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SN	IF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
115						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICABI	E SHOW LTC CAN	CELLATION DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	PPROVAL Date:
Jares Magdalene, HFE	NE II		08/25/2017	(L19)	Shellae Dietrich, Certifica	tion Specialist 09/18/2017
	PART II - TO BI	E COMPLETEI) BY HCFA RI	EGIONAI	C OFFICE OR SINGLE STA	ATE AGENCY
19. DETERMINATION OF ELIGIBI	ILITY		MPLIANCE WITH	CIVIL		cial Solvency (HCFA-2572)
X 1. Facility is Eligible	to Participate	R	IGHTS ACT:		 Ownership/Control Both of the Above 	Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Elig	-					
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	IENT	24. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTARY 00	INVOLUNTARY
11/01/1984					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	<u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		06201				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	ATE		
		02/02/2017				
	(L32)			(L33)	DETERMINATION APPR	OVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 65E8 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00255

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5289

On December 22, 2016 a survey was completed at this facility. The most serious deficiency was cited at a S/S level of G. This constituted a NOTC.

As a result of the survey findings State monitoring was imposed effective January 16, 2017. In addition, we recommended to the CMS RO the following remedy for imposition and CMS concurred:

- Civil money penalty for deficiency cited at F323

On February 14, 2017 a Life Safety Code PCR was completed and verified correction of LSC deficiencies. But, lack of verification of the health deficiencies by the 70 day, resulted in this Department recommending to the CMS RO, the following remedy for imposition and CMS concurred:

- Mandatory denial of payment for Medicare and Medicaid admissions effective March 22, 2017

If mandatory denial of payment goes into effect, the facility would be subject to the loss of NATCEP for a two year period beginning March 15, 2017.

On February 17, 2017 a health PCR was completed and three standard health deficiencies were reissued and one new standard deficiency was issued. As a result of this PCR, we recommended the following to CMS RO and they concurred:.

- State monitoring will remain in effect

- Civil money penalty cited at F323 be imposed

- Mandatory denial of payment for Medicare and Medicaid admissions effective March 22, 2017 was rescinded effective March 21, 2017

- On March 31, 2017 a second health PCR was completed and all health deficiencies were found corrected. The facility was found in substantial compliance as of March 21, 2017. As a result of this most recent PCR, we recommended the following to CMS RO and they concurred:

- State monitoring, which was imposed effective January 17, 2017, was discontinued effective March 21, 2017

- Civil money penalty cited at F323 be imposed

- Mandatory denial of payment for Medicare and Medicaid admissions effective March 22, 2017 was rescinded effective March 21, 2017

Since Mandatory denial of payment did not go into effect, the facility would not be subject to a loss of NATCEP.



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 24-5289

September 18, 2017

Mr. Ryan Chies, Administrator Centennial Gardens For Nursing & Rehabilitation 3245 Vera Cruz Avenue North Crystal, Minnesota 55422

Dear Mr. Chies:

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 21, 2017 the above facility is certified for:

115 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 115 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, Certification Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 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

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services Midwest Division of Survey and Certification Chicago Regional Office 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519



CMS Certification Number (CCN): 245289

August 25, 2017 By ePOC Only

Centennial Gardens for Nursing & Rehabilitation Attn: Administrator 3245 Vera Cruz Avenue North Crystal, MN 55422

Dear Administrator:

SUBJECT: SURVEY FINDINGS AND IMPOSITION/DISPOSITION OF REMEDIES Cycle Start Date: December 22, 2016

SURVEY RESULTS

On December 20, 2016, December 22, 2016, and February 27, 2017, Life Safety Code (LSC) Surveys and Health Surveys were completed at Centennial Gardens for Nursing & Rehabilitation by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level G, cited as follows:

• F323 -- S/S: G -- 483.25(d)(1)(2)(n)(1)-(3) – Free of Accident Hazards/Supervision/Devices

The MDH advised you of the deficiency that led to this determination and provided you with a copy of the survey reports (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES

As a result of these survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on January 11, 2017, and March 1, 2017, of the imposition of the following remedies, as well as your appeal rights:

- State Monitoring effective January 16, 2017
- Mandatory Three Month Denial of Payment for New Admissions effective March 22, 2017

Based on these survey findings, the MDH notified you they were recommending that the CMS impose an additional remedy, as follows:

• Federal Civil Money Penalty

However, before the effective date of this remedy, the MDH conducted a revisit at your facility on March 31, 2017, and found that your facility was in substantial compliance as of March 21, 2017. As a result of these survey findings, and in consideration of the results of the Informal Dispute Resolution you requested, the following remedies will not go into effect:

- Mandatory Three Month Denial of Payment for New Admissions effective March 22, 2017
- Mandatory Six Month Termination effective June 22, 2017

However, based on the period of time your facility was not in substantial compliance, the following remedies have gone into effect:

- State Monitoring effective January 16, 2017, is discontinued March 21, 2017
- Federal Civil Money Penalty, see below

The authority for the imposition of remedies is contained in §§ 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR § 488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

CIVIL MONEY PENALTY

On September 6, 2016 the Department of Health and Human Services (HHS) published an Interim Final Rule in the Federal Register which adjusts for inflation Civil Money Penalty (CMP) amounts authorized under the Social Security Act. *See* 45 CFR Part 102. In determining the amount of the CMP that we are imposing, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR § 488.404. Additionally, on July 7, 2017, CMS revised its CMP policies in S&C Memorandum 17-37-NH, effective July 17, 2017. We are imposing the following CMP in accordance with these revisions:

• Federal Civil Money Penalty of \$12,500.00 per instance for the instance of noncompliance at deficiency F323 (S/S: G) identified in the CMS-2567 survey ending December 22, 2016

The total amount of CMP imposed is \$12,500.00. If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted electronically to Mrs. Charlotte A. Hodder at Charlotte.Hodder@cms.hhs.gov within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities

- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after <u>one</u> of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, <u>in writing</u>, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification at <u>RO5LTCHearingWaivers@cms.hhs.gov</u>. **Please include your CCN and the Cycle Start Date in the subject line of your email.**

The failure to request a hearing within 60 calendar days from your receipt of this notice does <u>not</u> constitute a waiver of your right to a hearing for purposes of the 35% reduction.

CMP CASE NUMBER

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245289.
- The start date for this cycle is December 22, 2016.

CMP PAYMENT

When due, the CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services Division of Accounting Operations Mail Stop C3-11-03 Post Office Box 7520 Baltimore, MD 21207

If you use a delivery service, such as Federal Express, use the following address only:

Centers for Medicare & Medicaid Services Division of Accounting Operations Mail Stop C3-11-03 7500 Security Boulevard Baltimore, MD 21244

Note that your check <u>must</u> be sent to one of the above addresses--not to the Chicago Regional Office. If the total amount of the CMP is not received by the due date, interest will be assessed in accordance with the regulations at 42 CFR § 488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is 10.125%. The CMP, and any interest accrued after the due date, will be deducted from sums owing to you without any further notification from this office.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

This is to inform you that if you waive your right to a hearing within 60 calendar days of the receipt of this notice, the NATCEP prohibition will **not** go into effect since the reduced amount of the CMP will be less than \$10,483.00. However, if we do not receive your request to waive your right to a hearing within 60 calendar days of the receipt of this notice, the total amount of the CMP will not be reduced and the prohibition to conduct NATCEP will go into effect and remain in effect for two years from that date. Furthermore, if you request a hearing within 60 calendar days of the receipt of this notice for two years from that date. Furthermore, if you request a hearing within 60 calendar days of the receipt of this notice, the prohibition will remain in effect for two years from the date of a final administrative decision which upholds the CMP in the amount of \$10,483.00 or more. As of this date we have not received your notice of intent regarding your right to waive or request a hearing.

APPEAL RIGHTS

This formal notice imposed the following remedy:

• Federal Civil Money Penalty

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department

Page 5

of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR § 498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <u>https://dab.efile.hhs.gov/</u>. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at <u>https://dab.efile.hhs.gov/user_sessions/new</u> to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that <u>all</u> hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Nancy K. Rubenstein, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, D.C. 20201

A request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice.

INFORMAL DISPUTE RESOLUTION

You were previously advised by the State agency of the results of the informal dispute resolution (IDR) process. We have considered the IDR results in determining appropriate enforcement actions.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact Tamika J. Brown, Principal Program Representative, at (312) 353-1502 or Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Health Insurance Specialist, at (312) 353-5169. Information may also be faxed to (443) 380-6614.

Sincerely,

Sahana Sanyal Acting Branch Manager Long Term Care Certification & Enforcement Branch

 cc: Minnesota Department of Health Minnesota Department of Human Services Office of Ombudsman for Older Minnesotans Stratis Health U.S. Department of Justice, District of Minnesota

DEPARTMENT OF HEALTH AND HUM	AN SERVICES	CENTERS FOR MED	ICARE & MEDICAID SERVICES		
MEDI	CARE/MEDICAID CERTIFICATION	AND TRANSMITTAL	ID: 65E8		
PART	- TO BE COMPLETED BY THE STA	ATE SURVEY AGENCY	Facility ID: 00255		
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245289	3. NAME AND ADDRESS OF FACILITY (L3) CENTENNIAL GARDENS FOR N	URSING & REHABILITATIC	 TYPE OF ACTION: <u>2</u>(L8) Initial Recertification 		
2. STATE VENDOR OR MEDICAID NO. (L2) 604140000	(L4) 3245 VERA CRUZ AVENUE NORT (L5) CRYSTAL, MN	TH (L6) 55422	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY	<u>02</u> (L7)	 7. On-Site Visit 9. Other 8. Full Survey After Complaint 		
(L9) 03/01/2016	01 Hospital 05 HHA 09 ESRD				
6. DATE OF SURVEY 02/17/2016 ^(L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/I		09/30		
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	0750		
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:				
From (a):	A. In Compliance With	And/Or Approved Waivers Of			
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel	6. Scope of Services Limit		
	*	3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds 115 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SN			
13.Total Certified Beds 115 (L17)	X B. Not in Compliance with Program	5. Life Safety Code	9. Beds/Room		
	Requirements and/or Applied Waivers:	* Code: B	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS			
18 SNF 18/19 SNF 19 SNF	F ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)		
115					
(L37) (L38) (L39)	(L42) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLI	CABLE SHOW LTC CANCELLATION DATE)				
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:		
Glenora Souther, HFE NE II	03/20/2017	Kamala Fielda Downing	Enforcement Specialist 08/28/2017		
	(L19)		(L20)		
PART II - TO B	E COMPLETED BY HCFA REGIONA	AL OFFICE OR SINGLE S'	TATE AGENCY		
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Strnt (HCFA-1513) 			
1. Facility is Eligible to Participate	Nonits Act.	3. Both of the Above			
2. Facility is not Eligible					
(L21)		1			
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNI	NG DATE ENDING DATE	<u>VOLUNTARY</u> 00	INVOLUNTARY		
11/01/1984		01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse			
25. LTC EXTENSION DATE: 27. ALTERNA	TIVE SANCTIONS	03-Risk of Involuntary Termination	OTHER		
A. Suspens	ion of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change		
(L27) B. Bassind	(L44)		00-Active		
(L27) B. Rescind	Suspension Date:				
	(L45)				
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS			
	06201				
(L28)	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE				
(L32)	(L33)	DETERMINATION APPE	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 9, 2017

Mr. Ryan Chies, Administrator Centennial Gardens For Nursing & Rehabilitation 3245 Vera Cruz Avenue North Crystal, MN 55422

RE: Project Number S5289028

Dear Mr. Chies:

On January 11, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective January 16, 2017. (42 CFR 488.422)

Also, on January 11, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on December 22, 2016 that included an investigation of complaint number H5289051. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 17, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 10, 2017. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 22, 2016. The deficiencies not corrected are as follows:

F0225 -- S/S: D - 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals F0226 -- S/S: D - 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implment Abuse/neglect, Etc Policies F0323 -- S/S: D - 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices

In addition, at the time of this revisit, we identified the following deficiency:

Centennial Gardens For Nursing & Rehabilitation March 9, 2017 Page 2

F0282 -- S/S: D -- 483.21(b)(3)(ii) -- Services By Qualified Persons/per Care Plan

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of January 11, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 22, 2017.

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.

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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Centennial Gardens For Nursing & Rehabilitation March 9, 2017 Page 3

- 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 electronic acknowledgement signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified

Centennial Gardens For Nursing & Rehabilitation March 9, 2017 Page 4 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 June 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Centennial Gardens For Nursing & Rehabilitation March 9, 2017 Page 5

Sincerely,

Kumala Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	E SURVEY IPLETED
		245289	B. WING _			R 1 7/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	UL/	17/2017
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	{F 000	D}		
	completed on 2/16 tags that were correct CMS2567B. Tag/s t	ification revisit (PCR) was and 2/17/17. The certification ected can be found on the that were not found corrected PCR are located on the				
	signature is not req					
{F 225} SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility will be conducted to initial compliance with the en attained in accordance with 1)-(4) INVESTIGATE/REPORT DIVIDUALS	{F 22!	5}		3/21/17
	483.12(a) The facili	ty must-				
	(3) Not employ or o who-	therwise engage individuals				
		d guilty of abuse, neglect, propriation of property, or court of law;				
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or				
		ary action in effect against his license by a state licensure				
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					03/20/2017

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

		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING				ך 1 7/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	 exploitation, mistreat misappropriation of (4) Report to the Stalicensing authorities actions by a court of which would indicate nurse aide or other (c) In response to a exploitation, or mistal (1) Ensure that all at abuse, neglect, exploitation, or mistal (1) Ensure that all at abuse, neglect, exploitation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that cause abuse and do not rethe administrator of officials (including the administrator) in lor accordance with Staprocedures. (2) Have evidence the thoroughly investigation is in particulation, or mistal investigation is in particulation. 	a finding of abuse, neglect, atment of residents or resident property. ate nurse aide registry or any knowledge it has of f law against an employee, e unfitness for service as a facility staff. Illegations of abuse, neglect, reatment, the facility must: Illeged violations involving loitation or mistreatment, unknown source and resident property, are ly, but not later than 2 hours is made, if the events that n involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established that all alleged violations are ated.	{F 22	25}			

If continuation sheet Page 2 of 18

		AND HUMAN SERVICES			FOR	D: 03/20/2017 M APPROVED <u>O. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245289	B. WING	i	0	R 2/17/2017
	NAME OF PROVIDER OR SUPPLIER CENTENNIAL GARDENS FOR NURSING & REHABILITATION			3	TREET ADDRESS, CITY, STATE, ZIP CODE 245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	with State law, inclu Agency, within 5 wo if the alleged violati corrective action m This REQUIREMEN by: Based on interview facility failed to reponeglect to the admi and to investigate the residents (R43) rev the tub room when attempted to transference even though she has two staff and a med Findings include: R43's annual Minim 2/1/17, indicated Ra- required assistance (ADLs), except eati required two person bathing and that Ra- positions or walking required physical as the MDS included: muscle weakness. The corresponding Potential Care Area Worksheet dated 2 requires extensive The Falls CAA date a history of falls and injury during the qu	or her designated to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate	{F 2	25}	F225 Investigate/Report Allegations The incident involving R43 has been investigated for an alleged violation of neglect and has been reported to the State Agency (SA). Residents were reviewed for injuries and incidents that were potentially reportable Corrections have been made where necessary. The Administrator, Director of Nursing, Social Service Director and Nurse Managers will complete the Minnesota Department of Health Vulnerable Adult Mandated Reporter Training Certification by March 21, 2017. To ensure those responsible for reporting alleged violation of neglect to the State agency are operating under the same guidelines, activities that constitute abuse, neglect, exploitation, and misappropriation of resident property have been reviewed. The Administrator, Director of Nursing, Social Services Director and Nurse Managers have been enrolled and traine in the new Minnesota Department of Health Nursing Home Incident Reporting system. Facility policy regarding investigating and reporting alleged	ns d

Facility ID: 00255

If continuation sheet Page 3 of 18

CENTE STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	FORM OMB NO. (X3) DATI COM	03/20/2017 APPROVED 0938-0391 E SURVEY PLETED
		245289	B. WING			י 17/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2017
CENTEN	INIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
{F 225}	reviewed 2/8/17, inc for falls and was ob care plan indicated when leaning forwa for R43 to have ass (mechanical lift) for The NAR (nursing a (included directions 2/13/17, instructed of two staff for turni transfered using an NAR sheets also in room at all times du fall risk. A facility Incident Pot dated 2/15/17, iden The Incident Post F indicated R43 had fa and whirlpool chair. "Seems like she los lowered to the floor chair to whirlpool ch Documented root c felt weak during tra and was lowered to interventions implei use transferring der An undated hand w medication aide (TI R43's 2/15/17, fall. p.m. on 2/15/17, R and requested a sh	-		 violations has been reviewed. In we have created an Incident Rept tool and have adopted the Care of Minnesota, Abuse, Neglect, or Unexplained Injury Incident Repo Decision Tree. The tool is based CMS NF/SNF Requirements of Participation. The Administrator of designee will notify allegations of to the State Agency (SA) in a tim manner that follow facility policy, and Federal guidelines. The Administrator or designee w and audit incident reports daily x then weekly thereafter to ensure sustains compliance with State a Federal guidelines. The Administ to the Quality Assurance Commit The correction date for completion March 21, 2017. 	ort Guide Providers orting on the or neglect ely State, ill review 2 weeks, facility ind rator or monthly ttee.	

If continuation sheet Page 4 of 18

	IMENT OF HEALTH		FORM APPROVED OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
			A. BUILDI	ING			7
		245289	B. WING			02/	17/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	CENTENNIAL GARDENS FOR NURSING & REHABILITATION			-	245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	other staff were available cause she requiring the further indicates be able to stand and included, "The writter request and helped (sic) chair. As she with wheelpool (sic) chair. As she with with a she ped back to got her shower." During interview on manager (CM)-A satisfies an assist of two but and out of therapy as asys she is an assis. "There were not two her bath" and adder fall were because is therapy. One of the working with her in taking a few steps. To show the aide with During interview on director of nurses (I of the fall right away happened. I knew therapted of the care plan."	would need to wait until the ailable to help her shower ed a two person transfer. The ed R43 had insisted she would d sit on the whirlpool chair and er (sic) accepted [R43's] her to sit on the wheelpool vas pulling herself back on the ir she slided (sic) and sat she made a high voice which who came in to help. Then she the wheelpool (sic) chair and 2/17/17, at 11:00 a.m. clinical aid, "She [R43] is essentially can vary because she goes in a great deal. The care sheet st of two." CM-A also said, o staff members present for d, "The circumstances of the he has been in and out of therapy guys has been the hall and has had her She is very proud and wanted	{F 22	25}			

If continuation sheet Page 5 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245289	B. WING			२ 17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	Continued From pa were aware R43 ha time of the fall, and been followed for sa During interview on assistant (NA)-I said staff to transfer R43 chair after the fall. During interview on practical nurse (LPI to turn and two peo and sometimes mo keep her safe." The facility's policy Investigation dated will thoroughly inves or alleged abuse, n exploitation. Injuries investigated to rule policy also directed abuse or neglect to administrator, and i immediately report there was a suspici 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12	ge 5 d complained of pain at the that R43's care plan had not afe transfer. 2/17/17, at 2:15 p.m. nursing d it had taken three to four 8 from the floor back into her 2/17/17, at 2:23 p.m. licensed N)-D said, "It takes two people ple to transfer [R43] with a lift, re. I would use two people to for Abuse Reporting and 11/28/16, indicated the facility stigate all reports of suspected eglect, and financial s of unknown origin will be out potential abuse. The staff to immediately report the supervisor and the ndicated the supervisor should to the state agency (SA) if on that abuse occurred. 83.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC	{F 225 {F 226	DEFICIENCY) >} <tr< td=""><td></td><td>3/21/17</td></tr<>		3/21/17
	written policies and (1) Prohibit and pre exploitation of resid	t develop and implement procedures that: vent abuse, neglect, and ents and misappropriation of				
	resident property,					

Facility ID: 00255

If continuation sheet Page 6 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2017 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245289	B. WING	i		R 02/17/2017		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 226}	 investigate any such (3) Include training §483.95, 483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to t educates staff on- (c)(1) Activities that exploitation, and mi- property as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia ma prevention. This REQUIREMEN by: Based on interview facility failed to open prevention policy for reviewed for an alle Findings include: The facility's policy Investigation dated 	s and procedures to n allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also neir staff that at a minimum constitute abuse, neglect, sappropriation of resident n at § 483.12. or reporting incidents of abuse, n, or the misappropriation of nagement and resident abuse IT is not met as evidenced and document review, the rationalize their abuse r 1 of 3 residents (R43)	{F 2	26}	F226 Develop/Implement Abuse/Ne Policies The incident involving R43 has been investigated for an alleged violation neglect and has been reported to th State agency. Residents were reviewed for injuries incidents that were potentially repor	n of e s and		
	investigated to rule	eglect, and financial s of unknown origin will be out potential abuse. The staff to immediately report			Corrections have been made where necessary. The Administrator, Director of Nursi			

Facility ID: 00255

If continuation sheet Page 7 of 18

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN (F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			
		245289	B. WING			₹ 17/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2017
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
{F 226}	Continued From pa	ge 7	{F 226	5}		
	abuse or neglect to administrator, and i immediately report there was a suspici A facility Incident Ped dated 2/15/17, iden The Incident Post F indicated R43 had f and whirlpool chair. "Seems like she los lowered to the floor chair to whirlpool ch Documented root c felt weak during tra and was lowered to interventions impler use transferring dev An undated hand w medication aide (TN R43's 2/15/17 fall. T p.m. on 2/15/17, R and requested a sh she'd explained to busy and that R43 w other staff were ava because she requir note further indicate be able to stand an included, "The writt request and helped (sic) chair. As she w wheelpool (sic) cha down on the floor, s alarmed the nurse w	the supervisor and the ndicated the supervisor should to the state agency (SA) if on that abuse occurred. ost Fall Scene Investigation tified R43 had sustained a fall. fall Scene Investigation allen between the wheelchair Documentation included, at her balance and was during the transfer from wheel hair with assist of one." ause was indicated to be, "Leg nsfer and she lost her balance the floor." Immediate mented included: "staff were to <i>vice</i> during transfers." ritten note from tranined MA)-A included a description of The note indicated that at 7 43 had put on the call light ower. TMA-A documented R43 that the other staff were would need to wait until the ailable to help her shower ed a two person transfer. The ed R43 had insisted she would d sit on the whirlpool chair and er (sic) accepted [R43's] her to sit on the wheelpool vas pulling herself back on the ir she slided (sic) and sat she made a high voice which who came in to help. Then she the wheelpool (sic) chair and		 Social Service Director and Nurse Managers will complete the Minne Department of Health Vulnerable Mandated Reporter Training Certi by March 21, 2017. To ensure tho responsible for reporting alleged v of neglect to the State agency are operating under the same guidelin activities that constitute abuse, ne exploitation, and misappropriation resident property have been revie The Administrator, Director of Nur Social Services Director and Nurse Managers have been enrolled and in the new Minnesota Department Health Nursing Home Incident Re system. Facility policy regarding investigating and reporting alleged violations has been reviewed. In a we have created an Incident Report tool and have adopted the Care P of Minnesota, Abuse, Neglect, or Unexplained Injury Incident Report Decision Tree. The tool is based of CMS NF/SNF Requirements of Participation. The Administrator of designee will notify allegations of to the State Agency (SA) in a time manner that follow facility policy, s and Federal guidelines. The Administrator or designee will and audit incident reports daily x 2 then weekly thereafter to ensure f sustains compliance with State ar Federal guidelines. The Administr designee will report audit results r to the Quality Assurance Committ 	esota Adult fication se violations hes, eglect, of wed. sing, e d trained of porting d ddition, ort Guide roviders ting on the reglect ly State, e review 2 weeks, acility d ator or nonthly	

Facility ID: 00255

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TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY PLETED
		245289	B. WING	^	R 02/17/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2017
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION	:	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIC DATE
{F 226}	R43's annual Minim 2/1/17, indicated R4 required assistance (ADLs), except eatilized required two person bathing and that R4 positions or walking required physical as the MDS included: muscle weakness. The corresponding Potential Care Area Worksheet dated 2 requires extensive The Falls CAA date a history of falls and injury during the quithere had been car to decrease the potential Care plan reviewed 2/8/17, infor falls and was ob- care plan indicated when leaning forwa for R43 to have ass (mechanical lift) for The NAR (nursing a (included directions 2/13/17, instructed of two staff for turni- transfered using a for the state of the state of the state NAR sheets also in	ADL Functional/ Rehabilitation (ADL Functional/ Rehabilitation (ASSessment (CAA) (6/17, included: "[R43] to total assistance with ADL." (6/17, included: "[R43] to total assistance with ADL." (ADL Functional/ Rehabilitation (CAA) (6/17, included: "[R43] to total assistance with ADL." (ASSESSMENT (CAA) (CAA	{F 226}	The correction date for completion March 21, 2017.	n is	

If continuation sheet Page 9 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 226}	an assist of two but and out of therapy a says she is an assis "There were not two her bath" and adde fall were because s therapy. One of the working with her in taking a few steps. to show the aide wh During interview on director of nurses (I of the fall right away happened. I knew t present instead of t OHFC [State agence injury. We do not ha injury, even though care plan." During interview on facility's executive of were aware R43 ha time of the fall, and been followed for sa During interview on assistant (NA)-I sai staff to transfer R43 chair after the fall. During interview on practical nurse (LPI to turn and two peo	aid, "She [R43] is essentially can vary because she goes in a great deal. The care sheet st of two." CM-A also said, o staff members present for d, "The circumstances of the he has been in and out of therapy guys has been the hall and has had her She is very proud and wanted hat she could do." 2/17/17, at 11:08 a.m. the DON) stated, "I was informed y. They told me what here was only one aide wo. We did not report this to cy] because there was no ave to report falls without an the aide did not follow the 2/17/17, at 1:25 p.m. the director verified the facility staff id complained of pain at the that R43's care plan had not	{F 2;	26}			

If continuation sheet Page 10 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/20/2017 1 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245289	B. WING	i	02	n / 17/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	PERSONS/PER CA (b)(3) Comprehens The services provided as outlined by the c must- (ii) Be provided by c accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fai interventions were in residents (R43) rev in R43 falling. Findings include: An undated hand w medication aide (TM a fall R43 had sustai indicated that at 7 p on the call light and documented she'd other staff were bus wait until the other s shower because sh transfer. The note f insisted she would I whirlpool chair and accepted [R43's] ret the wheelpool (sic)	RVICES BY QUALIFIED ARE PLAN ive Care Plans led or arranged by the facility, omprehensive care plan,		282	F282 Services by Qualified Persons Per Care Plan Care plan for residents 43 has been reviewed and updated as necessary. The employee involved in the isolated incident has been provided one-on-one policy review and training regarding following the care plan. Residents throughout the facility have had their care plans and care sheets reviewed and updated as necessary. Nursing staff will be trained on the facility policy regarding following care plan interventions. The facility has revised a new program that reviews and monitors resident care plans to ensure appropriate interventions are updated when appropriate and that nursing care sheets reflect those changes. This program is in addition to	
	high voice which ala	down on the floor, she made a armed the nurse who came in vas helped back to the			updating that occurs as part of resident care and change of condition care planning. Under this program, resident	

Facility ID: 00255

If continuation sheet Page 11 of 18

		& MEDICAID SERVICES	1			0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245289	B. WING			R 02/17/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		17/2017	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORT CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 282	On 2/16/17, at 3:20 sitting in a wheelch about the fall she h evening R43 said, "	ir and got her shower." p.m. R43 was observed air in her room. When asked ad experienced the previous 'I was showing [TMA-A] I could d and lowered myself to the	F 28	2 care plans and care sheet for updating as needed at conferences and or when change in condition that w care plan change. This is addition to the care confet "care plan update review" Update Review is also con routinely at annual review	quarterly care there is a yould warrant a a purposeful rences, called . The Care Plan mpleted		
	2/1/17, indicated R4 required assistance (ADLs), except eati required two person bathing and that R4 positions or walking required physical as	num Data Set (MDS) dated 43 was cognitively intact and e with all activities of daily living ng. The MDS indicated R43 ns for physical assist with 43's balance when changing g was unstable, so R43 ssistance. R43's diagnoses on arthritis and generalized		 have revised our incident reporting form to include t Was the care plan followe the incident? Unit Nurse Managers will to audit 5% of resident ca nursing care sheets mont Managers will report audit Director of Nursing. Direct her designee will report or 	he question, d at the time of be responsible re plans and hly. Nurse data to the stor of Nursing or		
	Potential Care Area Worksheet dated 2 requires extensive The Falls CAA date a history of falls and injury during the qu	ADL Functional/ Rehabilitation Assessment (CAA) /6/17, included: "[R43] to total assistance with ADL." ed 2/6/17, included: "[R43] has d has had two falls without arter." The CAA also indicated e plan interventions developed cential for falls.		The correction date for co March 21st, 2017	uality Assurance		
	reviewed 2/8/17, inc for falls and was ob care plan indicated when leaning forwa for R43 to have ass	revised 11/11/16, and dicated R43 was at high risk bese with limited mobility. The R43 had a history of falls and interventions included sist of two staff and EZ stand all transfers, and bathing.					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/20/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED R	
		245289	B. WING			н 17/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 {F 323} SS=D	2/13/17, instructed s of two staff for turni transfered using a r NAR sheets also inc room at all times du fall risk. During interview on manager CM-A said of two but can vary of therapy a great d assist of two." CM-A staff members pres "The circumstances in and out of therap has her in the hall a very proud and wan could do." During interview on director of nurses (I of the fall right away me what happened one aide not two." During interview on executive director v complained of pain plan was not followe	for assigned duties) dated staff that R43 required assist ing and repositioning, and nechanical standing lift. The dicated two staff were to be in uring cares and that R43 was a 2/17/17, at 11:00 a.m. clinical d, "She is essentially an assist because she goes in and out eal. Care sheet says she is an A said, "There were not two ent for her bath." CM-A said, of the fall were she has been y. One of the therapy guys ind taking a few steps. She is ited to show the aide what she 2/17/17, at 11:08 a.m. the DON) stated, "I was informed /. The DON said. "They told . I knew that there was only 2/17/17, at 1:25 p.m. erified facility were aware R43 at time of fall, and that care ed for transfer.)-(3) FREE OF ACCIDENT	F 282 {F 323}			3/21/17
	The facility must en (1) The resident en	sure that - vironment remains as free rds as is possible; and				

Facility ID: 00255

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		AND HUMAN SERVICES				FORM /	APPROVED		
		& MEDICAID SERVICES					0938-0391		
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			/			F	3		
		245289	B. WING 02/17/20			7/2017			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
CENTENNIAL GARDENS FOR NURSING & REHABILITATION					3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422				
(X4) ID					(X5) COMPLETION				
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROPR		DATE		
	1		1		DEFICIENCY)				
{F 323}	Continued From pa	ge 13	{F 32	23}					
		eceives adequate supervision							
	and assistance dev	ices to prevent accidents.							
		e facility must attempt to use							
		ives prior to installing a side or side rail is used, the facility							
		t installation, use, and							
	maintenance of bec to the following eler	I rails, including but not limited nents.							
	(1) Assess the resic from bed rails prior	dent for risk of entrapment to installation.							
		and benefits of bed rails with dent representative and obtain rior to installation.							
	appropriate for the	bed's dimensions are resident's size and weight. NT is not met as evidenced							
	Based on observat	ion, interview and document			F323 Free of Accident				
		ailed to ensure interventions to prevent a fall for for 1 of 4			Hazards/Supervision/Devices				
		iewed for accidents.			Interventions have been developed				
	Findings include:				care planned to reduce the risk of f resident 43.	alls for			
	medication aide (TM a fall R43 had susta indicated that at 7 p	ritten note from tranined MA)-A included a description of ained on 2/15/17I. The note o.m. on 2/15/17, R43 had put			Residents throughout the facility we reviewed and care plans updated a needed for proper interventions reg falls.	S			
	documented she'd other staff were bus wait until the other s	requested a shower. TMA-A explained to R43 that the sy and that R43 would need to staff were available to help her e required a two person			Nursing staff will be trained on the Supervision/Intervention program a explained below by March 21st, 20				
		urther indicated R43 had			The facility has developed a new R	esident			

Facility ID: 00255

If continuation sheet Page 14 of 18

PHEFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECT CROSS-REFERENC CROSS-REFERENC DE{F 323}Continued From page 14 insisted she would be able to stand and sit on the whirlpool chair and included, "The writter (sic) accepted [R43's] request and helped her to sit on the wheelpool (sic) chair. As she was pulling herself back on the wheelpool (sic) chair she slided (sic) and sat down on the floor, she made a high voice which alarmed the nurse who came in to help. Then she was helped back to the wheelpool (sic) chair and got her shower."{F 323}A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall. The lncident Post Fall Scene Investigation indicated R43 had fallen between the wheelchair and whirlpool chair. Documentation included, "Seems like she lost her balance and was lowered to the floor during the transfer from wheel chair to whirlpool chair with assist of one." Documented not cause was indicated to be, "Leg felt weak during transfer and she lost her balance and was lowered to the floor." Immediate interventions implemented included: "staff were to use transferring device during transfers."F 323}On 2/16/17, at 3:20 p.m. R43 was observedImage and indentification of resident of and set of the staff were to use transferring device during transfers."F 323}	COMPLETED
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A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall.been identified with interventions/super implemented and a plan and nursing of Resident Supervise Checklist tool will bThe Incident Post Fall Scene Investigation indicated R43 had fallen between the wheelchair and whirlpool chair. Documentation included, "Seems like she lost her balance and was lowered to the floor during the transfer from wheel chair to whirlpool chair with assist of one." Documented root cause was indicated to be, "Leg felt weak during transfer and she lost her balance and was lowered to the floor." Immediate interventions implemented included: "staff were to use transferring device during transfers."The tool used for t to identify resident supervision needs supervision are ide implementation of this tool, nursing c identification of res for falls, interventio sitting in a wheelchair in her room. When asked about the fall she had experienced the previous evening R43 said, "I was showing [TMA-A] I couldbeen identified with interventions to identification of res for falls, interventions being developed, i communicated to a communicated to a	falls. If the resident has
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about the fall she had experienced the previous being developed, i evening R43 said, "I was showing [TMA-A] I could communicated to a	ns for preventing falls
do it myself but I slid and lowered myself to the	ppropriate staff.
	rsing or designee will
R43's annual Minimum Data Set (MDS) dated audit the Resident Supervision/Intervi	ntion Chooklist wookly
required assistance with all activities of daily living Director of Nursing	ention Checklist weekly
(ADLs), except eating. The MDS indicated R43 program to the Qu	ly thereafter. The
required two persons for physical assist with Committee.	ly thereafter. The will report on this
bathing and that R43's balance when changing	ly thereafter. The will report on this
positions or walking was unstable, so R43 The correction dat required physical assistance. R43's diagnoses on 03/21/2017.	ly thereafter. The will report on this ality Assurance

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/20/2017 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R	
		245289	B. WING	B. WING			n / 17/2017
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODI		
CENTENN	IIAL GARDENS FOR	NURSING & REHABILITATION			3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	muscle weakness. The corresponding Potential Care Area Worksheet dated 2/ requires extensive to The Falls CAA date a history of falls and injury during the qua- there had been care to decrease the pot R43's fall care plan reviewed 2/8/17, ind for falls and was ob care plan indicated when leaning forwa for R43 to have ass (mechanical lift) for The NAR (nursing a (included directions 2/13/17, instructed so of two staff for turni transfered using a r NAR sheets also ind room at all times du fall risk. During interview on manager (CM)-A sa an assist of two but and out of therapy a says she is an assis "There were not two her bath" and addee	ADL Functional/ Rehabilitation Assessment (CAA) (6/17, included: "[R43] o total assistance with ADL." d 2/6/17, included: "[R43] has d has had two falls without arter." The CAA also indicated e plan interventions developed	{F 3	23)			

Facility ID: 00255

If continuation sheet Page 16 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/20/2017 APPROVED 0938-0391
STATEMENT OF DI AND PLAN OF COF	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245289	B. WING				२ 1 7/2017
NAME OF PROVI	DER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTENNIAL	GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
work takin to si Duri dire of th hap press OHI injun care Duri facil were time bee Duri assis staf chai Duri prace Duri facil were time bee Duri assis staf chai	ng a few steps. S how the aide which ing interview on ctor of nurses (In the fall right away pened. I knew the sent instead of the FC [State agence ry. We do not have ry, even though the plan." ing interview on lity's executive do the aware R43 have of the fall, and in followed for sat ing interview on istant (NA)-I sate f to transfer R43 ir after the fall. ing interview on citical nurse (LPN urn and two peop sometimes mon p her safe." ing interview on sical therapy direct rything is right, of a for the day she of f yesterday on a	the hall and has had her She is very proud and wanted hat she could do." 2/17/17, at 11:08 a.m. the DON) stated, "I was informed 7. They told me what here was only one aide wo. We did not report this to y] because there was no ave to report falls without an the aide did not follow the 2/17/17, at 1:25 p.m. the lirector verified the facility staff d complained of pain at the that R43's care plan had not	{F 3	23}			

Facility ID: 00255

If continuation sheet Page 17 of 18

		AND HUMAN SERVICES			FORM	APPROVED
						0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
						R
		245289	B. WING _		02/	17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION					(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRC		COMPLÉTION DATE
				DEFICIENCY)		
(E 202)	O antinua d Frances		(= 00			
{F 323}	Continued From pa right."	ge 17	{F 32	3}		
	ngni.					

Facility ID: 00255

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REV	ISIT
	B. Wing	Y2	2/17/2017	Y3
NAME OF FACILITY CENTENNIAL GARDENS FOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH		
		CRYSTAL, MN 55422		

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

ITEM	DATE	ITEM			ITEM			DATE
Y4	Y5	Y4		Y5	Y4			Y5
ID Prefix F0250	Correction	ID Prefix F0280	Cor	rection	ID Prefix	F0334		Correction
Reg. # 483.40(d)	Completed	Reg. # 483.10 (3),483	(c)(2)(i-ii,iv,v) 5.21(b)(2) Con	npleted	Reg. #	483.80(d)(1)(2)		Completed
LSC	02/10/2017	LSC	02/1	0/2017	LSC			02/10/2017
ID Prefix F0441	Correction	ID Prefix	Cor	rection	ID Prefix			Correction
Reg. #	e)(f) Completed	Reg. #	Con	npleted	Reg. #			Completed
LSC	02/10/2017	LSC			LSC			
ID Prefix	Correction	ID Prefix	Cor	rection	ID Prefix			Correction
Reg. #	Completed	Reg. #	Con	npleted	Reg. #			Completed
LSC		LSC			LSC			
ID Prefix	Correction	ID Prefix	Cor	rection	ID Prefix			Correction
Reg. #	Completed	Reg. #	Con	npleted	Reg. #			Completed
LSC		LSC			LSC			
ID Prefix	Correction	ID Prefix	Cor	rection	ID Prefix			Correction
Reg. #	Completed	Reg. #	Con	npleted	Reg. #			Completed
LSC		LSC			LSC			
	EVIEWED BY NITIALS)	DATE	SIGNATURE OF SURV	/EYOR			DATE	
	GD/kfd	3/10/2017			35993		2/17/	2017
	EVIEWED BY NITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY CO 12/22/2016	OMPLETED ON	CHECK FOR UNCORREC	R ANY UNCORRECTED DTED DEFICIENCIES (C	DEFICIEN MS-2567) \$	CIES. WAS SENT TO TH	A SUMMARY OF IE FACILITY?		5 🗆 NO

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		0	DATE OF REVISI	Т
	A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	2 2	2/14/2017	Y3
NAME OF FACILITY CENTENNIAL GARDENS FOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH			
		CRYSTAL. MN 55422			

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5
	10	17	15			15
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
NFPA 101 Reg. #	Completed	Reg. # NFPA	Completed	Reg. #		Completed
LSC K0353	02/10/2017	LSC K052	3 02/10/2017	LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC				LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC				LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
		DATE	SIGNATURE OF SURVEYOR	1	DATE	
STATE AGENCY	(INITIALS) TL/kfd	3/10/2017		37009	2/14/	/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVE 12/20/2016	Y COMPLETED ON		DR ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567			5 🗆 NO



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on xxxxx, 2017.

March 9, 2017

Mr. Ryan Chies, Administrator Centennial Gardens For Nursing & Rehabilitation 3245 Vera Cruz Avenue North Crystal, MN 55422

Re: Project Number S5289028

Dear Mr. Chies:

On February 17, 2017, 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 December 22, 2016 with orders received by you electronically on January 11, 2017.

State licensing orders issued pursuant to the last survey completed on December 22, 2016 and found corrected at the time of this February 17, 2017 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on December 22, 2016, found not corrected at the time of this February 17, 2017 revisit and subject to penalty assessment are as follows:

F0830 MN Rule 4658.0520 Subp. 1Adequate And Proper Nursing Care; General	\$350.00
F1995 MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment Of Vulnerable	\$100.00
F2000 MN St. Statute 626.557 Subd. 14 (a)(c)Reporting-Maltreatment Of Vulnerable Adults	\$100.00

The details of the violations noted at the time of this revisit completed on February 17, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Centennial Gardens For Nursing & Rehabilitation March 9, 2017 Page 2

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$550.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, PO Box 64900 St Paul MN 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on February 17, 2017 an additional violation was cited as follows:

• F0565 MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use

They are delineated on the electronically delivered Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit.

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.

Centennial Gardens For Nursing & Rehabilitation March 9, 2017 Page 3

Sincerely,

Kumala Fiske Downing

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

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

Minneso	ta Department of He	alth				1 01 101	
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATION				(X3) DATE COMP	E SURVEY PLETED
		00255		B. WING			R 1 7/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REF		A CRUZ AVE , MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED SC IDENTIFYING INFOF	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments			{2 000}			
	****ATTEI	NTION*****					
	NH LICENSING	CORRECTION OI	RDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	ction order has be y. If, upon reinspe- iency or deficienci- ected, a fine for ea- be assessed in ac ines promulgated artment of Health. nether a violation h compliance with al rule provided at the ile number indicate several items, f the items will be con- Lack of complian ment of a fine eve	en issued ection, it is es cited ch violation cordance by rule of has been l ne tag ed below. ailure to considered ice upon art rule will n if the item				
	You may request a that may result from orders provided tha the Department with notice of assessme	n non-compliance t a written request hin 15 days of rece	with these is made to eipt of a				
	INITIAL COMMENT An onsite follow-up and 2/17/17. During determined that the # 570, 830, 1995, a The uncorrected or will be reviewed at t Uncorrected order/s	visit was complete this onsite visit it following correction nd 2000 were NO der/s will remain in the next onsite visit	was ons orders/s T corrected. n effect and it.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 03/20/17

Electronically Signed

STATE FORM

If continuation sheet 1 of 17

PRINTED: 03/20/2017 FORM APPROVED

	ta Department of He	(X1) provider/supplier/clia	(X2) MULTIPL	E CONSTRUCTION (X	3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		00255	B. WING		R 02/17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
CENTEN	NIAL GARDENS FOR	NURSING & REF	A CRUZ AVE , MN 55422	ENUE NORTH	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{2 000}	Continued From pa	ge 1	{2 000}		
	penalty assessmen	t.			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		3/21/17
		omprehensive plan of care personnel involved in the			
	by: Based on observati review, the facility fa interventions were i	ent is not met as evidenced on, interview and document ailed to ensure care plan mplemented for 1 of 4 iewed for accidents resulting		Corrected	
	Findings include:				
	medication aide (TM a fall R43 had sustaindicated that at 7 p on the call light and documented she'd other staff were bus wait until the other s shower because sh transfer. The note f insisted she would whirlpool chair and accepted [R43's] re the wheelpool (sic) herself back on the slided (sic) and sat	ritten note from tranined MA)-A included a description of ained on 2/15/17l. The note b.m. on 2/15/17, R43 had put requested a shower. TMA-A explained to R43 that the sy and that R43 would need to staff were available to help her re required a two person urther indicated R43 had be able to stand and sit on the included, "The writter (sic) quest and helped her to sit on chair. As she was pulling wheelpool (sic) chair she down on the floor, she made a armed the nurse who came in			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		R	
		00255	B. WING		02/17/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOF	R NURSING & REF	RA CRUZ AVE	NUE NORTH		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLET DATE
2 565	Continued From pa	age 2	2 565			
		was helped back to the air and got her shower."				
) p.m. R43 was observed air in her room. When asked				
	about the fall she h	ad experienced the previous				
		"I was showing [TMA-A] I could id and lowered myself to the				
	floor. I hurt my arm					
		num Data Set (MDS) dated				
		43 was cognitively intact and e with all activities of daily living	r			
	(ADLs), except eat	ing. The MDS indicated R43	3			
		ns for physical assist with 43's balance when changing				
	positions or walking	g was unstable, so R43				
		ssistance. R43's diagnoses on arthritis and generalized				
	muscle weakness.					
		ADL Functional/ Rehabilitation	ı			
		a Assessment (CAA) 2/6/17, included: "[R43]				
	requires extensive	to total assistance with ADL."				
		ed 2/6/17, included: "[R43] has d has had two falls without				
	injury during the qu	arter." The CAA also indicated				
	to decrease the po	e plan interventions developec tential for falls.	1			
	R43's fall care plar	revised 11/11/16, and				
	reviewed 2/8/17, in	dicated R43 was at high risk				
		bese with limited mobility. The I R43 had a history of falls				
	when leaning forwa	ard and interventions included				
		sist of two staff and EZ stand r all transfers, and bathing.				
	. , , , , , , , , , , , , , , , , , , ,	assistant registered) Sheets				
nesota De	epartment of Health		<u> </u>			

PRINTED: 03/20/2017 FORM APPROVED

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING			R 02/17/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
CENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI _, MN 55422	NUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	 (included directions 2/13/17, instructed of two staff for turni transfered using a r NAR sheets also in room at all times du fall risk. During interview on manager CM-A said of two but can vary of therapy a great of assist of two." CM-/ staff members press "The circumstances in and out of therap has her in the hall a very proud and war could do." During interview on director of nurses (I of the fall right away me what happened one aide not two." During interview on executive director v complained of pain plan was not follow. SUGGESTED MET The administrator of system to educate a system to ensure si directed by the writter of the system to ensure si directed by the wr	a for assigned duties) dated staff that R43 required assist ng and repositioning, and mechanical standing lift. The dicated two staff were to be in uring cares and that R43 was a 2/17/17, at 11:00 a.m. clinical d, "She is essentially an assist because she goes in and out leal. Care sheet says she is an A said, "There were not two sent for her bath." CM-A said, s of the fall were she has been by. One of the therapy guys and taking a few steps. She is need to show the aide what she 2/17/17, at 11:08 a.m. the DON) stated, "I was informed y. The DON said. "They told . I knew that there was only 2/17/17, at 1:25 p.m. rerified facility were aware R43 at time of fall, and that care ed for transfer. CHOD OF CORRECTION: or designee could develop a staff and develop a monitoring taff are providing care as					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		PLETED
		00255	B. WING		R 02/17/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVI _, MN 55422	ENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
{2 830}	Continued From pa	ige 4	{2 830}			
{2 830}	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	{2 830}			3/21/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observative review, the facility for were implemented residents (R43) rev Findings include: An undated hand we medication aide (The a fall R43 had sustain indicated that at 7 pon the call light and	ent is not met as evidenced ion, interview and document ailed to ensure interventions to prevent a fall for for 1 of 4 iewed for accidents. written note from tranined MA)-A included a description of ained on 2/15/17l. The note o.m. on 2/15/17, R43 had put I requested a shower. TMA-A		Corrected		
	documented she'd other staff were bus wait until the other s shower because sh transfer. The note f insisted she would	explained to R43 that the sy and that R43 would need to staff were available to help her ne required a two person urther indicated R43 had be able to stand and sit on the included, "The writter (sic)				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		COMI	E SURVEY PLETED
		00255	B. WING			R 1 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEN L, MN 55422	UE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 830}	the wheelpool (sic) herself back on the slided (sic) and sat high voice which ala to help. Then she w wheelpool (sic) cha A facility Incident Po dated 2/15/17, iden The Incident Post F indicated R43 had f and whirlpool chair. "Seems like she los lowered to the floor chair to whirlpool ch Documented root ca felt weak during trat and was lowered to interventions impler use transferring dev On 2/16/17, at 3:20 sitting in a wheelcha about the fall she ha evening R43 said, " do it myself but I slif floor. I hurt my arm. R43's annual Minim 2/1/17, indicated R4 required assistance (ADLs), except eatii required two persor bathing and that R4 positions or walking required physical as	quest and helped her to sit on chair. As she was pulling wheelpool (sic) chair she down on the floor, she made a armed the nurse who came in vas helped back to the ir and got her shower." ost Fall Scene Investigation tified R43 had sustained a fall. fall Scene Investigation allen between the wheelchair Documentation included, at her balance and was during the transfer from whee hair with assist of one." ause was indicated to be, "Leg nsfer and she lost her balance the floor." Immediate mented included: "staff were to vice during transfers." p.m. R43 was observed air in her room. When asked ad experienced the previous I was showing [TMA-A] I could d and lowered myself to the				

Minnesc	ota Department of He	alth	-			APPROVE
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00255	B. WING			R 1 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{2 830}	Potential Care Area Worksheet dated 2, requires extensive if The Falls CAA date a history of falls and injury during the qu there had been card to decrease the pot R43's fall care plan reviewed 2/8/17, ind for falls and was ob care plan indicated when leaning forwa for R43 to have ass (mechanical lift) for The NAR (nursing a (included directions 2/13/17, instructed of two staff for turni transfered using a r NAR sheets also in room at all times du fall risk. During interview on manager (CM)-A sa an assist of two but and out of therapy a says she is an assis "There were not two her bath" and adde fall were because s therapy. One of the working with her in	ADL Functional/ Rehabilitation Assessment (CAA) /6/17, included: "[R43] to total assistance with ADL." d 2/6/17, included: "[R43] has d has had two falls without arter." The CAA also indicated e plan interventions developed ential for falls. revised 11/11/16, and dicated R43 was at high risk ese with limited mobility. The R43 had a history of falls rd and interventions included sist of two staff and EZ stand all transfers, and bathing. assistant registered) Sheets for assigned duties) dated staff that R43 required assist ng and repositioning, and mechanical standing lift. The dicated two staff were to be in uring cares and that R43 was a 2/17/17, at 11:00 a.m. clinical aid, "She [R43] is essentially can vary because she goes in a great deal. The care sheet st of two." CM-A also said, o staff members present for d, "The circumstances of the he has been in and out of therapy guys has been the hall and has had her She is very proud and wanted				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			-			R	
		00255	B. WING		02/	17/2017	
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
CENTEN	NIAL GARDENS FOR		RA CRUZ AVEI L, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 830}	Continued From pa	age 7	{2 830}				
	director of nurses (of the fall right awa happened. I knew t present instead of t OHFC [State agence injury. We do not h	2/17/17, at 11:08 a.m. the DON) stated, "I was informed y. They told me what there was only one aide two. We did not report this to cy] because there was no ave to report falls without an the aide did not follow the					
	facility's executive of were aware R43 ha	a 2/17/17, at 1:25 p.m. the director verified the facility sta ad complained of pain at the I that R43's care plan had not afe transfer.	ff				
	assistant (NA)-I sai	a 2/17/17, at 2:15 p.m. nursing id it had taken three to four 3 from the floor back into her					
	practical nurse (LP to turn and two peo	n 2/17/17, at 2:23 p.m. licensed N)-D said, "It takes two people ople to transfer [R43] with a lift ore. I would use two people to	e				
	physical therapy din everything is right, would have two sta she is tired or sad i end of the day she staff yesterday on a	a 2/17/17, at 3:07 p.m. the rector said, "[R43] can if do a step, step transfer, but I off people there at this time. If t does not always work. By the can be tired. I worked with the a lift transfer it took three of us in the chair she was sitting)				
{21995}	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	{21995}			3/21/17	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SU COMPLE	
	01 001112011011		A. BUILDING	· 		
		00255	B. WING		R 02/17/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOF	NURSING & REF		ENUE NORTH		
		CRYSIA	L, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLET DATE
{21995}	Continued From pa	age 8	{21995}			
	 (a) Each facility shongoing written proplicable licensing of suspected maltrefacility has an intermandated reporter requirements of this internally. However responsible for comreporting requirements of the standard to investigate the residents (R43) revertes the tub room when attempted to transfere on though she has two staff and a mean to invest and a mean to invest and to invest and to invest the tub room when attempted to transfere on though she has two staff and a mean to include: R43's annual Mining 2/1/17, indicated R required assistance (ADLs), except eat required two persors bathing and that Repositions or walking required physical a mean to invest a mean to be a mean to the tub room when a transference includes in	I reporting of maltreatment. Aall establish and enforce an ocedure in compliance with grules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains nplying with the immediate ents of this section. ent is not met as evidenced r and document review, the ort an alleged violation of inistrator and State agency, he allegation for one of three riewed. R43 sustained a fall in a nursing assistant (NA) had fer the resident independently ad been assessed to require chanical lift for transfers.		Corrected		
		ADL Functional/ Rehabilitatior a Assessment (CAA)	1			

ND PLAN	IT OF DEFICIENCIES OF CORRECTION			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	01 001112011011		A. BUILDING:				
		00255	B. WING			R 02/17/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ENTEN	NIAL GARDENS FOF		RA CRUZ AVE	NUE NORTH			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21995}	Continued From pa	age 9	{21995}				
	requires extensive The Falls CAA date a history of falls an injury during the qu there had been car to decrease the po R43's fall care plan reviewed 2/8/17, in for falls and was ob care plan indicated when leaning forwa for R43 to have ass (mechanical lift) for The NAR (nursing (included directions 2/13/17, instructed of two staff for turn transfered using a NAR sheets also in	2/6/17, included: "[R43] to total assistance with ADL." ed 2/6/17, included: "[R43] has d has had two falls without arter." The CAA also indicated re plan interventions developed tential for falls. In revised 11/11/16, and idicated R43 was at high risk bese with limited mobility. The I R43 had a history of falls ard and interventions included sist of two staff and EZ stand r all transfers, and bathing. assistant registered) Sheets is for assigned duties) dated staff that R43 required assist ing and repositioning, and mechanical standing lift. The indicated two staff were to be in uring cares and that R43 was a					
	dated 2/15/17, ider The Incident Post I indicated R43 had and whirlpool chair "Seems like she loo lowered to the floor chair to whirlpool c Documented root of felt weak during tra and was lowered to	ost Fall Scene Investigation ntified R43 had sustained a fall. Fall Scene Investigation fallen between the wheelchair . Documentation included, st her balance and was r during the transfer from whee hair with assist of one." cause was indicated to be, "Leg ansfer and she lost her balance of the floor." Immediate mented included: "staff were to wice during transfers."	1				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COM	FLEIED	
		00255	B. WING			R 02/17/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR	R NURSING & REF	RA CRUZ AVEI	NUE NORTH			
(X4) ID	SUMMABY ST		L, MN 55422	PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
{21995}	Continued From pa	age 10	{21995}				
	medication aide (T R43's 2/15/17 fall. p.m. on 2/15/17, F and requested a sh she'd explained to busy and that R43 other staff were av because she requi note further indicat be able to stand ar included, "The writ request and helped (sic) chair. As she wheelpool (sic) cha down on the floor, alarmed the nurse was helped back to got her shower." During interview or manager (CM)-A s an assist of two bu and out of therapy says she is an assi "There were not tw her bath" and adde fall were because s therapy. One of the working with her in taking a few steps. to show the aide w	MA)-A included a description o The note indicated that at 7 A43 had put on the call light nower. TMA-A documented R43 that the other staff were would need to wait until the ailable to help her shower red a two person transfer. The ed R43 had insisted she would nd sit on the whirlpool chair and ter (sic) accepted [R43's] d her to sit on the wheelpool was pulling herself back on the air she slided (sic) and sat she made a high voice which who came in to help. Then she to the wheelpool (sic) chair and the vary because she goes in a great deal. The care sheet ist of two." CM-A also said, to staff members present for ed, "The circumstances of the she has been in and out of the the all and has had her She is very proud and wanted					
	director of nurses (of the fall right awa happened. I knew present instead of OHFC [State agen	DON) stated, "I was informed y. They told me what there was only one aide two. We did not report this to cy] because there was no ave to report falls without an					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _				
		00255	B. WING			R / 17/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR		RA CRUZ AVEI L, MN 55422	NUE NORTH			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE	
{21995}	Continued From pa	ige 11	{21995}				
	care plan."						
	facility's executive of were aware R43 ha time of the fall, and been followed for s						
	assistant (NA)-I sai	2/17/17, at 2:15 p.m. nursing d it had taken three to four 3 from the floor back into her					
	practical nurse (LP to turn and two peo	2/17/17, at 2:23 p.m. licensed N)-D said, "It takes two people ple to transfer [R43] with a lift, re. I would use two people to					
	Investigation dated will thoroughly inve or alleged abuse, n exploitation. Injuries investigated to rule policy also directed abuse or neglect to administrator, and immediately report	for Abuse Reporting and 11/28/16, indicated the facility stigate all reports of suspected eglect, and financial s of unknown origin will be out potential abuse. The staff to immediately report the supervisor and the indicated the supervisor should to the state agency (SA) if ion that abuse occurred.					
{22000}		6.557 Subd. 14 (a)-(c) Itment of Vulnerable Adults	{22000}			3/21/17	
	facility, except hom personal care atten establish and enfor	prevention plans. (a) Each e health agencies and idant services providers, shall ce an ongoing written abuse he plan shall contain an					

Minnesota Department of Health STATE FORM

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If continuation sheet 12 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00255	B. WING			R 17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEN L, MN 55422	IUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{22000}	assessment of the p environment, and its factors which may e and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, i agency and persons providers, shall dev prevention plan for residing there or ree The plan shall conta assessment of: (1) abuse by other indiv vulnerable adults; (2 other vulnerable ad specific measures t risk of abuse to that adults. For the purp term "abuse" includ (c) If the facility, e and personal care a knows that the vuln violent crime or an a toward others, the in plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Und of a vulnerable adul misconduct or phys such information fro authority or through another facility, ano	physical plant, its s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. including a home health care al care attendant services elop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the o be taken to minimize the t person and other vulnerable poses of this paragraph, the				

Minnesc	ta Department of He	alth			1 01 101	IT HOVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00255	B. WING		F 02/1	२ 7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REF	A CRUZ AVE , MN 55422	ENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{22000}	Continued From pa	ge 13	{22000}			
	by: Based on interview facility failed to ope prevention policy fo reviewed for an alle Findings include: The facility's policy Investigation dated will thoroughly inves or alleged abuse, n exploitation. Injuries investigated to rule policy also directed abuse or neglect to administrator, and i immediately report there was a suspici A facility Incident Pot dated 2/15/17, iden The Incident Post F indicated R43 had f and whirlpool chair. "Seems like she los lowered to the floor chair to whirlpool cf Documented root c felt weak during tra and was lowered to interventions impler	ent is not met as evidenced and document review, the rationalize their abuse r 1 of 3 residents (R43) gation of neglect. for Abuse Reporting and 11/28/16, indicated the facility stigate all reports of suspected eglect, and financial s of unknown origin will be out potential abuse. The staff to immediately report the supervisor and the ndicated the supervisor should to the state agency (SA) if on that abuse occurred. ost Fall Scene Investigation tified R43 had sustained a fall. fall Scene Investigation allen between the wheelchair Documentation included, of her balance and was during the transfer from wheel nair with assist of one." ause was indicated to be, "Leg nsfer and she lost her balance the floor." Immediate mented included: "staff were to vice during transfers."		Corrected		

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	 .		
		00255	B. WING			R 17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CENTEN	NIAL GARDENS FOF	NURSING & REF	RA CRUZ AVE L, MN 55422	NUE NORTH		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
{22000}	Continued From pa	age 14	{22000}			
	medication aide (TI R43's 2/15/17 fall. p.m. on 2/15/17, F and requested a sh she'd explained to busy and that R43 other staff were available because she require note further indicat be able to stand an included, "The writh request and helped (sic) chair. As she wheelpool (sic) chailable down on the floor, salarmed the nurse was helped back to got her shower." R43's annual Minin 2/1/17, indicated R required assistance (ADLs), except eat required two perso bathing and that Re positions or walking required physical a the MDS included: muscle weakness. The corresponding Potential Care Area Worksheet dated 2 requires extensive The Falls CAA date a history of falls an injury during the qu	written note from tranined MA)-A included a description o The note indicated that at 7 R43 had put on the call light nower. TMA-A documented R43 that the other staff were would need to wait until the ailable to help her shower red a two person transfer. The ed R43 had insisted she would do sit on the whirlpool chair and ter (sic) accepted [R43's] d her to sit on the wheelpool was pulling herself back on the air she slided (sic) and sat she made a high voice which who came in to help. Then she to the wheelpool (sic) chair and the wheelpool (sic) chair and a with all activities of daily living ing. The MDS indicated R43 ns for physical assist with 43's balance when changing g was unstable, so R43 ssistance. R43's diagnoses on arthritis and generalized ADL Functional/ Rehabilitation a Assessment (CAA) 2/6/17, included: "[R43] to total assistance with ADL." ed 2/6/17, included: "[R43] has d has had two falls without uarter." The CAA also indicated re plan interventions developed tential for falls.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED		
		00255	B. WING			R 02/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CENTEN	INIAL GARDENS FOR		RA CRUZ AVE L, MN 55422	NUE NORTH			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
{22000}	Continued From pa	age 15	{22000}				
	reviewed 2/8/17, in for falls and was ob- care plan indicated when leaning forwa for R43 to have ass (mechanical lift) for The NAR (nursing a (included directions 2/13/17, instructed of two staff for turn transfered using a NAR sheets also in	revised 11/11/16, and dicated R43 was at high risk bese with limited mobility. The R43 had a history of falls and and interventions included sist of two staff and EZ stand r all transfers, and bathing. assistant registered) Sheets a for assigned duties) dated staff that R43 required assist ing and repositioning, and mechanical standing lift. The idicated two staff were to be in uring cares and that R43 was a					
	manager (CM)-A sa an assist of two but and out of therapy says she is an assi "There were not two her bath" and adde fall were because s therapy. One of the working with her in	a 2/17/17, at 11:00 a.m. clinical aid, "She [R43] is essentially t can vary because she goes in a great deal. The care sheet st of two." CM-A also said, o staff members present for d, "The circumstances of the she has been in and out of the hall and has been the hall and has had her She is very proud and wanted hat she could do."	n				
	director of nurses (of the fall right awa happened. I knew t present instead of t OHFC [State agence injury. We do not he	2/17/17, at 11:08 a.m. the DON) stated, "I was informed y. They told me what there was only one aide two. We did not report this to cy] because there was no ave to report falls without an the aide did not follow the					

PRINTED: 03/20/2017 FORM APPROVED

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		BENNI IONION NOMBEN.	A. BUILDING: _				
		00255	B. WING			R 2/17/2017	
AME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
ENTEN	NIAL GARDENS FOF		RA CRUZ AVEI	NUE NORTH			
		CRYSIA	L, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE ⁻ DATE	
22000}	Continued From pa	age 16	{22000}				
	facility's executive of were aware R43 ha time of the fall, and been followed for s During interview or assistant (NA)-I sai staff to transfer R4 chair after the fall. During interview or practical nurse (LP to turn and two peo	n 2/17/17, at 1:25 p.m. the director verified the facility staff ad complained of pain at the 1 that R43's care plan had not afe transfer. n 2/17/17, at 2:15 p.m. nursing id it had taken three to four 3 from the floor back into her n 2/17/17, at 2:23 p.m. licensed N)-D said, "It takes two people ople to transfer [R43] with a lift, ore. I would use two people to					
	epartment of Health						

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVIS	SIT
	B. Wing	Y2	2/17/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
		OTTILLT ADDITEOU, OTT, OTATL, ZIL OODL		
CENTENNIAL GARDENS FOR	NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH		
		CRYSTAL, MN 55422		

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).

ITE	Μ	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20570	Correction	ID Prefix	21375	Correction	ID Prefix	21426	Correction
Reg. #	MN Rule 4658.0 Subp. 4	Completed		MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144 Subd. 3	A.04 Completed
LSC		02/10/2017	LSC		02/10/2017	LSC		02/10/2017
ID Prefix	21495	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.1 Subp. 5	005 Completed	Reg. #		Completed	Reg. #		Completed
LSC		02/10/2017	LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
REVIEWI		REVIEWED BY	DATE	SIGNATURE OF	SURVEYOR		D	ATE
STATE A		(INITIALS) GD/kfd	3/10/20	17		35993		2/17/2017
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE			D	ATE
FOLLOW 12/22/20		COMPLETED ON		CK FOR ANY UNCORRE ORRECTED DEFICIENC				YES 🗌 NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 1, 2017

Mr Ryan Chies, Administrator Centennial Gardens For Nursing & Rehabilitation 3245 Vera Cruz Avenue North Crystal, MN 55422

RE: Project Number Project Number S5289028 and Complaint Number H5289051

Dear Mr. Chies:

On January 11, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective January 16, 2017. (42 CFR 488.422)

In addition, on January 11, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

On February 14, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 20, 2017. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on December 22, 2016.

However, compliance with the health deficiencies issued pursuant to the December 22, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 22,

Centennial Gardens For Nursing & Rehabilitation March 1, 2017 Page 2

2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 22, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 22, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Centennial Gardens For Nursing & Rehabilitation is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 22, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division Centennial Gardens For Nursing & Rehabilitation March 1, 2017 Page 3

> 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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 June 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

Centennial Gardens For Nursing & Rehabilitation March 1, 2017 Page 4

dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 2, 2017

Mr. Ryan Chies, Administrator Centennial Gardens For Nursing & Rehabilitation 3245 Vera Cruz Avenue North Crystal, MN 55422

Subject: Centennial Gardens For Nursing & Rehabilitation - IDR Provider # 245289 Project # S4302

Dear Mr. Chies:

This is in response to your letter of January 19, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F323 §483.25 (d) issued pursuant to the survey event 65E811, completed on December 22, 2016.

The information presented with your letter, the CMS 2567 dated December 22, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F323 G level- 42 CFR §483.25 (d) Accidents.

The facility must ensure that resident environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

During the face-to-face IDR meeting held on March 2, 2017, the facility decided to remove their dispute of examples for R66 and R104, at F323 due to non harm citation. They only disputed R78 example at F323. The facility addressed that appropriate supervision was provided for resident R78, who fractured her hip as a result of a fall.

The facility identified that R78's care plan goals of supervision and redirection were being implemented. The facility alleges redirection included physically guiding the resident to a safe place, or away from trouble and alleged staff had been implementing this, as well as using distraction through activities, and talking to the resident to calm her down. The facility contests there was, "no foreseeability that 'walking fast' would result in a fall with injury." Staff were aware of R78's accelerated walking pace. The facility is asking to remove R78 from the tag, or reduce to D level scope and severity.

Centennial Gardens For Nursing & Rehabilitation June 2, 2017 Page 2

The 2567 identified R78 had nine falls, from February 2016 until November 2016, when she fractured her hip. Most of these falls occurred while she was walking, either in her room or in the hallway. The facility identified R78 had accelerated walking patterns, and had falls related to her gait and increased pace. The care plan interventions directed staff to, "Remind to slow down, anticipate her needs, and offer diversion of domestic task cleaning tables folding towels etc." The care plan does not mention that redirection included physical guiding the resident to safe place, or away from trouble, which is what the facility alleges staff were implementing, as well as using distraction through activities. Review of the activity logs identified R76 attended the scheduled activities, but there was no indication of what other individualized "diversional activities" could be utilized for R76 when her walking pacing accelerated.

Although the facility identified R78 had a pattern of accelerating speed with her gait, and on one occasion were observed running in the facility and fell. The facility did not complete a comprehensive assessment of her falls related to her accelerating walking pace to determine ongoing appropriate interventions to help reduce the risk of falling. R76 was last seen in physical therapy in February 2016, and had not been reassessed even though the facility identified her walking pace had accelerated.

This is a valid deficiency at this tag and at the correct scope and severity of G level, actual harm.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Grenda Lischer

Brenda Fischer, Unit Supervisor Licensing and Certification Program Health Regulation Division 3333 West Division St, Suite 212 St. Cloud, MN 56301 Telephone: 320-223-7338 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care Maria King, Assistant Program Manager Licensing and Certification File Gloria Derfus, Metro Team C Unit Supervisor

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAII) CERTIFIC	ATION A	AND TRANSMITTAL	ID: 65E8
	PART I -	TO BE COMPL	ETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00255
1. MEDICARE/MEDICAID PROVID NO.(L1) 245289	ER	3. NAME AND AD (L3) CENTENNIA			RSING & REHABILITATIO	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID (L2) 604140000	NO.	(L4) 3245 VERA ((L5) CRYSTAL, N		E NORTH	H (L6) 55422	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9) 03/01/2016	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
 6. DATE OF SURVEY 12/2 8. ACCREDITATION STATUS: 	22/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED A	AS:		
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re			2. Technical Personnel	6. Scope of Services Limit
		Compliance	Based On:		3. 24 Hour RN	7. Medical Director
12 Total Engility Pade	115 (L18)	1. Ac	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
12. Total Facility Beds		Value			5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	115 (L17)	X B. Not in Com Requirements	pliance with Progr and/or Applied W		* Code: B	(L12)
14. LTC CERTIFIED BED BREAKDC	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
115						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION D	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Barbara White, HF	E NE II	0	1/30/2017	(L19)	Kamala Fiske-Downing	Enforcement Specialist 01/31/2017 (L20)
PA	RT II - TO BE	COMPLETED B	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBIL	JTY		PLIANCE WITH TS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
 Facility is Eligible to F 	Participate	KIOII	IISACI.		3. Both of the Above	· · · · · · · · · · · · · · · · · · ·
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEM	ENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	Έ	VOLUNTARY 00	INVOLUNTARY
11/01/1984					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind S	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		06201				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

January 11, 2017

Mr. Ryan Chies, Administrator Centennial Gardens For Nursing & Rehabilitation 3245 Vera Cruz Avenue North Crystal, MN 55422

RE: Project Number S5289028 and Complaint Number H5289051

Dear Mr. Chies:

On December 22, 2016, 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. In addition, at the time of the December 22, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5289051. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

Centennial Gardens For Nursing & Rehabilitation January 11, 2017 Page 2

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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) was cited on the current survey. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective January 16, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Centennial Gardens For Nursing & Rehabilitation January 11, 2017 Page 3

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest

Centennial Gardens For Nursing & Rehabilitation January 11, 2017 Page 4

correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 22, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

Centennial Gardens For Nursing & Rehabilitation January 11, 2017 Page 5 dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

								APPROVED
		& MEDICAID SERVICES						. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCT		(E SURVEY IPLETED
		245289	B. WING _				12/	22/2016
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRES	SS, CITY, STATE, ZIP COE	ЭE		
CENTEN				3245 VERA CR	UZ AVENUE NORTH			
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		CRYSTAL, MI	N 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	DVIDER'S PLAN OF CORRI I CORRECTIVE ACTION SH REFERENCED TO THE AP DEFICIENCY)	HOULD E		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	0				
	enrolled in ePOC, y at the bottom of the	eptance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.						
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with						
F 225 SS=D	investigated and no	I)-(4) INVESTIGATE/REPORT	F 22	25				2/10/17
	(a) The facility mus	t-						
	(3) Not employ or o who-	therwise engage individuals						
		d guilty of abuse, neglect, propriation of property, or court of law;						
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or						
	or her professional body as a result of	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.						
LABORATOR	L	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURF		TITLE			(X6) DATE
	ically Signed							01/20/2017

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

PRINTED: 01/30/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION			E SURVEY PLETED
		245289	B. WING _			12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NOI CRYSTAL, MN 55422	111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 225	licensing authorities actions by a court of which would indicat nurse aide or other (c) In response to a exploitation, or mist (1) Ensure that all a abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective ser- for jurisdiction in lor accordance with Sta- procedures. (2) Have evidence to thoroughly investigat (3) Prevent further p exploitation, or mist investigation is in put (4) Report the resul administrator or his representative and with State law, inclu-	ate nurse aide registry or any knowledge it has of f law against an employee, e unfitness for service as a facility staff. Illegations of abuse, neglect, reatment, the facility must: Illeged violations involving loitation or mistreatment, unknown source and resident property, are ly, but not later than 2 hours is made, if the events that n involve abuse or result in r, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established hat all alleged violations are ated. potential abuse, neglect, reatment while the rogress. ts of all investigations to the	F 22				

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

If continuation sheet Page 2 of 59

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
ND PLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG	COM	PLETED
		245289	B. WING _		12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NOR CRYSTAL, MN 55422	ITH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 225	Continued From pa	ae 2	F 22	25		
		on is verified appropriate				
	by:	NT is not met as evidenced				
		tion, interview, and document ailed to immediately notify the		F225 Resident Supervis	sion	
	administrator, investor of mistreatment/elo	Vestigate and report allegations /elopement(s) to the State agency 2 of 4 residents (R77, R104). Resident 77 has been reviewed by a physician and care has been given as needed. Resident 104 has been review		been given as as been reviewed		
	Findings include:and screened for elopement risk and or plan has been updated.	nent risk and care				
	noted R77 to have memory impairmen assist of one for all	ta Set (MDS) dated 10/26/16, both long term and short it. In addition, R77 required activities of daily living (ADLs) of eating and R77 did not		Residents were reviewed incidents, and elopemen reportable. Corrections h where necessary.	its that were	
	11/8/16, noted R77	prehensive care plan dated 's diagnoses to include avioral disturbance and muscle		Nurses will be trained or to the shift-to-shift notific February 10th, 2017. Facility has modified the	ation form by shift-to-shift	
	R77 had a bruise to left forearm, a bruis knee. An Incident F the resident had be	te dated 12/3/16, indicated to the face, a skin tear on the se on the left wrist, and left Report dated 12/3/16, noted ten propelling himself in the		report form to trigger an notification of any injurie that may be reportable to designee. DON or desig allegations of mistreatme to the State Agency (SA)	s or elopement o the DON or nee will notify ent/elopement(s)) in a timely	
	doorway going into dated 12/10/16, ind bruise to the face a the left forearm, the	d he hit his arm on the his room. The bath skin check licated R77 noted a dark nd left wrist, and a skin tear to ere was no note of injury to the arm. A Progress Note dated		manner. Two questions to the shift-to-shift form t nurses at the end of the if an incident has occurre or elopement that should Those questions are: 1.	to prompt the shift to determine ed including injury d be reported.	
	12/18/16, at 4:00 p.	m. indicated R77 complained id could not move the arm on		elopement occurred this be reported? 2. Has an i reportable occurred this reportable incident will b	shift that should njury that is shift? Any	

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

Facility ID: 00255

If continuation sheet Page 3 of 59

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		TE SURVEY		
- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED		
	245289	B. WING		12	/22/2016		
ROVIDER OR SUPPLIER							
NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORT CRYSTAL, MN 55422	Н			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLETIO DATE		
elbow was observer approximately the s grimacing and state injured left arm had sling or wrap on the side to side and the the pillow. R77 state wrong with his arm. came to the room a yesterday." An x-ray report date had a complete frace arm bone) by the el separated by 5 milli indicated the x-ray in 12/19/16, at 10:45 p called to the physic A Progress Note at indicated R77 conti could not move the left elbow was "redow warm to touch." Registered nurse (F 12/19/16, at 4:00 p. had bumped into a had any fall. Licensed practical r on 12/20/16, at 2:15 the hospital emerge 12/20/16, to treat a "No one could tell w	d to be reddened and swollen, size of a baseball. R77 was ed, "I can't stand the pain." The I a pillow under it, there was no e arm. R77 was moving from e arm was not supported by ed he did not know what was . Nursing assistant (NA)-E and said, "He hurt his arm ed 12/19/16, indicated R77 cture of the humerus (upper bow and the bones were imeters. The progress notes results had been received on o.m. and the results were ian and the family. 6:30 a.m. on 12/19/16, nued to complain of pain, and left arm. The nurse noted the dened, a bit inflamed and RN)-A was interviewed on m. and stated the resident wall on 12/3/16, but had not	F 22	Audits of the shift-to-shift performed by the nurse m designee weekly x 4, then thereafter. The Director of report audit results month Assurance Committee.	anagers or monthly f Nursing will ly to the Quality			
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From para elbow was observe approximately the signification of the side injured left arm had sling or wrap on the side to side and the the pillow. R77 stat wrong with his arm. came to the room and yesterday." An x-ray report date had a complete frace arm bone) by the elese separated by 5 milling indicated the x-ray 12/19/16, at 10:45 p called to the physic A Progress Note at indicated R77 conting could not move the left elbow was "rede warm to touch." Registered nurse (ff 12/19/16, at 4:00 p. had bumped into and had any fall. Licensed practical red the hospital emergent 12/20/16, to treat and "No one could tell w	245289 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 elbow was observed to be reddened and swollen, approximately the size of a baseball. R77 was grimacing and stated, "I can't stand the pain." The injured left arm had a pillow under it, there was no sling or wrap on the arm. R77 was moving from side to side and the arm was not supported by the pillow. R77 stated he did not know what was wrong with his arm. Nursing assistant (NA)-E came to the room and said, "He hurt his arm yesterday." An x-ray report dated 12/19/16, indicated R77 had a complete fracture of the humerus (upper arm bone) by the elbow and the bones were separated by 5 millimeters. The progress notes indicated the x-ray results had been received on 12/19/16, at 10:45 p.m. and the results were called to the physician and the family. A Progress Note at 6:30 a.m. on 12/19/16, indicated R77 continued to complain of pain, and could not move the left arm. The nurse noted the left elbow was "reddened, a bit inflamed and warm to touch." Registered nurse (RN)-A was interviewed on 12/19/16, at 4:00 p.m. and stated the resident had bumped into a wall on 12/3/16, but had not	245289 B. WING ROVIDER ON SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 elbow was observed to be reddened and swollen, approximately the size of a baseball. R77 was grimacing and stated, "I can't stand the pain." The injured left arm had a pillow under it, there was no sling or wrap on the arm. R77 was moving from side to side and the arm was not supported by the pillow. R77 stated he did not know what was wrong with his arm. Nursing assistant (NA)-E came to the room and said, "He hurt his arm yesterday." An x-ray report dated 12/19/16, indicated R77 had a complete fracture of the humerus (upper arm bone) by the elbow and the bones were separated by 5 millimeters. The progress notes indicated the x-ray results had been received on 12/19/16, at 10:45 p.m. and the results were called to the physician and the family. A Progress Note at 6:30 a.m. on 12/19/16, indicated R77 continued to complain of pain, and could not move the left arm. The nurse noted the left elbow was "reddened, a bit inflamed and warm to touch." Registered nurse (RN)-A was interviewed on 12/219/16, at 4:00 p.m. and stated the resident had bumped into a wall on 12/3/16, but had not had any fall. Licensed practical nurse (LPN)-A was interviewed on 12/20/16, at 2:15 p.m. and stated R77 went to the hospital emergency room at lunch time on 12/20/16, to treat a left arm fracture. LPN-A said, "No one could tell what happened to the arm, it	A BUILING B. WING STREET ADDRESS, CITY, STATE, ZIF STREET ADDRESS, CITY, STATE, ZIF STREET ADDRESS, CITY, STATE, ZIF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CIT Continued From page 3 elbow was observed to be reddened and swollen, approximately the size of a baseball. RTY was grimacing and stated, "I can't stand the pain." The injured left arm had a pillow under it, there was no sling or wrap on the arm. RT7 was moving from side to side and the arm was not supported by the pillow. RT7 stated he did not know what was wrong with his arm. Nursing assistant (NA)-E carne to the room and said, "He hurt his arm yesterday." An x-ray report dated 12/19/16, indicated RT7 had a complete fracture of the humerus (upper arm bone) by the elbow and the bones were separated by 5 millimeters. The progress notes indicated the x-ray results had been received on 12/19/16, at 10:45 p.m. and the results were called to the physician and the family. A Progress Note at 6:30 a.m. on 12/19/16, indicated RT7 continued to complain of pain, and could not move the left arm. The nurse noted the left elbow was "reddened, a bit inflamed and warm to touch." Registered nurse (RN)-A was interviewed on 12/20/16, at 2:15 p.m. and stated RT7 went to the hospital emergency room at lunch time on 12/20/16, to reat a left arm fracture. LPN-A said, "No one could teil what happened to the arm, it	245289 B. WING		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245289	B. WING	i		12/2	22/2016			
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 225	reported to the nurse afternoon shift. NA- rest. NA-A stated R arm problems the w The director of nurse 12/21/16, at 9:20 a. been made to her, t a serious injury of u The DON stated a r the SA and an invest 12/20/16, at about 4 investigation was not the injury to an incide bumped into the wat experienced a chart that the appearance 12/19/16, which wat the nurse practition no known injury sind whether the fractur injury, she stated not On 12/21/16, at 10: interviewed and stat for R77 on 12/3/16, more on Monday 12 had been diagnosed that nursing was loor report to the SA had 12/20/16. He stated not new. NP-D was interview and stated she saw R77 had an acute in not move the arm.	day, and that he (NA-A) had se on 12/18/16, during the A said R77 remained on bed 77 was up and about with no veek before. Sing (DON) was interviewed on m. and stated no report had the administrator or the SA of inknown origin until 12/20/16. report had been submitted to stigation was initiated on 4:00 p.m The DON stated the ot complete but she attributed dent on 12/3/16, when R77 all. She confirmed R77 had nge in pain on 12/18/16, and e of the arm changed on s subsequently checked by er (NP). She stated there was ce 12/3/16. When asked re was considered a new	F	225						

Facility ID: 00255

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	12/3/16 due to the s felt the fracture was know the cause how determined when the The facility policy for Investigation dated will thoroughly invest or alleged abuse, ne exploitation. Injuries investigated to rule The policy directed abuse or neglect to administrator. The s report to the state a suspicion that abus R104's care plan da had limited physica use his walker, and going out of the bui 9/29/16, noted R100 impairment and was diagnoses of hepati with ascites and rec care plan also inclu indicated R104 was supervision with sm designated area. F 10/8/16, included "C Review of R104's P following entries: O member (F)-B "had [transitional care un (RN)-B] to report th cab yesterday and va asked R104 for the	severity of the fracture. She is a new injury and did not wever, stated it could not be he fracture occurred. or Abuse Reporting and 11/28/16, indicated the facility stigate all reports of suspected eglect, and financial is of unknown origin will be out potential abuse. staff to immediately report the supervisor and the supervisor should immediately igency (SA) if there was a	F 2	225			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245289	B. WING _			12/2	22/2016			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 225	[grocery store] for s she sticking her nos people.' Gave him r floor and then he sa is on a plaque in the p.m. "Writer noticed is not in his room. S family member carr [R104] on first floor. the smoking area a [R104] was not ther "Resident was repot this morning by the [sic] about 350 meter went to get him back and insisted that her redirected several ti and kept on walking Staff called the facil After about 10 minut then talked to him a Vital signs were cor denied having pain noted at the time m administered and a initiated. All parties gave new orders for out with [family]. Sta monitor the residen A care conference r R104 and family red required supervision medical record and evidence of any acc regarding R104 mis	e. Cab was ok. Went to Cub ome fruit and stuff. Why is se in? Why is she calling names of men working on 1st aid 'The one who's [sic] name e front.''' On 11/19/16, at 6:13 d at 1800 res [resident - R104] South nurse told writer that a ne to visit and went with res . Writer checked on 1st floor, nd front of the building res re. On 12/16/16, at 2:04 p.m. orted to be walking on the road staff along vera cruz ave n ers from the facility. Writer ek to the facility but he refused a was going to cub he was ime back but still he refused g with the walker towards 36th. lity who in turn called 911. utes, the police arrived who and he accepted to comeback. mpleted see vital section he no SOB [shortness of breath] orning medication 15 minutes check was were notified hospice nurse r see orders. He is currently aff will cont. [continue] to	F 22	25						

If continuation sheet Page 7 of 59

				APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES	1		OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION		E SURVEY PLETED			
245289	B. WING		12/2	22/2016			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
CENTENNIAL GARDENS FOR NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422					
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE			
PRÉFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)F 225Continued From page 7RN-A was interviewed on 12/20/16, at 3:12 p.m. who confirmed she called police on 12/16/16, when R104 went outside of the facility. RN-A indicated R104 can be "totally wonderful one moment and then confused, and he was confused on this morning, it took police another 10 minutes to talk him into coming back here." RN-A indicated R104 was discovered missing during morning rounds around 6:30 a.m. RN-A stated LPN-C was the nurse working and searched the building after R104 was valking down the road and LPN-C went outside to redirect R104 into the building. LPN-C could not redirect R104 and called RN-A from his cell phone. RN-A then called the police who were able to bring R104 back into the building. When R104 was back in the building, the facility began every 15 	F 2	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION			
facility at any other time and not familiar with the 11/19/16, Progress Note entry. RN-A stated she did not complete a wandering assessment for R104. RN-A stated "this one little trip outside the building was not an elopement; he had a destination" and further indicated the incident "really was not dangerous in any way." The DON was interviewed on 12/20/16, at 3:30 p.m. The DON stated R104 "goes for walks and							

If continuation sheet Page 8 of 59

	VIDER OR SUPPLIER L GARDENS FOR SUMMARY STA	IDENTIFICATION NUMBER: 245289 NURSING & REHABILITATION	A. BUILDIN B. WING _	NG	CO	MPLETED	
(X4) ID PREFIX	L GARDENS FOR		B. WING _				
(X4) ID PREFIX	L GARDENS FOR	NURSING & REHABILITATION			12/22/2016		
(X4) ID PREFIX	SUMMARY STA	NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COL	θE		
PREFIX				3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 225 Co	ontinued From pag	ge 8	F 22	25			
		and smokes." The DON did quired supervision for					
sm	oking. The DON	stated R104 was dressed weather on 12/16/16, and					
Ri	04 was not confu	ised. The DON confirmed cility grounds when he was					
foi	und by staff on 12	2/16/16, and she did not					
		nt an elopement. The DON 4 has been trying to go out					
an	d smoke and she	did not think R104 had a they had tried on in the past					
bu	t staff keep a rea	lly close eye on him. The DON					
wa	indering assessm	ment assessment or ent had not been completed					
		l there was a difference and going for a walk. The					
DC	ON further confirm	ned R104 was not on the rd list and stated "he shouldn't					
be	, he goes out all t	he time." The DON further					
		the right to wander and incident was not reported					
		t view the incident as an as found immediately by staff.					
Th	e DON defined a	n elopement a "someone who					
	s a wanderGuard und."	d but is gone, and cannot be					
		1 p.m. LPN-C was					
wo	orking on 12/16/16	stated he was the nurse 6, and during morning report a					
		nber who had left for the the the facility and stated R104					
wa	as outside on the	street. LPN-C confirmed no 04 had left the building.					
LF	N-C then went ou	utside the facility to bring R104					
		ted it was freezing outside dressed in a coat and had					
sh	oes on and was a	approximately 300 meters PN-C stated he was unable to					

If continuation sheet Page 9 of 59

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	D. 0938-039 TE SURVEY MPLETED			
				ING					
		245289	B. WING			2/22/2016			
	PROVIDER OR SUPPLIER	NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETIO DATE			
F 225	to call police. LPN-0 persuaded R104 ba gave both R104 and facility. LPN-C state they returned to the and F-B. LPN-C state every 15 minute cha any other time R10- unsupervised. LPN- how long R104 had RN-B was interview who stated she new F-B on 11/8/16. RN office and asked he a cab to Cub Foods unaware of that and DON about what wa F-B. RN-B stated sl further regarding th RN-A. RN-B was not the facility unsuperview aware of the 12/16/ working at the time The director of soci interviewed on 12/2 12/22/16, at 2:23 p. leave from the facili of the incident and a reporting the incide was not reported bas the resident and he safely and appropri- vacation during the know if R104 actua familiar with any oth	the building and called RN-A C stated police arrived and ack into the building and police d LPN-C a ride back to the ed he assessed R104 when facility and updated Hospice ated they then implemented ecks. LPN-C was unaware of 4 had left the building -C stated he was unaware at							

If continuation sheet Page 10 of 59

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING		12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	at 1:04 p.m. The ad notified on 12/16/16 understanding staff was walking down t followed him outside confirmed the incide stated the DON was she had told him sh situation. The admin aware of what an el	vas interviewed on 12/21/16, Iministrator stated he was 5, R104 was outside and to his had let him out front and he he side walk and a nurse e. The administrator ent was not reported and s aware of the incident and he had taken care of the nistrator confirmed he was lopement was and if that was	F 225	5		
	reported. The admir regarding the 11/8/1 he did not tell the R leave the facility. Th if R104 left the facili	to him it would have been nistrator was interviewed 16, Progress Note and stated 104 that he could call a cab to he administrator was unaware ity. The administrator was not 18/16, Progress Note or				
	investigate and reporesidents." The politic departing individual or Charge Nurse shares b. Notify the Attendic c. Notify the Attendic c. Notify the resider incident; d. Complete and file and e. Document the every record."	ident for injuries; ng Physician; nt's legal representative of the e Report of Incident/Accident; rent in the resident's medical				
F 226 SS=D		33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC	F 226	5		2/10/17

Facility ID: 00255

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		AND HUMAN SERVICES				FORM	01/30/2017 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		245289	B. WING			12/3	22/2016	
_	PROVIDER OR SUPPLIER	NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 226	 written policies and (1) Prohibit and pre exploitation of resideresident property, (2) Establish policies investigate any suce (3) Include training §483.95, 483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to t educates staff on- (c)(1) Activities that exploitation, and mi property as set forth (c)(2) Procedures for neglect, exploitation resident property (c)(3) Dementia ma prevention. This REQUIREMENT by: Based on observation 	t develop and implement procedures that: vent abuse, neglect, and lents and misappropriation of es and procedures to h allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum constitute abuse, neglect, isappropriation of resident h at § 483.12. or reporting incidents of abuse, n, or the misappropriation of unagement and resident abuse NT is not met as evidenced tion, interview, and document ailed to operationalize their olicy for 2 of 4 residents (R77,	F	226	F226 Resident Investigations Any investigations or related conceregarding resident 77 and resident have been reviewed by the Interdisciplinary Team (IDT) and cl	104		

Facility ID: 00255

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY	
ID PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	COMPLETED	
		245289	B. WING _		12/2	22/2016	
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
ENTEN	INIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NOR CRYSTAL, MN 55422	TH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 226	Continued From pa	age 12	F 22	26			
	The facility policy for Investigation dated will thoroughly inve- suspected or allege financial exploitatio will be investigated The policy directs se abuse or neglect to administrator. The report to the state as suspicion that abuse R77's Minimum Da noted R77 to have memory impairmer assist of one for all with the exception of ambulate. The com 11/8/16, noted R77 dementia with behave weakness. R77's Progress No R77 had a bruise to left forearm, a bruis knee. An Incident F the resident had be wheelchair and said doorway going into dated 12/10/16, ind bruise to the face a the left forearm, the left elbow or upper	or Abuse Reporting and 11/28/16, indicated the facility stigated all reports of ed abuse, neglect, and n. Injuries of unknown origin to rule out potential abuse. staff to immediately report to the supervisor and the supervisor should immediately agency (SA) if there was a		 out. Both residents have their physicians and any obeen resolved. Care plan and resident 104 have be updated as necessary. Residents with investigati past 30 days that may be now been reviewed and r Nursing staff will be in-se February 10th, 2017 on the incident/accident reporting below to ensure timely re As a function of IDT, a re - of incidents/investigation a designated monitor indi- resident, the date, descrip- incident, and the status of investigation. The design be responsible to track and appropriate team member of the incident/investigation establish timeframes rega- completion and complian reporting and investigation of incident (e.g. serious in origin, resident-to-resider alleged resident abuse.). Administrator or his design monitoring log weekly x 4 the program has been op it functioning appropriated continue monthly thereaft 	concerns have is for resident 77 een reviewed and ions over the incomplete have resolved. erviced by he new ig program stated porting. cord – new form ns will be kept by icating the ption of the f the case under ated monitor will nd notify ers of completion on. IDT will arding ce for timely ing for each type njury of unknown nt incident, gnee will audit the t to ensure that berationalized and ly. Audits will		

Facility ID: 00255

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	PLETED	
		245289	B. WING		12/	22/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR	R NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 226	his room laying in l elbow was observe approximately the grimacing and stat injured left arm had sling or wrap on th side to side and the the pillow. R77 stat wrong with his arm came to the room yesterday." An x-ray report dat had a complete frat arm bone) by the else separated by 5 mil indicated the x-ray 12/19/16, at 10:45 called to the physic A Progress Note at indicated R77 cont could not move the left elbow was "rec warm to touch." Registered nurse (12/19/16, at 4:00 p had bumped into a had any fall. Licensed practical on 12/20/16, at 2:1	age 13 I on 12/19/16, at 2:00 p.m. in his bed. The resident's left ed to be reddened and swollen, size of a baseball. R77 was ed, "I can't stand the pain." The d a pillow under it, there was no e arm. R77 was moving from e arm was not supported by ted he did not know what was h. Nursing assistant (NA)-E and said, "He hurt his arm ted 12/19/16, indicated R77 acture of the humerus (upper elbow and the bones were limeters. The progress notes results had been received on p.m. and the results were cian and the family. t 6:30 a.m. on 12/19/16, tinued to complain of pain, and e left arm. The nurse noted the idened, a bit inflamed and RN)-A was interviewed on o.m. and stated the resident a wall on 12/3/16, but had not	F 224		on is		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	On 12/20/16, at 3:2 and stated R77 had the left arm on Sum reported to the nurs afternoon shift. NA- rest. NA-A stated R arm problems the w The director of nurs 12/21/16, at 9:20 a. been made to her, t a serious injury of u The DON stated a n the SA and an inves 12/20/16, at about 4 investigation was not the injury to an incid bumped into the wa experienced a char that the appearance 12/19/16, which wa the nurse practition no known injury sim whether the fractur injury, she stated not On 12/21/16, at 10: interviewed and sta for R77 on 12/3/16, more on Monday 12 had been diagnose that nursing was loo report to the SA had 12/20/16. He stated not new.	0 p.m. NA-A was interviewed I complained of severe pain in day, and that he (NA-A) had se on 12/18/16, during the A said R77 remained on bed 77 was up and about with no veek before. Sing (DON) was interviewed on m. and stated no report had the administrator or the SA of inknown origin until 12/20/16. report had been submitted to stigation was initiated on 4:00 p.m The DON stated the ot complete but she attributed dent on 12/3/16, when R77 II. She confirmed R77 had nge in pain on 12/18/16, and e of the arm changed on s subsequently checked by er (NP). She stated there was ce 12/3/16. When asked re was considered a new	F 2	226			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	not move the arm. S cannot imagine that 12/3/16 due to the s felt the fracture was know the cause how determined when the R104: An undated elopern investigate and repor- residents." The poli departing individual or Charge Nurse sh "a. Examine the resider incident; d. Complete and file and e. Document the ev- record." R104's care plan da had limited physical use his walker, and going out of the bui 9/29/16, noted R104 impairment and was diagnoses of hepati with ascites and rec care plan also inclu indicated R104 was supervision with sm designated area. R 10/8/16, included "C Review of R104's P	She stated medically she t was from an injury on severity of the fracture. She is a new injury and did not wever, stated it could not be ne fracture occurred. Hent policy included "staff shall ort all cases of missing cy further indicated when a returns to the facility the DON hall: sident for injuries;	F2	226			

		AND HUMAN SERVICES				FORM	: 01/30/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245289	B. WING			12/	/22/2016
	PROVIDER OR SUPPLIER	NURSING & REHABILITATION		3	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	family member (F)- mgr [transitional ca Nurse (RN)-B] to re shopping by cab ye This writer asked R stated the following honcho. Talked abc ok. Went to Cub [gr stuff. Why is she st calling people.' Gav on 1st floor and the name is on a plaqu 6:13 p.m. "Writer no R104] is not in his r that a family memb res [R104] on first f floor, the smoking a res [R104] was not p.m. "Resident was road this morning b n [sic] about 350 m went to get him bac and insisted that he redirected several t and kept on walking Staff called the faci After about 10 minu then talked to him a Vital signs were con denied having pain noted at the time m administered and a initiated. All parties gave new orders fo out with [family]. Sta monitor the residen	B "had called 1st floor/TCU re unit/manager -Registered port that R104 had gone sterday and was staff aware. (104 for the details and he 'Talked to 1st floor male but rides available. Cab was rocery store] for some fruit and icking her nose in? Why is she ve him names of men working on he said 'The one who's [sic] e in the front."' On 11/19/16, at oticed at 1800 res [resident - oom. South nurse told writer er came to visit and went with loor. Writer checked on 1st area and front of the building there. On 12/16/16, at 2:04 a reported to be walking on the by the staff along vera cruz ave eters from the facility. Writer ex to the facility but he refused a was going to cub he was ime back but still he refused g with the walker towards 36th. lity who in turn called 911. utes, the police arrived who and he accepted to comeback. mpleted see vital section he no SOB [shortness of breath] forning medication .15 minutes check was were notified hospice nurse r see orders. He is currently aff will cont. [continue] to	F2	226			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	· /	TE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	COMPLETED	
		245289	B. WING		12	2/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTEN	NIAL GARDENS FOF	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 226	Continued From pa	age 17	F 22	6			
	medical record and evidence of any ac regarding R104 mis	n out of the building. R104's I facility documentation lacked cident/incident reports ssing from the facility on ssing on 11/19/16 or R104's					
	who confirmed she when R104 went of indicated R104 car moment and then of confused on this m 10 minutes to talk H RN-A indicated R10 during morning rou stated licensed pra nurse working and R104 was not in his someone outside th was walking down outside to redirect F cell phone. RN-A th able to bring R104 R104 was back in t every 15 minute ch hospice, the NP an	ved on 12/20/16, at 3:12 p.m. e called police on 12/16/16, utside of the facility. RN-A n be "totally wonderful one confused, and he was orning, it took police another nim into coming back here." 04 was discovered missing nds around 6:30 a.m. RN-A ctical nurse (LPN)-C was the searched the building after s room. RN-A indicated he building alerted staff R104 the road and LPN-C went R104 into the building. LPN-C R104 and called RN-A from his hen called the police who were back into the building. When the building, the facility began lecks and updated family, d the DON. RN-A indicated the ing to the SA and believed the					
	incident was report 11/8/16, Progress I the facility in a cab not occur. RN-A sta call a cab and inter occurred. RN-A wa missing from the fa familiar with the 11,	ed. When asked about the Note which indicated R104 left , RN-A stated the incident did ated staff knew he wanted to vened before anything s not familiar with R104 acility at any other time and not /19/16, Progress Note entry. d not complete a wandering					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ae 18	F 2	26			
	trip outside the build had a destination" a	ding was not an elopement; he and further indicated the not dangerous in any way."					
	p.m. The DON state goes out every day not know if R104 re smoking. The DON appropriately for the R104 was not confu R104 was not confu R104 was not on fa found by staff on 12 consider the incider went on to say R10 and smoke and she WanderGuard, but but staff keep a rea confirmed an elope wandering assessm for R104 and stated between going out a DON further confirm facility WanderGuan be, he goes out all indicated R104 had confirmed again the because she did no elopement as he wa The DON defined a has a WanderGuar found." On 12/21/16, at 3:2 interviewed. LPN-C working on 12/16/11 night shift staff mer morning, returned to	viewed on 12/20/16, at 3:30 ed R104 "goes for walks and and smokes." The DON did equired supervision for stated R104 was dressed e weather on 12/16/16, and used. The DON confirmed cility grounds when he was 2/16/16, and she did not nt an elopement. The DON 4 has been trying to go out e did not think R104 had a they had tried on in the past Ily close eye on him. The DON ment assessment or nent had not been completed d there was a difference and going for a walk. The ned R104 was not on the rd list and stated "he shouldn't the time." The DON further the right to wander and e incident was not reported by view the incident as an as found immediately by staff. In elopement a "someone who d but is gone, and cannot be 1 p.m. LPN-C was stated he was the nurse 6, and during morning report a nber who had left for the o the facility and stated R104 street. LPN-C confirmed no					

Facility ID: 00255

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		-	245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	LPN-C then went of back in. LPN-C stat however R104 was shoes on and was a from the building. L persuade R104 into to call police. LPN-C persuaded R104 ba gave both R104 and facility. LPN-C state they returned to the and F-B. LPN-C state they returned to the any other time R104 unsupervised. LPN- how long R104 had RN-B was interview who stated she nev F-B on 11/8/16. RN- office and asked he a cab to Cub Foods unaware of that and DON about what wa F-B. RN-B stated sh further regarding the RN-A. RN-B was not the facility unsuperv aware of the 12/16/ working at the time The director of soci interviewed on 12/2 12/22/16, at 2:23 p. leave from the facility of the incident and a reporting the incider	04 had left the building. utside the facility to bring R104 ed it was freezing outside dressed in a coat and had approximately 300 meters PN-C stated he was unable to the building and called RN-A C stated police arrived and tack into the building and police d LPN-C a ride back to the ed he assessed R104 when facility and updated Hospice tted they then implemented ecks. LPN-C was unaware of 4 had left the building -C stated he was unaware at	F2	226			

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		AND HUMAN SERVICES			FORM	01/30/2017 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		245289	B. WING		12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTEN	INIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226 F 250 SS=D	the resident and he safely and approprivacation during the know if R104 actual familiar with any oth missing or left the f The administrator w at 1:04 p.m. The action notified on 12/16/16 understanding staff was walking down t followed him outsid confirmed the incide stated the DON was he had told him sh situation. The admin aware of what an e what had been told reported. The admin regarding the 11/8/1 he did not tell the R leave the facility. Thi f R104 left the facil familiar with the 11/ incident. 483.40(d) PROVISI RELATED SOCIAL (d) The facility mus social services to a practicable physical well-being of each of This REQUIREMEN by: Based on observation	was returned to the facility ately. DSS stated she was on week of 11/8/16, and did not lly left the facility. DSS was not her time R104 had been acility without supervision. was interviewed on 12/21/16, dministrator stated he was 5, R104 was outside and to his had let him out front and he she side walk and a nurse e. The administrator ent was not reported and s aware of the incident and he had taken care of the nistrator confirmed he was lopement was and if that was to him it would have been nistrator was interviewed 16, Progress Note and stated 104 that he could call a cab to he administrator was unaware ity. The administrator was not 18/16, Progress Note or NOF MEDICALLY SERVICE t provide medically-related ttain or maintain the highest l, mental and psychosocial	F 226		t for	2/10/17

Facility ID: 00255

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		SURVEY
	of Connection	IDENTIFICATION NUMBER.	A. BUILDIN	NG	COIVIE	
		245289	B. WING _		12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 250	Continued From pa	ge 21	F 25	50		
	reviewed who requi	red a specialized wheel chair nd remain out of bed.		Resident 78 has received the medi necessary equipment per physician orders.		
	 Findings include: R78's significant change Minimum Data Set (MDS) assessment dated 11/25/16, indicated she was severely cognitively impaired, required extensive assist of two staff for bed mobility, toileting, and personal hygiene and did not transfer or ambulate. R78's care plan dated 12/7/16, indicated a self-care deficit and dependence on staff related to a hip fracture resulting in bed rest. A review of a Physician's Order dated 12/12/16, indicated an order for a tilt-in-space Broda Chair due to a hip fracture. 			Residents were reviewed for any physician ordered medically neces equipment or supplies to ensure compliance. All associated needs to been satisfied. Staff will be trained on the new poli procedure regarding the Fast Trac Resident Equipment and Supplies Requisition Program for obtaining medically necessary equipment an supplies that can't be obtained immediately in the facility. This pro explained below.	nave icy and k	
	Progress Notes dat indicated the follow - 12/12/16 - Has ne - 12/13/16 through shift for hip fracture - 12/20/16 - Reside party on unit. During continuous of 2:20 p.m., R78 was common area of the holiday party was b party continued with and presents for ea remained in bed an Music could be hea hall. At 3:10 p.m., F	lursing and Rehabilitation ed 12/12 through 12/20/16, ing: w orders for Broda chair. 12/19/16 - Broda chair, every , on order or not available. nt was in bed during holiday observation on 12/20/16, at lying awake in her bed. In the e adjoining unit, a resident eginning. At 2:33 p.m. the n live music, a visit from Santa ich resident. At 2:47 p.m., R78 d was observed to be awake. rd from the party down the R78 continued to lay awake in nued to lay awake in her bed		To ensure timely procurement of m necessary equipment or supplies, f facility has updated the policy and procedure to ensure compliance. T facility has initiated a program nam Fast Track Resident Equipment an Supplies Requisition Program. If pl ordered medically necessary equip or supplies can't be immediately su by the facility, nursing staff will fill of Fast Track requisition form and giv the Administrator or designee. The Administrator or designee will then on procuring in a reasonable perior time the medically necessary equip or supplies ordered by the physicial physician ordered medically neces equipment or supplies will be track designated calendar to ensure time	the The ned the nd hysician oment upplied out a re it to n work d of oment n. The sary ed on a	

Facility ID: 00255

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING _			12/2	22/2016
	PROVIDER OR SUPPLIER	NURSING & REHABILITATION		32	REET ADDRESS, CITY, STATE, ZIP CODE 245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	registered nurse (R bed rest and that the looking into a chair ordered by the physi in the facility so the one. During an interview physical therapist (I department was su chair for R78. Durin therapy director sta chair last week, wh R78 from bed rest. During an interview director of nursing (ordering the Broda During an observat Broda chair was av The DON stated du 12/21/16, at 11:06 at to find a vendor tha R78 as a rental. Sh only require the chair facility did not want to purchase one. The first ordered the chair than twenty four ho ordered. R78 had re while waiting for the activities including the activities	on 12/20/16, at 3:11 p.m., N)-D stated R78 had been on e therapy department was for her. She stated the chair sician was not readily available y had to either rent one or buy on 12/20/16 at 3:17 p.m., PT)-A stated the nursing pposed to be ordering a Broda og the same interview the ted she'd recommended the en the physician had released on 12/20/16, at 7:44 a.m., the (DON) stated she was chair for R78 that day. ion on 2/21/16, at 7:44 a.m., a ailalble for use in R78's room. tring a follow up interview on a.m., that she had been trying t could provide the chair for e stated because R78 would air for about a month, the to spend two thousand dollars ne DON acknowledged she'd	F 2	50	Administrator, entering the date the requisition was received from staff date the item was received. The Interdisciplinary Team will audi program including reviewing the Administrators Fast Track calendar weekly x 4 and monthly thereafter. Administrator will report to the Qua Assurance Committee monthly on to program. The correction date for compliance February 10th, 2017.	and the t the The lity this	

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		AND HUMAN SERVICES			-	: 01/30/201 APPROVEI . 0938-039	
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SU COMPLE		
		245289	B. WING _		12	/22/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NOR CRYSTAL, MN 55422	TH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 250	Continued From pa	ige 23 in a timely manner.	F 25	50			
F 000	A facility policy rega up on Physician's C received.	arding timeliness of following Orders was requested but not	For			0/10/17	
F 280 SS=D	483.10(c)(2)(1-11,17, PARTICIPATE PLA 483.10)(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 28	30		2/10/17	
	(c)(2) The right to p and implementation	participate in the development of his or her person-centered ing but not limited to:					
	including the right to be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to nd the right to request son-centered plan of care.					
	expected goals and amount, frequency,	icipate in establishing the d outcomes of care, the type, and duration of care, and any d to the effectiveness of the					
	(iv) The right to rec included in the plan	eive the services and/or items of care.					
		the care plan, including the gnificant changes to the plan					
	right to participate i	nall inform the resident of the n his or her treatment and sident in this right. The nust					
	(i) Facilitate the inc	lusion of the resident and/or					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245289	B. WING			12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			45 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa resident representa (ii) Include an asses	-	F 28	30			
		resident's personal and					
	483.21	s in developing goals of care.					
	(b) Comprehensive	e care plan must be-					
		7 days after completion of					
	(ii) Prepared by an i includes but is not li	nterdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	se with responsibility for the					
	(C) A nurse aide wit resident.	h responsibility for the					
	(D) A member of for	od and nutrition services staff.					
	the resident and the An explanation mus medical record if the and their resident re	acticable, the participation of e resident's representative(s). It be included in a resident's e participation of the resident epresentative is determined he development of the					
	(F) Other appropria	te staff or professionals in					

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM /	01/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (X:	,	E SURVEY PLETED
		245289	B. WING	i		12/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	or as requested by (iii) Reviewed and r team after each ass comprehensive and assessments. This REQUIREMEN by: Based on observat review, the facility fa interventions for 3 d who had a change Findings include: R77's Minimum Dat noted R77 to have memory impairmen assist of one for all with the exception of ambulate. The com 11/8/16, noted R77' dementia with beha weakness. R77 had not included on the comprehensive car how to care for the R77 was observed his room with the le baseball, and redde completed of the ar stated, "I can't stand arm was not support	mined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced tion, interview, and document ailed to revise care planned of 4 residents (R77, R78, R66) in care needs. ta Set (MDS) dated 10/26/16, both long term and short t. In addition, R77 required activities of daily living (ADLs) of eating and R77 did not prehensive care plan dated s diagnoses to include wioral disturbance and muscle d an injury to the arm that was care plan. The e plan lacked interventions on injured left arm. on 12/19/16, at 2:00 p.m. in ft elbow swollen the size of a ened. An x-ray was just m. R77 was grimacing and d the pain." The injured left rted in the bed nor was it in a	F	280	F280 Updating Resident Care Plans Care plans for residents 77, 78, 66 ha been reviewed and updated as neces Residents throughout the facility have their care plans reviewed and updated necessary. Nursing staff and other facility person involved in care plan updating will be trained on the new program explained below by February 10th, 2017. The facility has created a new program review and monitor resident care plan ensure appropriate interventions are revised when appropriate. This is a ne program in addition to updating that occurs as part of resident care plans be reviewed for updating as needed a quarterly care conferences and or wh there is a change in condition that wo warrant a care plan change. This is a purposeful addition to the care	e had d as inel d m to ns to ew nder s will at ien juld	
	wrong with his arm.	e did not know what was Nursing assistant (NA)-E Ind said, "He hurt his arm			conferences, called "care plan update review". The Care Plan Update Revie also to be done routinely at annual reviews.		

Facility ID: 00255

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245289	B. WING _		12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CENTEN	NIAL GARDENS FOF	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 26	F 28	0		
	on 12/20/16, at 2:1 the hospital emerge 12/20/16, to treat a "No one could tell v started on Sunday" - At 3:20 p.m. NA-A R77 had complained arm on Sunday (12) remained on bedree him to have R77 ref The NA Care Sheed any direction to keed arm, and did not m The director of nurs 12/21/16, at 9:20 a should be updated care needs. She ver been updated since on 12/18/16. The x complete fracture of R78's MDS dated 1 independent with a one staff assistanc significant change she was severely of extensive assist of toileting, and perso transfer or ambulat (CAA) dated 11/28/ based on an actual	A was interviewed and stated ed of severe pain in the left 2/18/16) afternoon shift, and st. NA-A stated the nurse told		Unit Nurse Managers will be to audit 5% of resident care p monthly. Nurse Managers will data to the Director of Nursin of Nursing or her designee w this program routinely to the n Quality Assurance Committee The correction date for comp February 10th, 2017	lans I report audit g. Director ill report on monthly e.	

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
			A. DOILDII	<u>.</u>			
		245289	B. WING _			12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION					
					RYSTAL, MN 55422		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
			ľ		· · · · ·		
F 280	Continued From pa	qe 27	F 28	30			
	fall.						
		nial Gardens for Nursing and - (Skilled Nursing facility)					
		ng with correlating Incident					
		estigation Tools indicated R78					
		between 2/5/16 and 2/22/16. I on 1/18/16, resulted in a					
		e plan dated 12/7/16, identified					
	the following fall inte	erventions: 1/23/15 - fall					
		licy, 1/23/15 - anticipate and needs, 1/23/15 - the resident					
		onment, 1/29/16 - offer					
	diversional activities	s, 1/29/16 - proper footwear					
		1/20/16 - check and change					
		esident every two hours. The clude any new interventions					
	after 4/20/16, even	though R78 sustained four					
	more falls including	a fall with a fracture.					
	During an interview	on 12/21/16, at 2:05 p.m.,					
	NA-B stated R78 ha	ad a history of falls but she					
		nany. She stated she used to					
		e unit. NA-B further stated she ny fall prevention interventions					
	and stated she was						
		on 12/21/16, at 2:19 p.m., N)-D stated when a resident					
	falls, the nurse on d						
	management report	t. She stated the nurse will put					
	an immediate interv	vention in place.					
	During an interview	on 12/21/16, at 2:37 p.m., the					
	DON stated when F	R78 fell, "It wasn't a surprise."					
		ked very fast and did not taff told her to slow down. The					
		ere reviewed by a fall					
		ed the fall committee was					

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		AND HUMAN SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245289	B. WING			12/;	22/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTER	INIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	"trying" to meet ever committee looks at to determine cause interview at 3:12 p.1 no review of R78's minutes and stated this week." R66 was observed the top of nose and 12/19/16, at 12:28 p noted on the face. I myself shaving." During observation was observed comi fresh blood on the r said, "It is just from blood. It will go awa shaving." Surveyor assistant of R66's b observed in dining off R66's face. The 1.5 cm longitudinal R66's quarterly MD R66 had moderate required assistance MDS indicated R66 hemiplegia and atri beat) on chronic Co The ADLs Function dated 7/8/16, indica dressing grooming up and supervision completed." Staff w	age 28 ery two months. She stated the the incident reports and tries s of falls. During a subsequent m., the DON stated there was fall history in the falls meeting "we were going to look at her in hallway with an abrasion on one on the side of nose on o.m. Traces of blood were R66 said, "I am okay I just cut on 12/21/16, at 7:27 a.m. R66 ing out of his room. There was right side of chin and jaw. R66 shaving and wiped at the ay soon. I just cut myself notified unknown nursing bleeding. At 8:13 a.m. R66 room, blood had been washed re was a 1 centimeter (cm) to cut on right side of the jaw. S dated 10/5/16, indicated cognitively impaired and e with personal hygiene. R66's S's had diagnoses of dementia, al fibrillation (irregular heart burnadin (blood thinner). /Rehabilitation Potential CAA ated R66 required, "Assist with and personal hygiene with set to ensure tasks have been were to continue with current tor for decline in self-care.	F	280			

	-	AND HUMAN SERVICES			FORM	APPROVED	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY	
		245289	B. WING _		12/:	22/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	Continued From pa	ge 29	F 28	30		E COMPLÉTION	
	had altered status in decision making an care plan instructed with shaving. The c 10/7/16, indicated F risk for bruising and nursing assistants t urine or pad tarry st discolorations prolo or lab draw sites. Th report to medical do family bruises and s care plan did not ad bleeding risks while on R66's safety to s	revised 7/15/15, indicated R66 n ADLs related to alteration in id thought process. The ADL d staff, R66 was independent eardiac care plan revised R66 was on Coumadin and at d bleeding and instructed to observe and report blood in tools, bruises skin ong bleeding from nose, gums he nurses were instructed to octor or nurse practitioner and symptoms of bleeding. The ddress how to minimize e shaving, effect of hemiplegia shave self with a disposable ventions for staff to take to					
	12/22/16, indicated - On 11/12/16, R66 from right thumb. Si antibiotic cream and indicated R66 states trying to shave. Will - On 12/5/16, R66 w on head with a sma indicated staff clear R66 not to use razo note, "[R66] stated i himself. Writer [sic] drawers as well. Wi - On 12/19/16, prog noted to have blood dining room for lund cleaned and two sp	s Notes from 11/1/16, to was noted to be bleeding staff cleaned area applied triple d a band-aid. The note d," to have injured self from I continue to be monitored." was noted to have scratches all amount of bleeding. Note ned up the area and warned or on his own. Per progress it was a result of him shaving took all razors from his ill continue to be monitored." gress note indicated, "Resident d to nose when walking to the ch. Resident's nasal was bots noted like from a scratch. I not know how it happened.					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		СОМ	PLETED
		245289	B. WING			12 /:	22/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 245 VERA CRUZ AVENUE NORTH		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	Will continue to mol- On 12/21/16, prog noted to have blood Scratches noted to idea where it came monitored." The 3rd Floor NA sl indicated R66 was i During interview on said, "I do not upda Managers do." During interview on said, "I do not have have seen regular r razors as he reques During interview on manager (NM)-A sa sometimes. We hav it. He sometimes us verified the care pla to prevent bleeding During interview on said, "for residents staff need to be awa electric razors not th resident, and notify problems. This sho assignment sheet."	nitor." Iress note indicated, "Resident I to his cheek this morning. the area. Resident stated no from. Will continue to be heets dated 12/13/16, independent with shaving. 12/21/16, at 2:19 p.m. RN-A te the care plan the Nurse 12/21/16, at 2:34 p.m. NA-G any idea who shaves him. I azors in his room. I give him sts, the plastic ones." 12/21/16, at 2:37 p.m. nurse aid, "He scratches himself ve an electric razor if he wants ses a regular razor." NM-A an lacked specific interventions with ADL's. 12/22/16, at 10:37 a.m. RN-E who are on blood thinners the are of bleeding risk, use he hand razors to shave a the nurse if there are any uld be on the care plan and	F 2	80			

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CC	MPLETED
		245289	B. WING _		12	2/22/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 280	Continued From pa	-	F 28	80		
	 disappear." When informed of the Progress Notes and observations of R66 the DON said, "We will buy him his own electric razor. This is the first time I have heard about this. I expect the staff to chart at the time of the event. We should have done something the first time he cut himself." DON stated when there was a change in a resident's ability to do something the care plan should be reviewed and revised if needed. A facility policy titled Care Planning - Interdisciplinary team, Superior Healthcare Management Minnesota Region, undated, was reviewed. The policy indicated a comprehensive care plan is developed within seven days of the completion of the resident's assessment. The 					
F 323 SS=G	483.25(d)(1)(2)(n)(HAZARDS/SUPER (d) Accidents. The facility must er (1) The resident en	sure that - vironment remains as free	F 32	23		2/10/17
	(2) Each resident re	rds as is possible; and eceives adequate supervision ices to prevent accidents.				
	appropriate alterna bed rail. If a bed of must ensure correct	e facility must attempt to use tives prior to installing a side or side rail is used, the facility t installation, use, and d rails, including but not limited ments.				
	(1) Assess the resident from bed rails prior	dent for risk of entrapment to installation.				

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		AND HUMAN SERVICES			FORM	01/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· · /	E SURVEY PLETED
		245289	B. WING _		12/22/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 32	F 32	3		
	()	s and benefits of bed rails with dent representative and obtain rior to installation.				
	appropriate for the This REQUIREMEN by: Based on observat review, the facility fi interventions to red residents (R78) rev actual harm for R78 resulting from a fall to provide adequate resident (R104) rev facility failed to sup safety related to us Findings include: R78 was observed	uce the risk of falls for 1 of 3 iewed for falls. This resulted in 3 who sustained a fracture . In addition, the facility failed e supervision for 1 of 1 iewed for elopements and the ervise 1 of 1 resident (R66) for e of a disposable razor.		F323 Supervision and Intervention Residents Interventions have been developed care planned to reduce the risk of resident 78. Interventions for ade supervision were developed and planned to reduce the risk of elop for resident 104. Resident 66 was reassessed for appropriate Interv regarding adequate supervision f shaving. Resident 66's care plan been updated. Residents throughout the facility reviewed and care plans updated needed for proper	ed and f falls for quate care bement s entions or safe has were	
	registered nurse (R rest following a frac R78's significant ch (MDS) dated 11/25/ severely cognitively assist of two staff for personal hygiene a ambulate. A previou indicated R78 had b ambulation and req	on 12/20/16, at 3:11 p.m., N)-D stated R78 was on bed sture of her right hip. ange Minimum Data Set (16, indicated she was rimpaired, required extensive or bed mobility, toileting, and nd did not transfer or us MDS dated 10/4/16, been independent with uired only one staff assistance as of daily living. R78's care		interventions/supervision regarding elopement, and shaving. Nursing staff will be trained on the Supervision/Intervention program explained below by February 10th The facility has developed a new Supervision/Intervention program identifies residents that are at risl elopement, and safe shaving. Th Resident Supervision/Intervention program will utilize the Resident	e as n, 2017. Resident that < for falls, e	

Facility ID: 00255

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		(X1) PROVIDER/SUPPLIER/CLIA					
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	PLETED
		245289	B. WING			12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ae 33	F 3	23			
	plan dated 12/7/16, due to cognitive def fracture had been s result of a fall. The anticipate her need slow down and ens on hold due to bed (CAA) dated 11/28/ based on an actual R78 was at modera A review of R78's P corresponding Incic Investigation Tools 11/15/16, and ident - On 2/15/16, Progr observed on the ea her stomach. The or indicated R78 was by night shift. The in review indicated a r R78 tasks such as to re-direct had bee - On 2/22/16, Progr walking very fast in fell onto left side. Th report indicated R77 close observation. indicated staff were when walking too fa - On 3/1/16, Progre the floor and landed corresponding incic helped to a chair ar position. The IDT re result included to en chair.	indicated a potential for falls ficit and identified a right hip sustained on 11/15/16, as a care plan directed staff to s, offer diversion, reminders to ure proper foot wear (currently rest.) A Area Assessment 16, identified a risk for falls fall on 11/15/16, and indicated the risk for falls. Progress Notes and dent Post Fall Scene were reviewed from 2/5/16 to ified the following falls: ess Note indicated R78 was st hallway floor lying flat on correlating incident report helped to bed and monitored nterdisciplinary team (IDT) new intervention of offering folding washcloth or cleaning		23	Supervision Checklist tool to identify residents that are or may be at risk appropriate interventions can be implemented. New admissions will be screened and assessed when nece for risks related to falls, elopement, safe shaving, utilizing the Resident Supervision Checklist tool. If the res has been identified with a fall, elope or safe shaving risk, appropriate interventions/supervision will be implemented and reflected in the ca- plan. The Resident Supervision/Intervention Checklist to be initiated in the event of resident of condition and or an applicable ind that relates to falls, elopements, or as shaving. The tool used for this prog- designed to identify residents at risk falls, elopements, or safe shaving supervision needs, then, intervention supervision are identified, followed be implementation of the supervision intervention. Using this tool, nursing be assured of identification of reside these (3) areas, interventions for supervision being developed, and implemented. The Director of Nursing or designed audit the Resident Supervision/Intervention Checklist v x 4 and then monthly thereafter. The Director of Nursing will report on this program to the Quality Assurance Committee. The correction date for completion i	so be ssary and sident ement are ool will change cident safe ram is c for ns for by g can ents in e will veekly e s	

Facility ID: 00255

IAIEMENI	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
		245289	B. WING		12	/22/2016
NAME OF I	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE
F 323	Continued From pa	age 34	F 323			
	corresponding incid immediately put on medication was adu the fall was not con - On 4/8/16, progre found on the floor a station lying on her later was found sitti corresponding incid immediately brough An IDT review of th - On 4/22/16, a note R78 had multiple fa walking. The recom for staff to continue - On 5/13/16, Progr found sitting on the immediate interven advise R78 to use If the fall was not con - On 7/8/16, a note R78 had experienc related to rapid pace evidence the IDT h causative factors o - On 7/16/16, progr found on the floor in The corresponding immediate interven The IDT review por not completed. - On 10/28/16, Prog following a loss of the	dent report indicated she was a one to one and pain ministered. An IDT review of npleted. ss note indicated R78 was at 9:00 a.m. by the nurse's left side and again an hour ing on the floor. The dent report indicated she was at closer to the nursing station. the incident was not completed. to labeled IDT Note indicated alls related to pacing/fast mended intervention included to re-direct prn (as needed). ress Note indicated R78 was floor in her room. The tion implemented was to her call light. An IDT review of npleted. labeled IDT note, indicated ed two falls without injury ce of wandering. There was no ad evaluated or assessed				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/;	22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	 On 11/16/16, Progresults had been calorders received to a for non-operative fractorresponding Incid IDT review was compuring an interview mursing assistant (Nof falls but she was stated R78 used to NA-B further stated prevention intervem During an interview registered nurse (R has a fall, the nurse management report an immediate interventhe IDT reviews fall an MDS but does n fall. During an interview director of nursing (wasn't a surprise." fast and does not u to slow down. The I reviewed by a fall committee was "tryimonths. She stated incident reports and factors of the falls." concerns about a p with the nurse management and the falls. 	ress Note indicated x-ray alled in to the physician and keep R78 at the care center acture care. The lent Report form indicated no	F3	323			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		245289	B. WING		12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	falls since February interview at 3:12 p.r no review of R78's f minutes and stated this week." During an interview medical director (M R78's fall history. Th changes in the facil be re-invigorated. H to review falls was r fall program went at An undated facility p and Their Causes w included: "Falls are and mortality amon homes." The policy identify possible or policy further indica include appropriate future falls. While R78 sustaine There was no evide falls since March of of interventions to p injury. Further, the f February and March however, R78 was a and the DON indica understand the dire R104's care plan da had limited physical	as an awareness of R78's nine of 2016. During a subsequent n., the DON verified there was fall history in the falls meeting "we were going to look at her on 12/22/16, at 1:30 p.m., the D) stated he was aware of ne MD stated, with all the ity, the falls program needs to le stated the person who used no longer at the facility and the way when she left. oolicy titled Assessing Falls vas reviewed. The policy a leading cause of morbidity g the elderly in nursing directed staff to begin to try to likely causes of the fall. The ted documentation should interventions taken to prevent d multiple falls in the facility. nce the facility reviewed the 2016. There was no evidence revent future falls or to reduce acility initiated interventions in n that included reminders, severely cognitively impaired ted she was unable to	F 323			
	use his walker, and					

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245289	B. WING		1	000/0016
NAME OF I	PROVIDER OR SUPPLIER	210200		STREET ADDRESS, CITY, STATE, ZIP CO	-	2/22/2016
		NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETIO DATE
F 323	impairment and wa diagnoses of hepat with ascites and rec care plan also inclu indicated R104 was supervision with sm designated area. F 10/8/16, included "C Review of R104's P following entries: O member (F)-B "had [transitional care un that R104 had gone and was staff aware the details and he s 1st floor male honc available. Cab was store] for some fruit her nose in? Why is him names of men he said 'The one wh in the front." On 11 noticed at 1800 res room. South nurse member came to vi on first floor. Writer smoking area and f was not there. On 1 "Resident was repo this morning by the [sic] about 350 met went to get him bac and insisted that he redirected several t and kept on walking Staff called the faci	ge 37 4 had severe cognitive s admitted to the facility with a ic failure, cirrhosis of the liver ceived hospice services. The ded a date of 9/30/16, which s a smoker who required noking in the outside R104's Physician Orders dated DK for WanderGuard." Progress Notes included the n 11/8/16, at 5:54 p.m. family called 1st floor/Tcu mgr nit/manager -RN-B] to report e shopping by cab yesterday e. This writer asked R104 for stated the following 'Talked to ho. Talked about rides ok. Went to Cub [grocery t and stuff. Why is she sticking s she calling people.' Gave working on 1st floor and then ho's [sic] name is on a plaque /19/16, at 6:13 p.m. "Writer [resident - R104] is not in his told writer that a family sit and went with res [R104] checked on 1st floor, the ront of the building res [R104] 2/16/16, at 2:04 p.m. orted to be walking on the road staff along vera cruz ave n ers from the facility. Writer ck to the facility but he refused g with the walker towards 36th. lity who in turn called 911. utes, the police arrived who	F3	323		

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	<mark>). 0938-039</mark> TE SURVEY MPLETED		
		BERTHIOMION NON BEN.		ING				
		245289	B. WING			2/22/2016		
	PROVIDER OR SUPPLIER	NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 323	then talked to him a Vital signs were co denied having pain noted at the time m administered and a initiated. All parties gave new orders fo out with [family]. St monitor the resider A care conference R104 and family re required supervisio medical record and evidence of any act regarding R104 mis 12/16/16, R104 mis leave on 11/7/16. T evidence of a comp R104's risk for pote RN-A was interview who confirmed she when R104 went or indicated R104 can moment and then o confused on this m 10 minutes to talk h RN-A indicated R10 during morning rou stated licesned pra nurse working and R104 was not in his someone outside th R104 was walking went outside to red LPN-C could not re from his cell phone	and he accepted to comeback. mpleted see vital section he no SOB [shortness of breath] norning medication 15 minutes check was were notified hospice nurse r see orders. He is currently aff will cont. [continue] to nt." note dated 11/17/16, indicated ceived re-clarification R104 n out of the building. R104's I facility documentation lacked cident/incident reports ssing from the facility on ssing on 11/19/16 or R104's he medical record also lacked orehensive assessment of	F 3	23				

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		AND HUMAN SERVICES				FORM	: 01/30/2017 APPROVED . 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION		TE SURVEY MPLETED
		245289	B. WING	i		12	/22/2016
	PROVIDER OR SUPPLIER	NURSING & REHABILITATION		3	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	building. When R10 the facility began ev updated family, hos RN-A indicated the SA and believed the asked about the 11 indicated R104 left stated the incident staff knew he wante before anything occ with R104 missing time and not familia Note entry. RN-A st wandering assessm "this one little trip of elopement; he had indicated the incide in any way." The DON was inter p.m. The DON state goes out every day not know if R104 re smoking. The DON appropriately for the R104 was not confit R104 was not on fa found by staff on 12 consider the incider went on to say R10 and smoke and she WanderGuard, but but staff keep a rea confirmed an elope wandering assessm for R104 and stated between going out DON further confirm	Age 39 24 was back in the building, very 15 minute checks and spice, the NP and the DON. DON did the reporting to the e incident was reported. When /8/16, Progress Note which the facility in a cab, RN-A did not occur. RN-A stated ed to call a cab and intervened curred. RN-A was not familiar from the facility at any other ar with the 11/19/16, Progress tated she did not complete a nent for R104. RN-A stated utside the building was not an a destination" and further int "really was not dangerous viewed on 12/20/16, at 3:30 ed R104 "goes for walks and and smokes." The DON did equired supervision for 1 stated R104 was dressed e weather on 12/16/16, and used. The DON confirmed toility grounds when he was 2/16/16, and she did not int an elopement. The DON 4 has been trying to go out e did not think R104 had a they had tried on in the past ally close eye on him. The DON ment assessment or nent had not been completed d there was a difference and going for a walk. The ned R104 was not on the rd list and stated "he shouldn't	F	323	3		

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION		D. 0938-039 TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		IG) ´cc	MPLETED
		245289	B. WING _		12	2/22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
CENTEN	INIAL GARDENS FOF	R NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 323	be, he goes out all indicated R104 had confirmed again th because she did no elopement as he w The DON defined a has a WanderGuan found." On 12/21/16, at 3:2 interviewed. LPN-C working on 12/16/1 night shift staff men morning, returned to was outside on the staff was aware R1 LPN-C then went of back in. LPN-C sta however R104 was shoes on and was from the building. L persuade R104 inter to call police. LPN- persuaded R104 built	age 40 the time." The DON further d the right to wander and e incident was not reported of view the incident as an vas found immediately by staff. an elopement a "someone who rd but is gone, and cannot be 21 p.m. LPN-C was C stated he was the nurse 6, and during morning report a mber who had left for the to the facility and stated R104 street. LPN-C confirmed no 104 had left the building. butside the facility to bring R104 ated it was freezing outside s dressed in a coat and had approximately 300 meters .PN-C stated he was unable to o the building and called RN-A C stated police arrived and ack into the building and police and LPN-C a ride back to the	F 32	23		
	they returned to the and F-B. LPN-C sta every 15 minute ch any other time R10 unsupervised. LPN how long R104 had The director of soc interviewed on 12/2 12/22/16, at 2:23 p	ed he assessed R104 when e facility and updated Hospice ated they then implemented becks. LPN-C was unaware of 04 had left the building I-C stated he was unaware at d been outside. ial services (DSS) was 21/16, at 8:42 a.m. and on .m. regarding R104's 12/16/16, lity. DSS stated she was aware				

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		AND HUMAN SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		-	245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	was not reported be the resident and he safely and appropri vacation during the know if R104 actua familiar with any oth missing or left the fa R104's F-B was inte p.m. F-B stated she outside on 12/16/16 observed R104 was was found walking facility. F-B stated F it does not alwasy v and was not sure if sounded. F-B stated other time unsuperv when he went to Cu facility staff contact them the administra cab and leave. F-B administrator had g leave in a cab. RN-B was interview who stated she nev F-B on 11/8/16. RN office and asked he a cab to Cub Foods unaware of that and DON about what was F-B. RN-B stated sh further regarding th RN-A. RN-B was no the facility unsuperv aware of the 12/16/	age 41 ecause there was no harm to e was returned to the facility ately. DSS stated she was on week of 11/8/16, and did not Illy left the facility. DSS was not her time R104 had been acility without supervision. erviewed on 12/21/16, at 12:43 e was informed of R104 being 5, and stated she was told staff s gone from the facility and up the path outside of the R104 had a Wanderguard but work when he has a coat on the wandergaurd had d R104 had left the facility one vised, probably in November, ub Foods in a cab. F-B stated ed her and had said R104 told ator told R104 he could call a did not believe that the given permission for R104 to ved on 12/21/16, at 12:06 p.m. ver received a call from R104's I-B stated F-B stopped in her er if she had heard R104 left in s yesterday. RN-B was d contacted RN-A and the as told to her about R104 from he did not hear anything the situation from the DON or ot aware of R104 ever leaving vised. RN-B stated she was '16, incident however, was not the incident occurred.	F 3	23			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245289	B. WING _			12/:	22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	The administrator w at 1:04 p.m. The ad notified on 12/16/16 understanding staff was walking down t followed him outsid confirmed the incide stated the DON was she had told him sh situation. The admin aware of what an el what had been told reported. The admin regarding the 11/8/7 he did not tell the R leave the facility. Th if R104 left the facil	ge 42 vas interviewed on 12/21/16, ministrator stated he was 5, R104 was outside and to his had let him out front and he he side walk and a nurse e. The administrator ent was not reported and s aware of the incident and he had taken care of the nistrator confirmed he was opement was and if that was to him it would have been nistrator was interviewed 16, Progress Note and stated 104 that he could call a cab to he administrator was unaware ity. The administrator was not 18/16, Progress Note or	F 3	23			
	the top of nose and 12/19/16, at 12:28 p	in hallway with an abrasion on one on the side of nose on o.m. Traces of blood were R66 said, "I am okay I just cut					
	was observed comi fresh blood on the r said, "It is just from blood. It will go awa shaving." Surveyor assistant of R66's b observed in dining r off R66's face. The	on 12/21/16, at 7:27 a.m. R66 ng out of his room. There was ight side of chin and jaw. R66 shaving and wiped at the y soon. I just cut myself notified unknown nursing leeding. At 8:13 a.m. R66 room, blood had been washed re was a 1 centimeter (cm) to cut on right side of the jaw.					

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PI		APPROVED
		& MEDICAID SERVICES					0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245289	B. WING			12/;	22/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>	
CENTEN	INIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 43	F 3	23			
	R66's quarterly Min 10/5/16, indicated F impaired and requir hygiene. R66's MDS diagnoses of deme fibrillation (irregular Coumadin (blood th The ADLs Function dated 7/8/16, indicat dressing grooming up and supervision completed." Staff w care plan and moni The ADL care plan had altered status in decision making an care plan instructed with shaving. The c 10/7/16, indicated F risk for bruising and nursing assistants t urine or pad tarry st discolorations prolo or lab draw sites. Th report to medical do family bruises and s care plan did not ac bleeding risks while on R66's safety to s razor, or other inter prevent bleeding. Review of Progress 12/22/16, indicated - On 11/12/16, R66	imum Data Set (MDS) dated R66 had moderate cognitively red assistance with personal S indicated R66's had ntia, hemiplegia and atrial heart beat) on chronic hinner). /Rehabilitation Potential CAA ated R66 required, "Assist with and personal hygiene with set to ensure tasks have been rere to continue with current tor for decline in self-care. revised 7/15/15, indicated R66 n ADLs related to alteration in d thought process. The ADL d staff, R66 was independent ardiac care plan revised R66 was on Coumadin and at d bleeding and instructed to observe and report blood in tools, bruises skin ong bleeding from nose, gums he nurses were instructed to octor or nurse practitioner and symptoms of bleeding. The ddress how to minimize e shaving, effect of hemiplegia shave self with a disposable ventions for staff to take to					

Facility ID: 00255

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PRINTED: 01/30/2017

		AND HUMAN SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/:	22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	antibiotic cream and indicated R66 state trying to shave. Wil - On 12/5/16, R66 v on head with a sma indicated staff clear R66 not to use razo note, "[R66] stated himself. Writer [sic] drawers as well. Wi - On 12/19/16, prog noted to have blood dining room for lund cleaned and two sp Resident stated did Will continue to mo - On 12/21/16, prog noted to have blood Scratches noted to idea where it came monitored." The unlabeled Cou 12/9/16, R66's INR recheck INR on 12/ indicated R66 was Tuesday Thursday The 3rd Floor NA st indicated R66 was During interview on registered nurse (R blood on his nose. I and washed it off at asked him, where of	d a Band-Aid. The note d," to have injured self from l continue to be monitored." was noted to have scratches all amount of bleeding. Note ned up the area and warned or on his own. Per progress it was a result of him shaving took all razors from his ill continue to be monitored." gress note indicated, "Resident d to nose when walking to the ch. Resident's nasal was bots noted like from a scratch. I not know how it happened. nitor." gress note indicated, "Resident d to his cheek this morning. the area. Resident stated no from. Will continue to be madin flow sheet indicated on was 1.9 and staff were to (23/16. The flow sheet also on Coumadin 4 milligrams /ednesday, Friday and to receive Coumadin 3 mg. on	F	323			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	he has a tendency is razors out that I four razors in there in the the cause. It would the nursing assistant razors. I chart on the not do follow up on cuts from shaving." During interview on nursing assistant (N idea who shaves hi in his room. I give he plastic ones." During interview on manager (NM)-A sa sometimes. We hav it. He sometimes us verified that care pla interventions to pre During interview on said, "I ask the staff me. Sometimes I cu stop eventually." During interview on Staff development for are on blood thinne of bleeding risk, use razors to shave a re there are any proble During interview or director of nursing (have been just usin have not had any is	to shave himself. I took all ind in his room. I have found e past and that seems to be not surprise me to see that hts are giving him more is incident at the time but I do skin issues if they are small 12/21/16, at 2:34 p.m. NA)-G said, "I do not have any m. I have seen regular razors tim razors as he requests, the 12/21/16, at 2:37 p.m. nurse aid, "He scratches himself ve an electric razor if he wants ses a regular razor." NM-A an lacked specific vent bleeding with ADLs. 12/22/16, at 11:16 a.m. R66 f for a razor and they give it to ut myself but the bleeding will 12/22/16, at 10:37 a.m. RN-E hurse said, "for residents who rs the staff need to be aware e electric razors not the hand esident, and notify the nurse if	F 3	23			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245289	B. WING			12/	22/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323 F 334 SS=E	for everyone but the of the progress note the DON said, "We razor. This is the first this. I expect the sta event. We should h time he cut himself. Undated Shaving th provided by facility if of this procedure is provide skin care. 1 plan to assess for a resident." The polic an electric versus a policy requested bu 483.80(d)(1)(2) INF PNEUMOCOCCAL (d) Influenza and pr (1) Influenza. The fa and procedures to e (i) Before offering th each resident or the receives education potential side effect (ii) Each resident is immunization Octob annually, unless the contraindicated or t immunized during th (iii) The resident or	ey disappear. When informed es and observations of R66 will buy him his own electric st time I have heard about aff to chart at the time of the ave done something the first " he Resident policy page 78 nstructed staff "The purpose to promote cleanliness and to . Review the resident's care my special needs of the y did not indicate when to use safety razor. The complete t not received. LUENZA AND IMMUNIZATIONS neumococcal immunizations acility must develop policies ensure that- ne influenza immunization, e resident's representative regarding the benefits and s of the immunization; offered an influenza per 1 through March 31 e immunization is medically he resident has already been	F 3				2/10/17

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245289	B. WING		12/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334	 documentation that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider immunization or did immunization due to refusal. (2) Pneumococcal of develop policies and (i) Before offering th immunization, each representative receive benefits and potentiation; (ii) Each resident is immunization, unless 	nedical record includes indicates, at a minimum, the at or resident's representative ation regarding the benefits ffects of influenza at either received the influenza not receive the influenza o medical contraindications or disease. The facility must d procedures to ensure that- ne pneumococcal resident or the resident's ives education regarding the ial side effects of the offered a pneumococcal as the immunization is	F 334			
	already been immu (iii) The resident or	icated or the resident has nized; the resident's representative to refuse immunization; and				
		nedical record includes indicates, at a minimum, the				
	was provided educa	at or resident's representative ation regarding the benefits ffects of pneumococcal				

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	01/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		E SURVEY PLETED
		245289	B. WING			12/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	Continued From pa immunization; and	ge 48	F	334			
	pneumococcal imm the pneumococcal i contraindication or This REQUIREMEN by: Based on interview facility failed to impl of immunization for residents (R120, R2 residents over 65 yr histories were revie Findings include: R120's record indic a Pneumovax vacc did not indicate whi stated "Historical." R29's record indica a Pneumovax vacc however it did not ir administered, state R108's record indic a Pneumovax vacc however it did not ir administered, state R108's record indic a Pneumovax vacc however it did not ir administered, state R94's record indicate whi stated "Historical."	NT is not met as evidenced y and document review, the lement the current standards pneumonia for 5 of 5 29, R108, R94, R114) for ears old, whose vaccination wed. ated the resident had received ination on 10/15/15, however it ch vaccine was administered, ted the resident had received ination given on 7/15/16, hdicate which vaccine was d "Historical." ated the resident had received ination given on 10/26/14, hdicate which vaccine was			F334 Resident Vaccinations/Immunizations Resident 120, 29, 108, 94, and 114 h had their records of vaccination/immunization reviewed an updated with actual names of vaccinations/immunizations as given. Resident 120, 29,108, 94, and 114 ha been offered PCV13 or PPSV23 as p "CDC Standing Orders for Administer Pneumococcal Vaccines to adults 65 older". Residents have been reviewed to ma sure that any historical vaccine have appropriate name in their vaccination/immunization record. Additionally, residents have been reviewed to ensure that any aged age or older have been offered the approp vaccination per the CDC Standing Or for Administering Pneumococcal Vaccine (PCV13 and PPSV23) to Adults. Nurses will be trained on all elements the CDC Standing Orders for Administering Pneumococcal Vaccine February 10th, 2017 and the new trac program explained below. Staff Development or designee will ut	nd ave ber ring 5 and ake an ed 65 priate rders ccines s of es by cking	

Facility ID: 00255

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		AND HUMAN SERVICES				FORM	01/30/2017 APPROVED 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245289	B. WING			12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTE	NNIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	Continued From pa	ge 49	F 3	34			
	did not indicate whi The infection contro (RN)-E was intervie RN-E stated that sh documenting the sp and offering the PC facility greater or ed older. The Center for Dise dated 10/6/09, iden or older who have r [pneumococcal 13- and who have prev doses of PPSV23 [I vaccine 23] should pneumococcal 13- udose of PCV13 sho one year after the m Pneumovax Vaccin provided by Pathwa Infection Control M. "as a result of this w has instituted as a Pneumovax Vaccin residents receive th that no opportunity prevention." "General Procedure 1. Primary care phy facility Medical Dire new admissions will Pneumovax vaccin otherwise by Prima orders. a. This letter is	ch vaccine was administered. of director, registered nurse ewed at 2:53 p.m. on 12/22/16. he was not aware of becific Pneumovax vaccination EV-13 to all residents in their qual to 65 years of age or ease Control and Prevention tified "Adults 65 years of age not previously received PCV13 valent Conjugate Vaccine] iously received one or more pneumococcal polysaccharide receive a dose of valent Conjugate Vaccine. The build be administered at least nost recent PPSV23 dose." e - Administration Policy ays Health Service In., anual 2010. welcome guidance, this facility Standing Order for e to assure that all eligible he vaccine. This is to assure is missed for disease		.54	an Immunization Tracking Record specifically designed to identify res aged 65 or older log to whom the pneumococcal vaccines identified i Standing Orders for Administering Pneumococcal Vaccines to adults older" should be offered. This tool of track the age of current residents at age of residents at new admissions at re-admission to ensure residents offered appropriate pneumococcal immunizations per the CDC Standi Orders for Administering Pneumoc Vaccines at age 65 or older (reflect residents who may have a birthday on LOA, at hospital, or any other fu found on re-admission, also). The DON or her designee will audi Vaccination and Immunization Trac Record designed for residents 65 or weekly x 4 and monthly thereafter the ensure compliance. The DON or her designee will report on the progres this program monthly to the Quality Assurance Committee. The correction date for completion February 10th, 2017	n "CDC 65 and will ind the s, and s are ng occal ing while nction t the eking or older s of	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY
		245289	B. WING		12	/22/2016
	PROVIDER OR SUPPLIER	NURSING & REHABILITATION	32	TREET ADDRESS, CITY, STATE, ZIP CODE 245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 334	Continued From pa b. Nursing staff	ge 50 does not need to contact the	F 334			
F 441 SS=F	administration of th c. Nursing staff physician if they ha cannot be answere decision maker ab Standing Orders fo disease or allergy h vaccine). 3. Every admission contraindications for within the standing vaccine, if indicated 4. Licensed nursing and vaccine admini 5. A record of vacci resident's medi vaccination record. 483.80(a)(1)(2)(4)(0) PREVENT SPREA (a) Infection preven The facility must es and control program a minimum, the foll (1) A system for pre- investigating, and c communicable dise volunteers, visitors, providing services to arrangement based conducted accordin	blowing the criteria contained orders and administered the d. g staff performs the screening istration. nation will be placed in the ical record and in their " e)(f) INFECTION CONTROL, D, LINENS ation and control program. tablish an infection prevention n (IPCP) that must include, at owing elements: eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards (facility assessment	F 441			2/10/17

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245289	B. WING		·····	12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 441	 for the program, while limited to: (i) A system of surve possible communic before they can spread facility; (ii) When and to whice communicable disereported; (iii) Standard and trates to be followed to predime the followed to predime the followed to predime the second and the second a	ds, policies, and procedures ich must include, but are not eillance designed to identify able diseases or infections ead to other persons in the om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; isolation should be used for a out not limited to: uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility by es with a communicable skin lesions from direct at the disease; and ne procedures to be followed direct resident contact.	F 4	41			

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CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	FOR OMB N	D: 01/30/2017 M APPROVED <u>D. 0938-0391</u> ATE SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245289	B. WING		1	2/22/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From pa	ge 52	F 4	41		
		nel must handle, store, port linens so as to prevent the				
	annual review of its program, as necess This REQUIREMEN by: Based on interview facility failed to ensi- performed to preve- infection for 3 of 5 r whose cares were of Findings include: R48 During observation nursing assistant (N hands and put glow you ready to get up R48's face and rem R48's upper body a R48's upper abdom R48's upper abdom R48's face and upp weight sweater on N and applied new glo sanitizing hands. N incontinence produ- from back to front v cloth had brown sul NA-H rolled R48 to R48's bottom. With placed a clean inco	NT is not met as evidenced y, and document review the ure proper hand hygiene was nt the potential spread if residents (R48, R30, R25)			 F441 Infection Control – Handwashing and Gloving Resident 48, 30, and 25 were reviewed to the infection control nurse with regard to handwashing and gloving and any associated concerns were resolved. Residents have been reviewed to determine if any problems associated with handwashing/gloving have occurred and so, they have been resolved. Nursing will be retrained on the following 1. Infection control principles for basic handwashing/gloving based on the I-CAF program. Infection control principle for basic handwashing/gloving based on Association for Professionals in Infection Control and Epidemiology programs such as APIC - Minnesota. Nurses as part of re-training will be required to provide return demonstration on proper basic handwashing/gloving for the Staff Development Director or designee. Instructions on proper 	h if ? ?

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245289	B. WING		12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	ЭЕ	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 441	Continued From pa	ige 53	F 44 ⁻	1		
	and shoes. R48's quarterly Mir 10/12/16, indicated impairment and rec activities of daily liv indicated R48's dia to communicate ne During interview on verified not washing NA-G said, "I must from front to back. R30 During observation NA-C explained to to get her dressed. gloves on. NA-C wa washed arms, unde NA-C put a shirt on incontinence produ R30's abdomen, pet then R30's bottom. brown. NA-C then washing hands. NA	's lower body with pants, socks imum Data Set (MDS) dated R48 had severe cognitive quired assistance with all ing, except eating. R48's MDS gnoses were aphasia [inability reds] and dementia. 12/21/16, at 2:34 p.m. NA-G g hands after changing gloves. been nervous. I always wash I should have done so today." on 12/21/16, at 10:28 a.m. R30 what she was going to do NA-C washed hands and put ashed R30's face, then er arms and under breasts. R30, NA-C removed R30's ct and then NA-C washed eri area from front to back and The wash cloth was stained washed R30's legs and feet without removing gloves or A-C put pants socks and shoes sted R30's head scarf and		prior to the launch of the dem sessions. Infection control program: The obtaining guidance in the dev a complete infection control p including handwashing and gl APIC Minnesota, infectious di epidemiology, prevention com Additional insight into infection associated with handwashing will be obtained from MDOH - program. Infection control pra new policy and procedure was for proper basic handwashing Each nursing staff member w retraining and be required to p returned demonstration on bo handwashing and gloving. Nur required to pass with a perfect graduate from this retraining. will be completed by February The standard required for pas demonstration – and as taugf current acceptable standards handwashing technique and g basic resident care and clean (sterile technique is not being part of this project).	e facility is elopment of rogram - oving – from sease, trol division. n control and gloving - I-CAR ctices: A s developed and gloving. Il receive provide th basic rses will be t score to Retraining 10th, 2017. sing the t – are the for loving for technique	
	removed gloves an R30's quarterly MD R30 had severe co required assistance living, except eating diagnosis was dem	S dated 11/16/16, indicated gnitive impairment and with all activities of daily g. R30's MDS indicated R30's		Staff Development or designer conduct nursing basic handwa gloving spot audits weekly x 4 monthly thereafter on each ur Handwashing will include use light" and gloving will include a demonstration of proper clear technique for basic procedure written test on when gloving is and associated questions. Sta	ashing and and it. of the "blue a gloving s and a appropriate	

Facility ID: 00255

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TATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'	IPLE CONSTRUCTION	(X3) DA). 0938-03 TE SURVEY MPLETED
		245289	B. WING _		12	2/22/2016
NAME OF	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP		
CENTEN	INIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422	l	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 441	said "I made a mist one pair of gloves t During interview on registered nurse (R their gloves and wa incontinence cares else. During interview on Staff development a assistants are taug sanitizer every time they must change t peri area and a resi wash a female resid of the perineum, the inner thigh, then to RN-E said, "They a soiled gloves to tou resident." During interview on director of nursing (to wash their hands gloves after doing p before doing anythi [nursing staff] are to pericare. I started of R25 was observed 8:30 a.m. (NA)-C e box of gloves on the applied gloves. NA- leave the room to g padding and dispos a new pair of gloves exposing the peri-a	ge 54 ake" and verified using only o get R30 ready for the day. 12/21/16, at 2:19 p.m. N)-A said staff are to change sh their hands after doing and before doing anything 12/22/16, at 10:37 a.m. RN-E nurse said, the nursing ht to wash hands or use they remove their gloves, that heir gloves after washing the ident's bottom. I teach them to dent from the front to the back en from front to back of each wash the resident's bottom. re told, "do not use the dirty ch a brief or to put cream on a 12/22/16, at 2:32 p.m. the (DON) said she expected staff s after using gloves, to change bericare and wash hands ng else. DON said, "They o wash front to back with loing audits this morning." on 2/22/16, at 7:15 through ntered the room and placed a e foot of R25 ' s bed and then -C then removed the gloves to ather more equipment i.e., sable washcloth. NA-C donned s and pulled down R25 covers rea. R25 ' s front peri area ront to back. Then R25 was	F 44	41 Development or designee of the progress of this program the Quality Assurance Com The correction date for con February 10th, 2017	m monthly to mittee.	

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- CORRECTION	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		10	CON	IPLETED
		A. BOILDIN	NG		
	245289	B. WING _		12/	22/2016
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	D BE	(X5) COMPLETIC DATE
Continued From pa	ige 55	F 44	41		
backside with a dis brown substance of cleansing the soiled the soiled incontine 's bottom, rolled it if the trashcan next to gloves, NA-C place on R25. NA-C place on R25. NA-C rumr drawers gathered a to R25 's back, with gloves. R25 remain down to knees thro person entered the (RN)-D, and whispe applied gloves. RN- NA-C went into the water, (did not remo RN-C and NA-C sta side of neck, under not changed the so to dry R25 face and items of clothing an which landed on the chest as they remo began redressing F employees remove or cleansing their h began cleaning R25 dressing, (RN)-C re cleaning them and removed gloves an washing or cleansir the EZ lift sling. NA	posable wash cloth which had n it after being used. After d back area, NA-C then pulled ent product out from under R25 into a ball and tossed it into b the bed. Without changing ed a clean incontinent product maged in R25's bed side table a tube of lotion, then applied it hout changing the soiled ned totally exposed from head ughout the process. A second room, registered nurse ered into R25 ear and then -D immediately covered R25. bathroom to get a basin of ove the soiled gloves). Both arted washing R25 ' s face, left arm and arm (NA-C still had iled gloves). Both staff started d arms, then RN-C tossed nd linen at the foot of the bed e floor. RN-D covered R25 ' s ved R25 night clothes and R25 with new clothing. Both d their gloves without applied another pair. NA-C d left the room without ng hands and came back with -C stretched it out over the				
	(EACH DEFICIENC' REGULATORY OR L Continued From par rolled over by NA-C backside with a dis brown substance o cleansing the soiled the soiled incontine 's bottom, rolled it the trashcan next to gloves, NA-C place on R25. NA-C rum drawers gathered a to R25 's back, wit gloves. R25 remain down to knees thro person entered the (RN)-D, and whispe applied gloves. RN NA-C went into the water, (did not rem RN-C and NA-C sta side of neck, under not changed the so to dry R25 face and items of clothing ar which landed on the chest as they remo began redressing F employees remove or cleansing their h began cleaning R22 dressing, (RN)-C re- cleaning them and removed gloves an washing or cleansing the EZ lift sling. NA	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 55 rolled over by NA-C and started to wash the backside with a disposable wash cloth which had brown substance on it after being used. After cleansing the soiled back area, NA-C then pulled the soiled incontinent product out from under R25 's bottom, rolled it into a ball and tossed it into the trashcan next to the bed. Without changing gloves, NA-C placed a clean incontinent product on R25. NA-C rummaged in R25's bed side table drawers gathered a tube of lotion, then applied it to R25 's back, without changing the soiled gloves. R25 remained totally exposed from head down to knees throughout the process. A second person entered the room, registered nurse (RN)-D, and whispered into R25 ear and then applied gloves. RN-D immediately covered R25. NA-C went into the bathroom to get a basin of water, (did not remove the soiled gloves). Both RN-C and NA-C started washing R25 's face, left side of neck, underarm and arm (NA-C still had not changed the soiled gloves). Both staff started to dry R25 face and arms, then RN-C tossed items of clothing and linen at the foot of the bed which landed on the floor. RN-D covered R25 's chest as they removed R25 night clothes and began redressing R25 with new clothing. Both employees removed their gloves without washing or cleansing their hands, applied new gloves and began cleaning R25 lower extremities and dressing, (RN)-C removed gloves without cleaning them and applied another pair. NA-C removed gloves and left the room without washing or cleansing hands and came back with the EZ lift sling. NA-C stretched it out over the resident, then left the room and came back with	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 55 rolled over by NA-C and started to wash the backside with a disposable wash cloth which had brown substance on it after being used. After cleansing the soiled back area, NA-C then pulled the soiled incontinent product out from under R25 's bottom, rolled it into a ball and tossed it into the trashcan next to the bed. Without changing gloves, NA-C placed a clean incontinent product on R25. NA-C rummaged in R25's bed side table drawers gathered a tube of lotion, then applied it to R25 's back, without changing the soiled gloves. R25 remained totally exposed from head down to knees throughout the process. A second person entered the room, registered nurse (RN)-D, and whispered into R25 ear and then applied gloves. RN-D immediately covered R25. NA-C went into the bathroom to get a basin of water, (did not remove the soiled gloves). Both RN-C and NA-C started washing R25 's face, left side of neck, underarm and arm (NA-C still had not changed the soiled gloves). Both staff started to dry R25 face and arms, then RN-C tossed items of clothing and linen at the foot of the bed which landed on the floor. RN-D covered R25 's chest as they removed R25 night clothes and began redressing R25 with new clothing. Both employees removed their gloves without washing or cleansing their hands, applied new gloves and began cleaning R25 lower extremities and dressing, (RN)-C removed gloves without cleaning them and applied another pair. NA-C removed gloves and left the room without washing or cleansing hands and came back with	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCE) TO THE APPRO DEFICIENCY) Continued From page 55 F 441 cleansing the solied back area, NA-C then pulled the solied incontinent product out from under R25 's bottom, rolled it into a ball and tossed it into the trashcan next to the bed. Without changing gloves, NA-C placed a clean incontinent product on R25. NA-C rummaged in R25's bed side table drawers gathered a tube of lotion, then applied it to R25 's back, without changing the solied gloves. R25 remained totally exposed from head down to knees throughout the process. A second person entered the room, registered nurse (RN)-D, and whispered into R25 ar and then applied gloves. RN-D immediately covered R25. NA-C went into the bathroom to get a basin of water, (did not remove the soiled gloves). Both RN-C and NA-C started washing R25 's face, left side of neck, underarm and arm (NA-C still had not changed the soiled gloves). Both RN-C and NA-C started washing R25 's face, left side of neck, underarm and arm (NA-C still had not changed the floor. RN-D covered R25 's chest as they removed R25 night clothes and began redressing R25 with new clothing. Both employees removed the floor, RN-D covered R25 's chest as they removed R25 night clothes and began cleaning R25 lower extremities and dressing, (RN)-C removed gloves without cleaning their hands, applied another pair. NA-C removed gloves and left the room without washing or cleansing hands and came back with the EZ lift sling. NA-C stretched it out over the	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 55 rolled over by NA-C and started to wash the backside with a disposable wash cloth which had brown substance on it after being used. After cleansing the soiled back area, NA-C then pulled the soiled incontinent product out from under R25 's bottom, rolled it into a ball and tossed it into the trashcan next to the bed. Without changing gloves, NA-C placed a clean incontinent product on R25. NA-C rummaged in R25's bed side table drawers gathered a tube of lotion, then applied it to R25 's back, without changing the soiled gloves. R25 remained totally exposed from head down to knees throughout the process. A second person entered the room, registered nurse (RN)-D, and whispered into R25 ear and then applied gloves. RN-D immediately covered R25. NA-C went into the bathwing R25 's face, left side of neck, underarm and arm (NA-C still had not changed the soiled gloves). Both RN-C and NA-C strated washing R25 's face, left side of neck, underarm and arm (NA-C still had not changed the floor. RN-D covered R25 's chest as they removed R25 inght clothes and began redressing R25 lower extremities and dressing, (RN)-C removed gloves without washing or cleansing their hands, applied ance we gloves and began cleaning R25 lower extremities and dressing, (RN)-C stretched it out over the

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245289	B. WING			12/	22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	gloves to comb R28 the lap, and gave R requested. R25's quarterly MD R25 had mild cogni extensive assistance living, except eating During interview on indicated she expect giving morning care area then remove th hands and apply se complete the care. director just complet talked about gloving During an interview NA-C said, "I chang dirty area, wash my of gloves if needed. During an interview director of staff dev about glove changin "We just had a skill about this and it is a their gloves, wash or removing their glove second pair. The D at the same time, w and glove use. The staff to wash their h change gloves after their hands before of skills fair that addre	5 's hair, applied a blanket to 25 the stuff animal as S dated 10/19/16, indicated tive impairment and required with all activities of daily g. 12/22/16, at 11:45a.m. RN-P cted staff to apply gloves when a, wash the face and chest heir gloves and wash their cond pair of gloves to "Our staff development eted a skills fair where we g." on 12/22/16, at 11:48 a.m. ge my gloves anytime I touch a hands and apply another pair	F 4	141			

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		MPLETED
		245289	B. WING _			2/22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 57	F 44	41		
	instructed staff;	-				
	"This facility considers hand hygiene the primary means to prevent the spread of infections."					
	Undated Perineal Care policy instructed staff; "9. For a female resident:					
		sident: Ind apply soap or skin				
	cleansing agent.					
	b. Wash perineal a	rea from front to back.				
		and wash area downward from e: if the resident has an				
		, gently wash the juncture of				
	the tubing from the	urethra down the catheter				
		ntly rinse and dry the area.)				
		sh the perineum moving from nd including thighs, alternating				
		and using downward strokes.				
		ame wash cloth or water to				
	clean the urethra o	r labla.				
		and a clean washcloth. (Note: if				
		indwelling catheter, hold the				
		and support the tubing against ction or unnecessary				
	movement of the ca					
	(4) Gently dry perir	neum.				
		the resident to turn on her				
		g slightly bent if able. and apply soap or skin				
	cleansing agent.					
		area thoroughly, wiping from				
		a towards and extending over ot reuse the same washcloth or				
	water to clean the l					
	f. Rinse thoroughly	using the same technique as				
	described in "e " al					
	 g. Dry area thoroug 11. Discard disposa 	able items into designated				

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		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				0938-0391 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		IPLETED
		245289	B. WING		12/	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 /	22/2010
OFNITEN				3245 VERA CRUZ AVENUE NORTH		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
			n			

Facility ID: 00255

If continuation sheet Page 59 of 59

PRINTED: 01/30/2017

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´	F528927 IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	FORM OMB NO (X3) DAT	2: 01/23/2017 1 APPROVED 0: 0938-0391 TE SURVEY MPLETED
		245289	B. WING		12	/20/2016
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE.		*		
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Division the time of this sum found not in compli- participation in Mec Subpart 483.70(a), 2012 edition of Nat Association (NFPA	Survey was conducted by the nent of Public Safety, State on on December 20, 2016. At vey, Centennial Gardens was ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety oter 19 Existing Health Care.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55107 By email to:	R THE FIRE SAFETY -TAGS) TO: pections Division Suite 145		EPOC		
	Y DIRECTOR'S OR PROVID Nically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 01/20/2017

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

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION MAIN BUILDING 01		E SURVEY PLETED
		245289	B. WING			12/2	20/2016
NAME OF F	PROVIDER OR SUPPLIER	1		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	h	
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION			VERA CRUZ AVENUE NORTH STAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000		-	K 00	00			
	Marian.Whitney@s Angela.Kappenmar			C.			
		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
9	constructed in 197 Type II (111) constr and is fully fire sprin has a fire alarm sys the corridors and s that is monitored for notification. The fac	s is a 3-story building that was 1 and was determined to be of function. It has a full basement inkler protected. The facility stem with smoke detection in paces open to the corridors or automatic fire department cility has a capacity of 130 insus of 98 at time of the					
K 353 SS=F	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: r System - Maintenance and	К 3	53			2/10/17
	Automatic sprinkler inspected, tested, a with NFPA 25, Star	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire					
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 65E82	1	Facility	ID: 00255 If contin	uation she	et Page 2 of 6

		& MEDICAID SERVICES	()(0) 141 11 71		1	0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245289	B. WING		12/2	0/2016	
NAME OF I	PROVIDER OR SUPPLIER		<i>,</i>	STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 353	maintenance, insper maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMAR any non-required of system. 9.7.5, 9.7.7, 9.7.8, This STANDARD is Based on observa facility did not main fire sprinkler system and the 2012 LSC This deficient pract residents. Findings include: 1. On a facility tour and 1700 on Dece revealed that the a system inspection after the last annua (02/19/2015-11/30/ 2. On a facility tour and 1700 on Dece revealed that the fa documentation for	s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage for r partial automatic sprinkler and NFPA 25 is not met as evidenced by: tion and document review, the itain and test their automatic m in accordance with NFPA 25 NFPA 101. 9.7.5, 9.7.7, 9.7.8. tice could effect all 98	K 35	3 K353 NFPA 101 Sprinkler Syster Maintenance and Testing The facility has made the necess corrections regarding maintaining testing the automatic fire sprinkle in accordance with NFPA 25 and LSC NFPA 101.9.7.5, 9.7.7, 9.7.8 An annual automatic sprinkler tes completed on 11/30/2016. The quautomatic sprinkler system and fit testing is scheduled for February 2017. Records of the system insp and testing are maintained and s secure location and are readily ar The facility reviewed and confirm contract schedule for quarterly ar inspections with Viking Automatic Sprinkler Co, 301 York Ave, St. P Mn55130 to ensure testing is cor in accordance with NFPA rules. T following inspections have been confirmed for 2017 and will be up	ary and r system the 2012 t was larterly ow 14th, bection tored in a vailable. ed the d annual aul, npleted the		

3

Event ID: 65E821

Facility ID: 00255

If continuation sheet Page 3 of 6

TATEMATH	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) MULTI	PLE CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		LETED
		245289	B. WING		12/2	20/2016
AME OF	PROVIDER OR SUPPLIEF	र		STREET ADDRESS, CITY, STATE, ZIP CODE		
ENTEN	NIAL GARDENS FO	R NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 353		page 3 otice was verified by the director the time of inspection.	K 35	 A) Quarterly Automatic Sprinkler Inspection and Flow Test: Februa 2017 B) Quarterly Automatic Sprinkler Inspection and Flow Test: May 20 C) Quarterly Automatic Sprinkler Inspection and Flow Test: August D) Annual Automatic Sprinkler S Inspection and Test: November 2 To ensure that quarterly and annua automatic sprinkler system inspect and testing are completed within timeframes set by the NFPA, the Maintenance Director and Admini have developed a new tracking a notification system to ensure time and inspections are completed. T tracking and notification system is follows. The Maintenance Directo established a tracking calendar th monthly required testing and insp This record is maintained and sto secure location and is readily ava This tracking calendar is reviewer monthly by both the Maintenance and Administrator. The Administra set up an automatic system that a alerts via email notifying both the Maintenance Director and Admini scheduled automatic sprinkler test inspections. The alerts are set to both the Maintenance Director ar Administrator on the first day on to month the test and inspection is scheduled. A follow up alert will b 	ry 14th, System 17 System 2017 ystem 017 ial ctions the strator nd ely testing he s as in has nat list ections. red in a ilable. d Director ator has sends out strator of sting and notify id he	

Event ID: 65E821

Facility ID: 00255

If continuation sheet Page 4 of 6

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		<u>O. 0938-0391</u> ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			01 - MAIN BUILDING 01	OMPLETED
		245289	B. WING		1	2/20/2016
AME OF I	PROVIDER OR SUPPLIER			SI	REET ADDRESS, CITY, STATE, ZIP CODE	
ENTEN	NIAL GARDENS FOR	NURSING & REHABILITATION		-	245 VERA CRUZ AVENUE NORTH RYSTAL, MN 55422	
(X4) ID PREFIX T A G	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From pa	age 4	KS	353	Automatic Sprinkler Co. Those documents will be maintained and stored in a secure location and will be readily available. The correction date for completion is February 14th, 2017	Ŀ
K 523 SS=D	Suspended Unit He Suspended unit he the following are m	aters are permitted provided	Κŧ	523		2/10/17
	rooms. * Located high eno people in the area. * Has a safety feature equipment if there ignition failure. 18.5.2.3(1), 19.5.2. This STANDARD in Based on observa	ugh to be out of reach of ure to stop fuel and shut down is excessive temperature or			K523 NFPA 101 HVAC □ Suspended U Heaters	nit
	accordance with th Safety Code NFPA practice could affect room.	e 2012 edition of The Life 101. 19.5.2.3(1). This deficient ct the residents within the			The portable space heaters were immediately removed from room 301 ar 327. All resident rooms were audited and no	ıd
	1700 on Decembe revealed that porta used in resident ro				other space heaters were found. To ensure continued compliance with th 2012 edition of The Life Safety Code NFPA 101.19.5.2.3(1), staff have been trained that space heaters are not permitted in the facility and what to do if space heater is found. Informational sig stating space heaters are not allowed in	a ns
		tice was verified by the director the time of inspection.			the facility have been posted at the reception desk, both elevators, and on each nursing unit. The training and sign	

Facility ID: 00255

If continuation sheet Page 5 of 6

TEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				0938-039 E SURVEY PLETED	
PLANO	FCORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG 01 - MAIN BUILDING 01	COMPLETED		
		245289	B. WING			12/20/2016	
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
ENTEN	NIAL GARDENS FOR	R NURSING & REHABILITATION		3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
K 523	Continued From pa	age 5	K 52	direct staff to inform the Dire Maintenance or the Administ remove the space heater im section has been added to o Gardens for Nursing and Re Life Safety monthly audit for space heaters. This docume maintained and stored in a s location and will be readily a The Administrator or designe and review the Life Safety at ensure no space heaters are The correction date for comp February 10th, 2017.	rator and to mediately. A ur Centennial habilitation m addressing nts will be ecure vailable. ee will monitor udit monthly to e in the facility.		



Protecting, maintaining and improving the health of all Minnesotans

REVISED LETTER

Electronically submitted January 11, 2017

Mr. Ryan Chies, Administrator Centennial Gardens For Nursing & Rehabilitation 3245 Vera Cruz Avenue North Crystal, MN 55422

Revision to letter is regarding the unsubstantiated complaint.

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5289028 and Complaint Number H5289051

Dear Mr. Chies:

The above facility was surveyed on December 19, 2016 through December 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5289051 which was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

Centennial Gardens For Nursing & Rehabilitation January 11, 2017 Page 2

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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact **Gloria Derfus, Unit Supervisor at (651)201-3792.**

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,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u> Centennial Gardens For Nursing & Rehabilitation January 11, 2017 Page 3

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00255	B. WING		12/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY	STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REF	VERA CRUZ AN TAL, MN 5542	VENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been	s on : : : :			
	You may request a that may result fron orders provided tha the Department wit	hearing on any assessmen n non-compliance with thes It a written request is made hin 15 days of receipt of a ent for non-compliance.	e			
	electronic receipt of consistent with the	rS: eed to participate in the f State licensure orders Minnesota Department of al Bulletin 14-01, available a	.t:			
	-	tate.mn.us/divs/fpc/profinfo	/inf			
Minnesota D LABORATOR	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S	SIGNATURE	TITLE		(X6) DATE
	ically Signed					01/20/17

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If continuation sheet 1 of 57

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00255	B. WING		12/	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVE L, MN 55422	ENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	obul.htm					
	attached Minnesota being submitted ele of correction is nec Statutes/Rules, ple in the box available electronic State lice heading completion be corrected prior t the Minnesota Dep An investigation of	ase enter the word "corrected" for text. Then indicate in the ensure process, under the date, the date your orders wil o electronically submitting to	1			
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			2/10/17
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview and document ailed to revise care planned of 4 residents (R77, R78, R66) in care needs.		Corrected		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00255	B. WING		12/3	22/2016		
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE				
ENTENI	NIAL GARDENS FOR		RA CRUZ AVEI L, MN 55422	NUE NORTH				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE		
2 570	Continued From pa	ige 2	2 570					
	Findings include:							
	noted R77 to have memory impairment assist of one for all with the exception of ambulate. The com 11/8/16, noted R77 dementia with behave weakness. R77 have not included on the comprehensive car how to care for the R77 was observed his room with the less baseball, and redde completed of the and stated, "I can't stan arm was not suppor sling. R77 stated how wrong with his arm	e plan lacked interventions on	•					
	on 12/20/16, at 2:1 the hospital emerge 12/20/16, to treat a "No one could tell v started on Sunday" - At 3:20 p.m. NA-A R77 had complaine arm on Sunday (12	A was interviewed and stated ed of severe pain in the left /18/16) afternoon shift, and st. NA-A stated the nurse told						

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00255	B. WING		12/3	22/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOR		RA CRUZ AVEI ., MN 55422	NUE NORTH		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 570	Continued From pa	age 3	2 570			
		ep on bedrest or to support the ention a fracture to the arm.				
	12/21/16, at 9:20 a. should be updated care needs. She ve been updated since on 12/18/16. The x	sing (DON) was interviewed on .m. and stated care plans with changes to the resident's erified R77's care plan had not e R77 had complained of pain -ray on 12/19/16, had noted a of the humerus (arm bone).				
	independent with a one staff assistance significant change I she was severely c extensive assist of toileting, and perso transfer or ambulat (CAA) dated 11/28/ based on an actual R78 was at modera plan dated 12/7/16, due to cognitive de	10/4/16, indicated she was mbulation and required only e for all other ADLs. R78's MDS dated 11/25/16, indicated ognitively impaired, required two staff for bed mobility, nal hygiene and did not e. A Care Area Assessment (16, identified a risk for falls fall on 11/15/16, and indicated ate risk for falls. R78's care , indicated a potential for falls ficit and identified a right hip on 11/15/16, as a result of a				
	Rehabilitation - SNI Progress Notes alo Post Fall Scene Inv sustained nine falls The most recent fa fracture. R78's care the following fall int assessment per po	nial Gardens for Nursing and F (Skilled Nursing facility) ong with correlating Incident vestigation Tools indicated R78 between 2/5/16 and 2/22/16. Il on 1/18/16, resulted in a plan dated 12/7/16, identified erventions: 1/23/15 - fall vicy, 1/23/15 - anticipate and needs, 1/23/15 - the resident				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURV COMPLETE	
		00255	- B. WING		12/	22/2016
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	12/	22/2010
	NIAL GARDENS FOR	3245 VEI	RA CRUZ AVEI L, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 4	2 570			
	diversional activitie (currently on hold) and reposition the care plan did not in after 4/20/16, even more falls including During an interview NA-B stated R78 h was not sure how r walk very fast on th was not aware of a and stated she was During an interview	onment, 1/29/16 - offer s, 1/29/16 - proper footwear 4/20/16 - check and change resident every two hours. The iclude any new interventions though R78 sustained four g a fall with a fracture. y on 12/21/16, at 2:05 p.m., ad a history of falls but she many. She stated she used to he unit. NA-B further stated she uny fall prevention interventions s told to watch R78. y on 12/21/16, at 2:19 p.m., RN)-D stated when a resident				
	falls, the nurse on of management report an immediate inter During an interview DON stated when She stated she wat understand when s	duty fills out a risk rt. She stated the nurse will put				
	committee and star "trying" to meet ever committee looks at to determine cause interview at 3:12 p. no review of R78's	ted the fall committee was ery two months. She stated the the incident reports and tries as of falls. During a subsequen m., the DON stated there was fall history in the falls meeting I "we were going to look at her				
	Souther, Glenora R66 was observed					

Minneso	ta Department of He	alth			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00255	B. WING		12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR		RA CRUZ AVE ., MN 55422	NUE NORTH		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
2 570	Continued From pa	ge 5	2 570			
		o.m. Traces of blood were R66 said, "I am okay I just cut				
	was observed comi fresh blood on the r said, "It is just from blood. It will go awa shaving." Surveyor assistant of R66's b -8:13 a.m. R66 obs had been washed o	on 12/21/16, at 7:27 a.m. R66 ng out of his room. There was ight side of chin and jaw. R66 shaving and wiped at the sy soon. I just cut myself notified unknown nursing bleeding. erved in dining room, blood off R66's face. There was a 1 1.5 cm longitudinal cut on right				
	R66 had moderate required assistance MDS indicated R66 hemiplegia and atri	S dated 10/5/16, indicated cognitively impaired and with personal hygiene. R66's 's had diagnoses of dementia, al fibrillation (irregular heart pumadin (blood thinner).				
	7/8/16, indicated R6 dressing grooming up and supervision completed." Staff w	of daily living) tion Potential CAA dated 66 required, "Assist with and personal hygiene with set to ensure tasks have been ere to continue with current tor for decline in self-care.				
	had altered status i decision making an care plan instructed with shaving. The c 10/7/16, indicated F risk for bruising and	revised 7/15/15, indicated R66 n ADL's related to alteration in d thought process. The ADL d staff, R66 was independent ardiac care plan revised R66 was on Coumadin and at d bleeding and instructed o observe and report blood in tools, bruises skin				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2016	
		00255	B. WING			
					12/	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST RA CRUZ AVEI			
ENTEN	NIAL GARDENS FOR	NURSING & REF	L, MN 55422			
X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
RÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 570	Continued From pa	age 6	2 570			
	or lab draw sites. T report to medical de family bruises and care plan did not ac bleeding risks while on R66's safety to s razor, or other inter prevent bleeding. The 3rd Floor NA s indicated R66 was Review of Progress 12/22/16, indicated - On 11/12/16, R66 from right thumb. S antibiotic cream an indicated R66 state trying to shave. Wil - On 12/5/16, R66 v on head with a sma indicated staff clear R66 not to use razo note, "[R66] stated himself. Writer [sic] drawers as well. W - On 12/19/16, prog noted to have blood dining room for lund cleaned and two sp Resident stated did Will continue to mo - On 12/21/16, prog noted to have blood	was noted to be bleeding staff cleaned area applied triple d a band-aid. The note ed," to have injured self from I continue to be monitored." was noted to have scratches all amount of bleeding. Note ned up the area and warned or on his own. Per progress it was a result of him shaving took all razors from his ill continue to be monitored." gress note indicated, "Residen d to nose when walking to the ch. Resident's nasal was bots noted like from a scratch. I not know how it happened.				
	monitored."	from. Will continue to be 12/21/16, at 2:19 p.m. RN-A				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00255			12/	22/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOR		RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 7	2 570			
	said, "I do not upda Managers do."	said, "I do not update the care plan the Nurse Managers do."				
	said, "I do not have have seen regular	n 12/21/16, at 2:34 p.m. NA-G e any idea who shaves him. I razors in his room. I give him sts, the plastic ones."				
	manager (NM)-A sa sometimes. We ha it. He sometimes u	n 12/21/16, at 2:37 p.m. nurse aid, "He scratches himself ve an electric razor if he wants ses a regular razor." NM-A an lacked specific interventions with ADL's.				
	said, "for residents staff need to be aw electric razors not t resident, and notify	n 12/22/16, at 10:37 a.m. RN-E who are on blood thinners the vare of bleeding risk, use the hand razors to shave a the nurse if there are any build be on the care plan and				
	DON said lately the disposable razors. with residents bleed to initiate electric ra disappear." When in Notes and observa "We will buy him hi first time I have head staff to chart at the have done somethin himself." DON state change in a resider	a 12/22/16, at 2:32 p.m. the e staff have been just using the We have not had any issues ding. I know that we are trying azors for everyone but they informed of the Progress tions of R66 the DON said, s own electric razor. This is the ard about this. I expect the time of the event. We should ing the first time he cut ed that when there was a ht's ability to do something the e reviewed and revised if				

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If continuation sheet 8 of 57

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00255	B. WING	B. WING		12/22/2016	
	PROVIDER OR SUPPLIER	3245 VEI	DDRESS, CITY, ST RA CRUZ AVEI L, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 570	Management Minnereviewed. The polic care plan is develo completion of the repolicy did not addres SUGGESTED MET The director of nurs develop and impler related to updating designee, could pro staff related to the plans. The quality a	age 8 am, Superior Healthcare esota Region, undated, was cy indicated a comprehensive ped within seven days of the esident's assessment. The ess updates to the care plan. THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures care plans. The DON or ovide training for all nursing timeliness of updating care assessment and assurance erform random audits to	2 570				
2 830	ensure compliance TIME PERIOD FOI (21) days. MN Rule 4658.052 Proper Nursing Ca	R CORRECTION: Twenty-one 0 Subp. 1 Adequate and re; General	2 830			2/10/17	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on of preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident n bed.	1 t				
	This MN Requirem	ent is not met as evidenced					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00255	B. WING		12/	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
		3245 VE		ENUE NORTH		
CENTEN	NIAL GARDENS FOR	NURSING & REF CRYSTA	L, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 9	2 830			
	review, the facility fr interventions to red residents (R78) rev actual harm for R78 resulting from a fall to provide adequate resident (R104) rev facility failed to sup	on, interview, and document ailed to implement uce the risk of falls for 1 of 3 iewed for falls. This resulted in 3 who sustained a fracture . In addition, the facility failed e supervision for 1 of 1 iewed for elopements and the ervise 1 of 1 resident (R66) for e of a disposable razor.		Corrected		
	Findings include:					
		on 12/20/16, at 2:20 p.m. R78 ile a holiday party was in t.				
	registered nurse (R	on 12/20/16, at 3:11 p.m., N)-D stated R78 was on bed ture of her right hip.				
	(MDS) dated 11/25, severely cognitively assist of two staff for personal hygiene a ambulate. A previou indicated R78 had b ambulation and req for all other activitie plan dated 12/7/16, due to cognitive det fracture had been s result of a fall. The anticipate her need slow down and ens on hold due to bed	ange Minimum Data Set (16, indicated she was r impaired, required extensive or bed mobility, toileting, and nd did not transfer or us MDS dated 10/4/16, been independent with uired only one staff assistance is of daily living. R78's care indicated a potential for falls ficit and identified a right hip sustained on 11/15/16, as a care plan directed staff to s, offer diversion, reminders to ure proper foot wear (currently rest.) A Area Assessment 16, identified a risk for falls				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED
		00055	B. WING		10/00/0010	
		00255			12/2	22/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ENTEN	NIAL GARDENS FOF		RA CRUZ AVE L, MN 55422			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLE DATE
				DEFICIENC	CY)	
2 830	Continued From pa	age 10	2 830			
	R78 was at modera	ate risk for falls.				
	A roviow of P78's P	Progress Notes and				
		dent Post Fall Scene				
	Investigation Tools	were reviewed from 2/5/16 to				
		tified the following falls:				
		ress Note indicated R78 was ast hallway floor lying flat on				
		correlating incident report				
		helped to bed and monitored				
		interdisciplinary team (IDT)				
		new intervention of offering				
		folding washcloth or cleaning				
	to re-direct had bee					
		ress Note indicated R78 was hallway, missed her step and				
		The corresponding incident				
		78 was redirected and put in				
		The IDT review of the fall				
	indicated staff were	e to remind R78 to slow down				
		ast, and to redirect as able.				
		ess Note indicated R78 slid to				
		d on her bottom. The				
		dent report indicated R78 was nd educated on proper sitting				
		eview intervention initiated as a				
		encourage her to sit back in the				
	chair.					
	- On 3/20/16, Prog	ress Note indicated R78 was				
	found sitting on the	e floor facing the elevator. The				
		dent report indicated she was				
		a one to one and pain				
		ministered. An IDT review of				
	the fall was not cor	npleted. ess note indicated R78 was				
		at 9:00 a.m. by the nurse's				
		left side and again an hour				
		ing on the floor. The				
		dent report indicated she was				
	immediately broug					1

	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING	B. WING		22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVE L, MN 55422	NUE NORTH		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	 On 4/22/16, a note R78 had multiple fa walking. The recomfor staff to continue On 5/13/16, Proground sitting on the immediate intervent advise R78 to use at the fall was not comformed and the related to rapid pace evidence the IDT has a note R78 had experience related to rapid pace evidence the IDT has a note R78 had experience related to rapid pace evidence the IDT has a note related to rapid pace immediate intervent the corresponding immediate intervent to bear weight. On 11/15/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com to bear weight. On 11/16/16, Proground lying on floor side. She was com 	labeled IDT note, indicated eed two falls without injury ce of wandering. There was no ad evaluated or assessed f the falls. ress note indicated R78 was n the dining room at 7:50 p.m. incident report indicated an ation of offering her a snack. rtion of the incident form was gress Note indicated R78 fell balance. No incident report the fall, nor was an IDT review gress Note indicated R78 was near the elevator on her right plaining of hip pain and unable gress Note indicated x-ray alled in to the physician and keep R78 at the care center racture care. The dent Report form indicated no				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00255	B. WING		10/	12/22/2016	
	PROVIDER OR SUPPLIER	00255	DRESS, CITY, ST		12/	22/2016	
		3245 VEF	RA CRUZ AVEI				
ENTEN	NIAL GARDENS FOR	NURSING & REF CRYSTAI	., MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 830	Continued From pa	lge 12	2 830				
	NA-B further stated she was not aware of any fall prevention interventions other than to watch R78.						
	registered nurse (R has a fall, the nurse management repor an immediate interv the IDT reviews fall	on 12/21/16, at 2:19 p.m. N)-D stated when a resident on duty fills out a risk t. She stated the nurse will put vention in place. RN-D stated s quarterly when completing not do a review following each					
	director of nursing of wasn't a surprise." 'f fast and does not u to slow down. The reviewed by a fall c committee was "try months. She stated incident reports and factors of the falls. concerns about a p with the nurse man prior to R78's fall w had no concerns ab "since I have been 2016) I don't think s DON did not express falls since February interview at 3:12 p. no review of R78's	on 12/21/16, at 2:37 p.m., the (DON) stated when R78 fell, "It The DON said R78 walks very inderstand when staff tell her DON further stated falls were ommittee and stated the fall ing" to meet every two d the committee looks at the d tries to determine causative The DON stated if she has varticular resident she will meet ager after a fall, and stated ith fracture, she (the DON) bout R78. The DON stated, here (she started in January of she's had any other falls." The ss an awareness of R78's nine y of 2016. During a subsequent m., the DON verified there was fall history in the falls meeting "we were going to look at her					
	medical director (M R78's fall history. T changes in the facil	on 12/22/16, at 1:30 p.m., the D) stated he was aware of he MD stated, with all the lity, the falls program needs to de stated the person who used					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING	B. WING		12/22/2016	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		12/	22/2010	
	NIAL GARDENS FOR	3245 VFF	RA CRUZ AVEI				
	INIAL GANDENS FOR	CRYSTAI	, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 830	Continued From pa	ige 13	2 830				
	to review falls was no longer at the facility and the fall program went away when she left.						
	and Their Causes wincluded: "Falls are and mortality amon homes." The policy identify possible or policy further indica	policy titled Assessing Falls was reviewed. The policy a leading cause of morbidity g the elderly in nursing directed staff to begin to try to likely causes of the fall. The ted documentation should interventions taken to prevent					
	There was no evide falls since March of of interventions to p injury. Further, the February and Marc however, R78 was	ed multiple falls in the facility. ence the facility reviewed the f 2016. There was no evidence prevent future falls or to reduce facility initiated interventions in h that included reminders, severely cognitively impaired ated she was unable to ections.					
	had limited physica use his walker, and going out of the bui 9/29/16, noted R10 impairment and wa diagnoses of hepat with ascites and red care plan also inclu- indicated R104 was supervision with sm designated area. F	ated 7/31/16, indicated R104 I mobility, needed reminders to I may need a wheelchair when Iding. R104's MDS dated 4 had severe cognitive s admitted to the facility with a ic failure, cirrhosis of the liver ceived hospice services. The ided a date of 9/30/16, which s a smoker who required noking in the outside R104's Physician Orders dated DK for WanderGuard."					
	following entries: O	Progress Notes included the n 11/8/16, at 5:54 p.m. family I called 1st floor/Tcu mgr					

STATEMEN	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00255	B. WING	B. WING		22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ENTEN	INIAL GARDENS FOF	NURSING & REF	RA CRUZ AVE	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	that R104 had gone and was staff awar the details and he s 1st floor male hond available. Cab was store] for some frui her nose in? Why i him names of men he said 'The one w in the front." On 11 noticed at 1800 res room. South nurse member came to v on first floor. Writer smoking area and was not there. On "Resident was repor this morning by the [sic] about 350 met went to get him bac and insisted that he redirected several fa and kept on walkin Staff called the faci After about 10 minut then talked to him a Vital signs were co denied having pain noted at the time m administered and a initiated. All parties gave new orders for out with [family]. St monitor the resider A care conference R104 and family re required supervision	a 15 minutes check was were notified hospice nurse or see orders. He is currently aff will cont. [continue] to				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING	B. WING		22/2016
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
			RA CRUZ AVEI	NUE NORTH		
	NIAL GARDENS FOR	CRYSTA	L, MN 55422			
(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
2 830	Continued From pa	age 15	2 830			
	regarding R104 mis 12/16/16, R104 mis leave on 11/7/16. T evidence of a comp R104's risk for pote RN-A was interview who confirmed she when R104 went ou indicated R104 can moment and then of confused on this m 10 minutes to talk h RN-A indicated R10 during morning rou stated licesned pra nurse working and R104 was not in his someone outside th R104 was walking went outside to red LPN-C could not ree from his cell phone who were able to b building. When R10 the facility began er updated family, hos RN-A indicated the SA and believed the asked about the 11	ved on 12/20/16, at 3:12 p.m. called police on 12/16/16, utside of the facility. RN-A be "totally wonderful one confused, and he was orning, it took police another nim into coming back here." O4 was discovered missing nds around 6:30 a.m. RN-A ctical nurse (LPN)-C was the searched the building after s room. RN-A indicated ne building alerted staff that down the road and LPN-C irect R104 into the building. direct R104 and called RN-A . RN-A then called the police ring R104 back into the D4 was back in the building, very 15 minute checks and spice, the NP and the DON. DON did the reporting to the e incident was reported. When /8/16, Progress Note which the facility in a cab, RN-A				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00255	B. WING		12/	12/22/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
ENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 16	2 830				
	elopement; he had a destination" and further indicated the incident "really was not dangerous in any way."						
	p.m. The DON stat goes out every day not know if R104 re smoking. The DON appropriately for the R104 was not confi R104 was not confi R104 was not on fa found by staff on 12 consider the incide went on to say R10 and smoke and she WanderGuard, but but staff keep a rea confirmed an elope wandering assess for R104 and stated between going out DON further confirm facility WanderGua be, he goes out all indicated R104 had confirmed again the because she did no elopement as he w The DON defined a	rviewed on 12/20/16, at 3:30 and Smokes." The DON did equired supervision for I stated R104 was dressed e weather on 12/16/16, and used. The DON confirmed acility grounds when he was 2/16/16, and she did not nt an elopement. The DON 04 has been trying to go out e did not think R104 had a they had tried on in the past ally close eye on him. The DON ement assessment or nent had not been completed d there was a difference and going for a walk. The med R104 was not on the ard list and stated "he shouldn't the time." The DON further d the right to wander and e incident was not reported of view the incident as an ras found immediately by staff. an elopement a "someone who rd but is gone, and cannot be					
	interviewed. LPN-C working on 12/16/1 night shift staff mer morning, returned t	S stated he was the nurse 6, and during morning report a mber who had left for the to the facility and stated R104 street. LPN-C confirmed no					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00055		B. WING			
		00255			12/	22/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
CENTEN	NIAL GARDENS FOR		RA CRUZ AVE L, MN 55422				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLET	
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
2 830	Continued From pa	age 17	2 830				
		outside the facility to bring R104	4				
		ated it was freezing outside s dressed in a coat and had					
		approximately 300 meters					
		_PN-C stated he was unable to					
		o the building and called RN-A					
		C stated police arrived and					
		ack into the building and police nd LPN-C a ride back to the	•				
		ed he assessed R104 when					
	-	e facility and updated Hospice					
	and F-B. LPN-C st	ated they then implemented					
		necks. LPN-C was unaware of					
		04 had left the building I-C stated he was unaware at					
	how long R104 had						
	The director of soc	ial services (DSS) was					
		21/16, at 8:42 a.m. and on					
		.m. regarding R104's 12/16/16					
		lity. DSS stated she was aware stated there was discussion of					
		ent later in the day however, it					
		ecause there was no harm to					
		e was returned to the facility					
		iately. DSS stated she was on					
		e week of 11/8/16, and did not ally left the facility. DSS was no	+				
		her time R104 had been					
	missing or left the	facility without supervision.					
		terviewed on 12/21/16, at 12:43	3				
		e was informed of R104 being					
		6, and stated she was told staf	t				
		s gone from the facility and up the path outside of the					
		R104 had a Wanderguard but					
		work when he has a coat on					
	and was not sure if	f the wandergaurd had					
	sounded. F-B state	ed R104 had left the facility one					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING	B. WING		22/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOF	R NURSING & REF	RA CRUZ AVE L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	other time unsupervised, probably in November, when he went to Cub Foods in a cab. F-B stated facility staff contacted her and had said R104 told them the administrator told R104 he could call a cab and leave. F-B did not believe that the administrator had given permission for R104 to leave in a cab.					
	who stated she new F-B on 11/8/16. RN office and asked he a cab to Cub Food unaware of that an DON about what w F-B. RN-B stated s further regarding th RN-A. RN-B was n the facility unsuper aware of the 12/16	ved on 12/21/16, at 12:06 p.m. ver received a call from R104's I-B stated F-B stopped in her er if she had heard R104 left in s yesterday. RN-B was d contacted RN-A and the ras told to her about R104 from she did not hear anything he situation from the DON or ot aware of R104 ever leaving vised. RN-B stated she was /16, incident however, was not e the incident occurred.				
	at 1:04 p.m. The ad notified on 12/16/1 understanding staf was walking down followed him outsic confirmed the incid stated the DON wa she had told him sl situation. The adm aware of what an e what had been told reported. The adm	was interviewed on 12/21/16, dministrator stated he was 6, R104 was outside and to his f had let him out front and he the side walk and a nurse de. The administrator lent was not reported and as aware of the incident and he had taken care of the inistrator confirmed he was elopement was and if that was I to him it would have been inistrator was interviewed (16, Progress Note and stated				
	he did not tell the F leave the facility. T if R104 left the faci	16, Progress Note and stated R104 that he could call a cab to he administrator was unaware lity. The administrator was not /18/16, Progress Note or				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING		12/	12/22/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
		3245 VE	RA CRUZ AVE				
ENTEN	NIAL GARDENS FOF	R NURSING & REF CRYSTA	L, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 19	2 830				
	incident.						
	R66 was observed in hallway with an abrasion on the top of nose and one on the side of nose on 12/19/16, at 12:28 p.m. Traces of blood were noted on the face. R66 said, "I am okay I just cut myself shaving."						
	was observed com fresh blood on the said, "It is just from blood. It will go awa shaving." Surveyor assistant of R66's I observed in dining off R66's face. The	o on 12/21/16, at 7:27 a.m. R66 ing out of his room. There was right side of chin and jaw. R66 a shaving and wiped at the ay soon. I just cut myself notified unknown nursing bleeding. At 8:13 a.m. R66 room, blood had been washed ere was a 1 centimeter (cm) to cut on right side of the jaw.					
	10/5/16, indicated l impaired and requi hygiene. R66's MD diagnoses of deme	nimum Data Set (MDS) dated R66 had moderate cognitively red assistance with personal S indicated R66's had entia, hemiplegia and atrial r heart beat) on chronic hinner).					
	dated 7/8/16, indica dressing grooming up and supervision completed." Staff v	n/Rehabilitation Potential CAA ated R66 required, "Assist with and personal hygiene with set to ensure tasks have been vere to continue with current itor for decline in self-care.					
	had altered status decision making ar care plan instructed with shaving. The c	revised 7/15/15, indicated R66 in ADLs related to alteration in nd thought process. The ADL d staff, R66 was independent cardiac care plan revised R66 was on Coumadin and at	3				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00255	B. WING		12/22/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
		3245 VE	RA CRUZ AVEI			
ENIEN	NIAL GARDENS FOR	R NURSING & REF CRYSTA	L, MN 55422			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
2 830	Continued From pa	age 20	2 830			
	urine or pad tarry s discolorations proto or lab draw sites. T report to medical de family bruises and care plan did not ac bleeding risks while on R66's safety to s razor, or other inter prevent bleeding. Review of Progress 12/22/16, indicated - On 11/12/16, R66 from right thumb. S antibiotic cream an indicated R66 state trying to shave. Wil - On 12/5/16, R66 y on head with a sma indicated staff clear R66 not to use razo note, "[R66] stated himself. Writer [sic] drawers as well. W - On 12/19/16, prog noted to have blood	and bleeding from nose, gums the nurses were instructed to octor or nurse practitioner and symptoms of bleeding. The ddress how to minimize a shaving, effect of hemiplegia shave self with a disposable rventions for staff to take to a Notes from 11/1/16, to a was noted to be bleeding Staff cleaned area applied triple d a Band-Aid. The note ed," to have injured self from Il continue to be monitored." was noted to have scratches all amount of bleeding. Note ned up the area and warned or on his own. Per progress it was a result of him shaving I took all razors from his ill continue to be monitored." gress note indicated, "Resident d to nose when walking to the				
	cleaned and two sp	ch. Resident's nasal was bots noted like from a scratch. I not know how it happened.				
	- On 12/21/16, prog noted to have blood	gress note indicated, "Resident d to his cheek this morning. the area. Resident stated no	t			
		from. Will continue to be				
		madin flow sheet indicated on				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00255	B. WING		12/22/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVE L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 21	2 830			
	12/9/16, R66's INR recheck INR on 12 indicated R66 was (mg) on Monday, W Saturday. R66 was Tuesday Thursday The 3rd Floor NA s indicated R66 was During interview on registered nurse (F blood on his nose. and washed it off a asked him, where of did not know. I don he has a tendency razors out that I fou razors in there in th the cause. It would the nursing assista razors. I chart on th not do follow up on cuts from shaving.'	was 1.9 and staff were to /23/16. The flow sheet also on Coumadin 4 milligrams Vednesday, Friday and to receive Coumadin 3 mg. or and Sunday. heets dated 12/13/16, independent with shaving. n 12/21/16, at 2:19 p.m. RN)-A said, "Monday I noticed I took him back to his room nd it was two small scrapes. I did it come from? He said he 't know where it came from but to shave himself. I took all and in his room. I have found he past and that seems to be not surprise me to see that nts are giving him more he incident at the time but I do skin issues if they are small				
	manager (NM)-A sa sometimes. We ha it. He sometimes u verified that care pl	a 12/21/16, at 2:37 p.m. nurse aid, "He scratches himself ve an electric razor if he wants ses a regular razor." NM-A lan lacked specific event bleeding with ADLs.				
		n 12/22/16, at 11:16 a.m. R66 if for a razor and they give it to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOF		RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	age 22	2 830			
	me. Sometimes I cut myself but the bleeding will stop eventually."					
	Staff development are on blood thinne of bleeding risk, us	n 12/22/16, at 10:37 a.m. RN-E nurse said, "for residents who ers the staff need to be aware e electric razors not the hand esident, and notify the nurse if lems."				
	director of nursing have been just usin have not had any is know that we are the for everyone but th of the progress not the DON said, "We razor. This is the fin this. I expect the st	n 12/22/16, at 2:32 p.m. the (DON) said lately the staff ng the disposable razors. We ssues with residents bleeding. rying to initiate electric razors ey disappear. When informed res and observations of R66 e will buy him his own electric rst time I have heard about raff to chart at the time of the nave done something the first	ł			
	provided by facility of this procedure is provide skin care. plan to assess for a resident." The polic	he Resident policy page 78 instructed staff "The purpose to promote cleanliness and to 1. Review the resident's care any special needs of the cy did not indicate when to use a safety razor. The complete ut not received.				
	Director of Nursing provide education i importance of ensu- and plans of care of receive care and su- The DON or design	THOD OF CORRECTION: The (DON) or designee, could to nursing staff about the uring assessment is conducted developed to ensure residents upervision in a safe manner. nee, could randomly audit to be nursing care is provided the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00255	B. WING		12/22/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
CENTEN	NIAL GARDENS FOR		A CRUZ AV ., MN 55422	ENUE NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
2 830	Continued From pa	ge 23	2 830		
	residents.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375		2/10/17
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.				
	by: Based on interview facility failed to ens performed to preve infection for 3 of 5 m whose cares were facility failed to dev maintain an infection program related to investigation, and a diseases/infections recognized and cor onset and spread of	in order to prevent, atrol, to the extent possible, the f infections within the facility. he potential to affect all		Corrected	
	nursing assistant (N hands and put glov you ready to get up	on 12/21/16, at 7:34 a.m. VA)-G and NA-H washed their es on. NA-G asked R48, "Are for breakfast." NA-G washed noved gown. NA-G washed			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00255	B. WING		12/	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 24	21375			
	R48's upper abdom R48's face and upp weight sweater on and applied new gl sanitizing hands. N incontinence produ from back to front v cloth had brown su NA-H rolled R48 to R48's bottom. With placed a clean inco pulled down R48's R48's from bed sid for R48. NA-G was	avoiding gauze dressing on nen. NA-G applied lotion to ber body. NA-G put a red, light R48. NA-G removed gloves oves without washing or A-G loosened R48's ct and wiped R48's peri area with a wet wash cloth. Wash bstance on it after being used. left side and NA-G wiped rout changing gloves, NA-G ontinence product on R48 and sweater. NA-G rummaged in e table drawers to find socks hed hands and left room. 's lower body with pants, socks				
	10/12/16, indicated impairment and rec activities of daily liv indicated R48's dia	imum Data Set (MDS) dated R48 had severe cognitive quired assistance with all ing, except eating. R48's MDS gnoses were aphasia [inability eds] and dementia.				
	verified not washing NA-G said, "I must	12/21/16, at 2:34 p.m. NA-G g hands after changing gloves. been nervous. I always wash I should have done so today."				
	NA-C explained to to get her dressed. gloves on. NA-C wa washed arms, unde NA-C put a shirt on incontinence produ	on 12/21/16, at 10:28 a.m. R30 what she was going to do NA-C washed hands and put ashed R30's face, then er arms and under breasts. R30, NA-C removed R30's ct and then NA-C washed eri area from front to back and				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 25	21375			
	and applied lotion v washing hands. NA on R30. NA-C adju transferred R30 fro removed gloves an R30's quarterly MD R30 had severe co required assistance living, except eating diagnosis was dem During interview on said "I made a mist one pair of gloves t During interview on registered nurse (R their gloves and wa	S dated 11/16/16, indicated gnitive impairment and with all activities of daily g. R30's MDS indicated R30's				
	Staff development assistants are taug sanitizer every time they must change t peri area and a res wash a female resi of the perineum, th inner thigh, then to RN-E said, "They a soiled gloves to tou resident."	a 12/22/16, at 10:37 a.m. RN-E nurse said, the nursing ht to wash hands or use they remove their gloves, that heir gloves after washing the ident's bottom. I teach them to dent from the front to the back en from front to back of each wash the resident's bottom. are told, "do not use the dirty the a brief or to put cream on a 12/22/16, at 2:32 p.m. the (DON) said she expected staff				
	to wash their hands	s after using gloves, to change pericare and wash hands				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/22/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOF		RA CRUZ AVE L, MN 55422	NUE NORTH		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 26	21375			
	[nursing staff] are t	ing else. DON said, "They o wash front to back with doing audits this morning."				
	8:30 a.m. (NA)-C e box of gloves on th applied gloves. NA leave the room to g padding and dispose a new pair of glove exposing the peri-a was cleaned from f rolled over by NA-C backside with a dis brown substance of cleansing the soiled the soiled incontine 's bottom, rolled it the trashcan next to gloves, NA-C place on R25. NA-C runn drawers gathered a to R25 's back, wit gloves. R25 remain down to knees thro person entered the (RN)-D, and whisp applied gloves. RN NA-C went into the water, (did not rem RN-C and NA-C sta side of neck, under not changed the so	on 2/22/16, at 7:15 through entered the room and placed a le foot of R25 's bed and then -C then removed the gloves to gather more equipment i.e., sable washcloth. NA-C donned is and pulled down R25 covers area. R25 's front peri area front to back. Then R25 was C and started to wash the sposable wash cloth which had on it after being used. After d back area, NA-C then pulled ent product out from under R25 into a ball and tossed it into o the bed. Without changing ed a clean incontinent product maged in R25's bed side table a tube of lotion, then applied it thout changing the soiled ned totally exposed from head bughout the process. A second e room, registered nurse ered into R25 ear and then I-D immediately covered R25. bathroom to get a basin of ove the soiled gloves). Both arted washing R25 's face, left rarm and arm (NA-C still had biled gloves). Both staff started d arms, then RN-C tossed				
anesota Di	to dry R25 face and items of clothing ar which landed on th					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00255	B. WING		12/	22/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	•	
PENTEN	NIAL GARDENS FOR	3245 VE	RA CRUZ AVE			
JEINTEIN		CRYSTA	L, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 27	21375			
	employees remove or cleansing their h began cleaning R2 dressing, (RN)-C re cleaning them and removed gloves an washing or cleansin the EZ lift sling. NA resident, then left th larger sling. Both st and transferred R2 removed the sling. the room, NA-C con gloves to comb R2	R25 with new clothing. Both d their gloves without washing ands, applied new gloves and 5 lower extremities and emoved gloves without applied another pair. NA-C d left the room without ng hands and came back with A-C stretched it out over the he room and came back with a taff assisted R25 into the sling 5 into the motorized chair, ther RN-C removed gloves and left ntinued with the same pair of 5 's hair, applied a blanket to R25 the stuff animal as	1			
	10/19/16, indicated impairment and rec	imum Data Set (MDS) dated R25 had mild cognitive quired extensive assistance daily living, except eating.				
	indicated she expendition giving morning care area then remove thands and apply se complete the care.	12/22/16, at 11:45a.m. RN-P cted staff to apply gloves wher e, wash the face and chest heir gloves and wash their econd pair of gloves to "Our staff development eted a skills fair where we g. "				
	NA-C said, "I char	on 12/22/16, at 11:48 a.m. nge my gloves anytime I touch ny hands and apply another eded. "				
	director of staff dev	on 12/22/16, at 2:34 P.M, the velopment (DSD) was asked ng during cares. DSD stated,				

Minneso	ta Department of He	alth			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING	:	COM	FLETED
		00255	B. WING	B. WING		22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
		3245 VE		ENUE NORTH		
CENTEN	NIAL GARDENS FOR	R NURSING & REF CRYSTA	L, MN 55422	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ige 28	21375			
	about this and it is their gloves, wash or removing their glow second pair. The D at the same time, w and glove use. The staff to wash their h change gloves afte their hands before skills fair that addre Undated Handwash instructed staff; "This facility consid means to prevent the Undated Perineal O "9. For a female rest a. Wet washcloth a cleansing agent. b. Wash perineal a (1) Separate labia a front to back. (Note indwelling catheters the tubing from the about 3 inches. Ge (2) Continue to was inside outward to a	nd apply soap or skin rea from front to back. and wash area downward fron : if the resident has an , gently wash the juncture of urethra down the catheter ntly rinse and dry the area.) sh the perineum moving from nd including thighs, alternating	g a			
	Do not reuse the sa clean the urethra o (3) Rinse perineum using fresh water a the resident has an tubing to one side a	nd using downward strokes. ame wash cloth or water to r labia. thoroughly in same direction, nd a clean washcloth. (Note: i indwelling catheter, hold the and support the tubing against ction or unnecessary	f			
	movement of the c: (4) Gently dry perin c. Instruct or assist epartment of Health	atheter.)				
ATE FORI	N		6899	65E811	If continuati	on sheet 29 d

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING		12/	12/22/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
CENTEN	NIAL GARDENS FOR		RA CRUZ AVEI L, MN 55422	NUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLET DATE	
21375	Continued From pa	ige 29	21375				
	d. Rinse washcloth cleansing agent. e. Wash the rectal the base of the labit the buttocks. Do no water to clean the l f. Rinse thoroughly described in "e " al g. Dry area thoroug 11. Discard disposa container. Wash ar SUGGESTED MET director of nursing of review, and/or revis ensure hand hygier director of nursing of appropriate staff or The director of nursing compliance.	using the same technique as bove.					
21426	Prevention And Co		21426			2/10/17	
	maintain a compred infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease htion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and					

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00255	B. WING		12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR	NURSING & REF	A CRUZ AVE ., MN 55422	ENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 30	21426			
21426	unpaid employees, residents, and volu Health shall provide regarding implement (b) Written complia be maintained by the This MN Requirement by: Based on interview facility failed to ensu- baseline screening was completed for R94, R114) and 3 of upon hire, accordin Control and Preven Findings include: Employee TB symp administration: E1 had a hire date provided a TB scree Care Worker 's (Ho noted to be incomp ever had the BCG v received a live-virus weeks?" were void Have you ever had	contractors, students, nteers. The Department of technical assistance ntation of the guidelines.	21426	Corrected		
		creen noted a chest x-ray completed due to "History of +				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00255	B. WING		12/22/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
ENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE
21426	Continued From pa	age 31	21426		
	to complete a TB s	of 10/29/13. The facility failed ymptom screening. The facility a first and second step TST ed.	,		
	to complete a TB s When interviewed of	of 10/16/12. The facility failed ymptom screening. on 12/22/16, at 2:34 p.m. with nurse (RN)-E verified the			
	TB screening comp TST was administer record did not indic of the first step TST step TST was not a R120's medical rec for previous Nursin	I on $8/30/16$, had a baseline bleted on $8/30/16$, first step ered on $9/9/16$. R120's medical ate the date when the results T were completed. The second administered as indicated on cord as the facility was waiting g Home to fax over the results no call was returned as of			
	screening complete TST was administe second step TST w Both the first step a evidence of the dat	on 1/5/16, had a baseline TB ed on 1/5/16. The first step ered on 1/15/16, and the vas administered on 1/25/16. and second step TST lacked te, time and results of the ers (mm) and as negative or			
	baseline TB Screer The baseline scree have a previous po provided from 1/28 was for hypotension indicate it was for T	I on 6/29/16. R108 had a ning completed on 6/29/16. ning indicated R108 did not sitive TST. A chest x-ray was /14, however, it indicated it n and the chest xray did not 'B. The x-ray stated, "Has mild atelectasis in lung base. No			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00255	B. WING		12/	22/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOF	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21426	Continued From pa	age 32	21426			
	evidence of acute changes." The x-ray form was electronically signed 2/21/14, placed in the nurses notes 6/30/15.		5			
	baseline TB Screet R94 had three TST first TST record as results of being rea documented on 4/1 which arm it was ac documented on 4/2 mm or if it was pos third TST documen Medication Adminis administered on 4/2 arm it was adminis	on 3/22/16. R94 had a ning completed, date unknown recorded as being given: The given on 3/23/16, without ad. The second TST was 1/16, without documenting dministered. The results were 8/16, however, did not indicate itive or negative results. The ted on the April 2016 stration Record as being 23/16, did not document which tered in as well as they did not lts of the reading on 4/25/16, gative or positive.				
	TB Screening com was given on 6/14/	I on 12/29/15. Had a baseline pleted on 6/13/16. First TST 16, without documenting which tered in, they did not documen TST.				
	The above findings 12/22/16, at 2:34 p	were verified by the RN-E on .m.				
	could not find a cop Assessment for 20 indicate TB educat the facility TB infect	N-E confirmed the facility by of the Facility TB Risk 16. The facility policies did not ion with employees regarding tion control plan. The last TB it was conducted on 7/31/14.				
	and Control dated	uberculosis (TB) Prevention 8/2013, indicated in ate and federal law health care				

D0255 B. WING D222/2016 ADME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE COLSPANE CARDENS FOR NURSING A REL STREET ADDRESS. CITY. STATE. ZIP CODE COLSPANE CARDENS FOR NURSING A REL COLSPANE CARDENS FOR NURSING A REL SUMMARY STATEMENT OF DEFORENCES COLSPANE CARDENS FOR NURSING A REL COLSPANE CARDENS FOR NURSING CARDENS COLSPANE CARDENS FOR NURSING CARDENS COLSPANE CARDENS FOR NURSING CARDENS COLSPANE CARDENS FOR NURSING CARDENS <td colspans<="" th=""><th>AND PLAN</th><th>NT OF DEFICIENCIES</th><th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th><th></th><th></th><th></th><th>E SURVEY PLETED</th></td>	<th>AND PLAN</th> <th>NT OF DEFICIENCIES</th> <th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th> <th></th> <th></th> <th></th> <th>E SURVEY PLETED</th>	AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
Batter Discrete Constraints of the constraints and consequiten measing within 72 hours of admission or within s			00255	B. WING		12/	22/2016	
CHAILENNAL GARDERS FOR NURSING & REF CRYSTAL, MN 55422 (M) ID PRETX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY NURSITE FRECEDED BY FULL REGULATORY OR LSCIDENTFYING INFORMATION) ID PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE APPROPRIATE DEFICIENCY 00000 (ME) (EACH DEPICIENCY NURSITE FRECEDED BY FULL REGULATORY OR LSCIDENTFYING INFORMATION) 10 PRETX TAG PROVIDERS FLAN OF CORRECTION SHOULD BE CROSS-REFERENCE APPROPRIATE DEFICIENCY 00000 (ME) (EACH DEPICENCY 21426 Continued From page 33 facilities must ensure that employees, prior to employment and volunteers prior to volunteering show freedom from active TB. Employees and volunteers will have initial and periodic testing if necessary for TB. A. An education program will be in place for employees/volunteers. This will consist of ongoing surveillance and implementation of policies in the event of a suspected or active case of TB at which time guidance and support are provided for the employs/volunteer. Baseline screening at the time of hire is required for all health care workers in Minnesota. Baseline TB screening within 72 hours of admission or within 3 months prior to admission. Baseline consists of three components (1) assessing for current symptoms of active TB on the most current standards and requirements in regards to TB control. Facility policies and procedures related to TB could be reviewed and revised if necessary. An auditing system could be developed, with review by the quality assessment and assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21495 21495	NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
MAILD PRETX TAG SUMMARY STATEMENT OF DEFICENCIES (EACH DEFICIENCY NUST GE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY NUST GE PRECEDED BY FULL PRETX TAG ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) V////////////////////////////////////	ENTEN	INIAL GARDENS FOF			NUE NORTH			
facilities must ensure that employees, prior to employment and volunteers prior to volunteering show freedom from active TB. Employees and volunteers will have initial and periodic testing if necessary for TB. 3. An education program will be in place for employees/volunteers. This will consist of ongoing surveillance and implementation of policies in the event of a suspected or active case of TB at which time guidance and support are provided for the employs/volunteer. Baseline screening at the time of hire is required for all health care workers in Minnesota. Baseline TB screening consists of two components (1) assessing for current symptoms of active TB disease and (2) testing for the presence of infection by administering a two-step TST or single TB blood test. All resident will receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. Baseline consists of three components (3) testing for the presence of infection by administering wither a two-step TST or a single blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all standards and requirements in regards to TB control. Facility policies and procedures related to TB could be reviewed and revised if necessary. An auditing system could be developed, with review by the quality assessment and assurance committee to ensure ongoing compliance. 21495 2/10/17	PRÉFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLET	
employment and volunteers prior to volunteering show freedom from active TB. Employees and volunteers will have initial and periodic testing if necessary for TB. 3. An education program will be in place for employees/volunteers. This will consist of ongoing surveillance and implementation of policies in the event of a suspected or active case of TB at which time guidance and support are provided for the employes/volunteer. Baseline correnting at the time of hire is required for all health care workers in Minnesota. Baseline TB screening consists of two components (1) assessing for current symptoms of active TB disease and (2) testing for the presence of infection by administering tor the presence of infection by administering if the at wo-step TST or single TB blood test. All resident will receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. Baseline consists of three components (3) testing for the presence of infection by administering wither a two-step TST or a single blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff responsible for TB on the most current standards and requirements in regards to TB control. Facility policies and proceduped, with review by the quality assessment and assurance committee to ensure ongoing compliance.214952/10/17	21426	Continued From pa	age 33	21426				
		employment and version show freedom from volunteers will have necessary for TB. 3 be in place for emp consist of ongoing implementation of psuspected or active guidance and suppemploys/volunteer. of hire is required f Minnesota. Baselin components (1) as of active TB diseas presence of infection TST or single TB b receive baseline TB admission or within Baseline consists of for the presence of wither a two-step T SUGGESTED MET director of nursing responsible for TB and requirements i Facility policies and could be reviewed auditing system co by the quality asset committee to ensure the set of the s	olunteers prior to volunteering a active TB. Employees and e initial and periodic testing if 3. An education program will oloyees/volunteers. This will surveillance and policies in the event of a e case of TB at which time or are provided for the Baseline screening at the tim or all health care workers in the TB screening consists of tw sessing for current symptoms and (2) testing for the on by administering a two-step lood test. All resident will B screening within 72 hours of a 3 months prior to admission. of three components (3) testing infection by administering ST or a single blood test. THOD OF CORRECTION: The could inservice all staff on the most current standards n regards to TB control. d procedures related to TB and revised if necessary. An uld be developed, with review ssment and assurance	0)) 9				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REF	A CRUZ AV ., MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21495	services must be pridentified social ser according to the co assessment and co described in parts This MN Requireme by: Based on observati review, the facility fa necessary equipme reviewed who requi in order to get up at Findings include: R78's significant ch (MDS) dated 11/25/ severely cognitively assist of two staff fo personal hygiene at ambulate. R78's ca indicated a self-card staff related to a hip A review of a Physic indicated an order f due to hip fracture. A review of R78's C and Rehabilitation F 12/12/16 through 12 following: - 12/12/16 - Has ne - 12/13/16 - 12/19/1 hip fracture, on order	rovided on the basis of vice needs of each resident, mprehensive resident omprehensive plan of care 4658.0400 and 4658.0405. ent is not met as evidenced on, interview and document ailed to provide medically ent for 1 of 1 resident (R78) ired a specialized wheel chair nd remain out of bed. ange Minimum Data Set (16, indicated she was rimpaired, required extensive or bed mobility, toileting, and nd did not transfer or re plan dated 12/7/16, e deficit and dependence on o fracture resulting in bed rest. cian ' s Order dated 12/12/16, for a tilt in space Broda Chair Centennial Gardens for Nursing Progress Notes dated 2/20/16, indicated the w orders for Broda chair. 16 - Broda chair, every shift for	21495	Corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE		
	NIAL GARDENS FOR	NUBSING & BEL 3245 VEI	RA CRUZ AVEI			
		CRYSTA	L, MN 55422			-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
21495	Continued From pa	ge 35	21495			
	2:20 p.m., R78 was common area of the holiday party was b party continued with and presents for ea lay awake in her be R78 remained in be the bed. Music coul down the hall. At 3: awake in her bed. During an interview registered nurse (R bed rest and stated looking into a chair that was ordered by	bbservation on 12/20/16, at s lying awake in her bed. In the e adjoining unit, a resident eginning. At 2:33 a.m. the n live music, a visit from Santa ach resident. R78 continued to ed at this time. At 2:47 p.m., ed. She was moving around in ld be heard from the party 10 p.m., she continued to lay on 12/20/16, at 3:11 p.m., N)-D stated R78 had been on I the therapy department was for her. She stated the chair y the physician was no lity so they had to either rent				
	physical therapist (I department was su Broda chair for R78 the therapy director	o on 12/20/16, at 3:17 p.m., PT)-A stated the nursing pposed to be ordering the 3. During the same interview stated she recommended the reek, after the physician bed rest.				
	director of nursing (on 12/20/16, at 7:44 a.m., the (DON) stated she was chair for R78 that day.				
	During an observat Broda chair was in	ion on 2/21/16, at 7:44 a.m., a R78's room.				
	the DON stated she that could provide t She stated R78 wo	on 12/21/16, at 11:06 a.m., was trying to find a vendor he chair for R78 as a rental. uld only need the chair for the facility did not want to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CENTEN	NIAL GARDENS FOF		RA CRUZ AVEN L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21495	Continued From pa	age 36	21495			
	stated she ordered The DON stated th they were waiting for	d dollars to buy one. She the chair the previous day. e reason for the delay was or a rental chair, which we got der was written by the				
	less than twenty for R78 remained in be released from bed unable to attend the	air was received in the facility ur hours after it was ordered, ed for eight days after she was rest. Furthermore, R78 was e resident holiday party due to e to timely provide physician quipment.				
		arding timeliness of following rders was requested but not				
	The administrator of arrangements were required physician	THOD OF CORRECTION: or designee could ensure e made for residents that ordered equipment were nedically necessary euipment				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One	,			
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			2/10/17
	(a) Each facility sh ongoing written pro applicable licensing of suspected maltro facility has an inter	I reporting of maltreatment. all establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00255	B. WING		12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
CENTEN	NIAL GARDENS FOR		RA CRUZ AV L, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 37	21995			
	internally. Howeve	s section by reporting r, the facility remains nplying with the immediate ents of this section.				
	by: Based on observat review, the facility f administrator, inves of mistreatment/elo	ent is not met as evidenced ion, interview, and document ailed to immediately notify the stigate and report allegations opement(s) to the State agency 4 residents (R77, R104).	,	Corrected		
	Findings include:					
	noted R77 to have memory impairment assist of one for all with the exception of ambulate. The corr 11/8/16, noted R77	ta Set (MDS) dated 10/26/16, both long term and short at. In addition, R77 required activities of daily living (ADLs) of eating and R77 did not oprehensive care plan dated 's diagnoses to include avioral disturbance and muscle				
	R77 had a bruise to left forearm, a bruis knee. An Incident F the resident had be wheelchair and said doorway going into dated 12/10/16, inc bruise to the face a the left forearm, the left elbow or upper 12/18/16, at 4:00 p	te dated 12/3/16, indicated o the face, a skin tear on the se on the left wrist, and left Report dated 12/3/16, noted een propelling himself in the d he hit his arm on the his room. The bath skin check licated R77 noted a dark and left wrist, and a skin tear to ere was no note of injury to the arm. A Progress Note dated .m. indicated R77 complained and could not move the arm on				

65E811

If continuation sheet 38 of 57

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	1	
ENTEN	NIAL GARDENS FOF		RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 38	21995			
	his room laying in h elbow was observe approximately the s grimacing and state injured left arm had sling or wrap on the side to side and the the pillow. R77 stat wrong with his arm came to the room a yesterday." An x-ray report dat had a complete fra arm bone) by the e separated by 5 mill indicated the x-ray 12/19/16, at 10:45	on 12/19/16, at 2:00 p.m. in his bed. The resident's left ed to be reddened and swollen, size of a baseball. R77 was ed, "I can't stand the pain." The d a pillow under it, there was no e arm. R77 was moving from e arm was not supported by ted he did not know what was n. Nursing assistant (NA)-E and said, "He hurt his arm ed 12/19/16, indicated R77 cture of the humerus (upper elbow and the bones were limeters. The progress notes results had been received on p.m. and the results were	9			
	indicated R77 cont could not move the	tian and the family. t 6:30 a.m. on 12/19/16, inued to complain of pain, and e left arm. The nurse noted the Idened, a bit inflamed and				
	12/19/16, at 4:00 p	RN)-A was interviewed on .m. and stated the resident .wall on 12/3/16, but had not				
	on $12/20/16$, at 2:1 the hospital emerg 12/20/16, to treat a	nurse (LPN)-A was interviewed 5 p.m. and stated R77 went to ency room at lunch time on a left arm fracture. LPN-A said, what happened to the arm, it ' (12/18/16).				
	On 12/20/16, at 3:2	20 p.m. NA-A was interviewed				

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		00255	B. WING		12/	22/2016
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		22/2010
	NIAL GARDENS FOR	3245 VEI	RA CRUZ AVEI			
		CRYSIA	L, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 39	21995			
	the left arm on Sun reported to the nurs afternoon shift. NA rest. NA-A stated F arm problems the v The director of nurs 12/21/16, at 9:20 a been made to her, a serious injury of u The DON stated a the SA and an inve 12/20/16, at about investigation was n the injury to an inci- bumped into the wa experienced a char that the appearanc 12/19/16, which wa the nurse practition no known injury sin	sing (DON) was interviewed or .m. and stated no report had the administrator or the SA of unknown origin until 12/20/16. report had been submitted to stigation was initiated on 4:00 p.m The DON stated the ot complete but she attributed dent on 12/3/16, when R77 all. She confirmed R77 had nge in pain on 12/18/16, and e of the arm changed on as subsequently checked by her (NP). She stated there was ice 12/3/16. When asked re was considered a new				
	interviewed and sta for R77 on 12/3/16 more on Monday 1 had been diagnose that nursing was lo report to the SA ha	30 a.m. the administrator was ated he'd heard about the injury , and was told the arm hurt 2/19/16, and that the resident ed with a fracture. He stated oking into it, but confirmed a d not been made until d he assumed the injury was				
	and stated she saw R77 had an acute i not move the arm.	ved on 12/21/16, at 12:07 p.m. v R77 on 12/19/16. NP-D said njury to the left arm and could She stated medically she tt was from an injury on				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NIIRSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)				(X5) COMPLET DATE
21995	Continued From pa	age 40	21995			
	12/3/16 due to the severity of the fracture. She felt the fracture was a new injury and did not know the cause however, stated it could not be determined when the fracture occurred.					
	Investigation dated will thoroughly inve or alleged abuse, n exploitation. Injurie	or Abuse Reporting and 11/28/16, indicated the facility stigate all reports of suspected reglect, and financial s of unknown origin will be out potential abuse.				
	abuse or neglect to administrator. The	staff to immediately report the supervisor and the supervisor should immediately agency (SA) if there was a se occurred.				
	had limited physical use his walker, and going out of the bui 9/29/16, noted R10 impairment and wa diagnoses of hepat with ascites and red care plan also inclui indicated R104 was supervision with sm designated area. F	ated 7/31/16, indicated R104 I mobility, needed reminders to I may need a wheelchair when ilding. R104's MDS dated 4 had severe cognitive s admitted to the facility with a ic failure, cirrhosis of the liver ceived hospice services. The ided a date of 9/30/16, which s a smoker who required noking in the outside R104's Physician Orders dated OK for WanderGuard."				
	following entries: O member (F)-B "hac [transitional care ur (RN)-B] to report th cab yesterday and asked R104 for the	Progress Notes included the In 11/8/16, at 5:54 p.m. family I called 1st floor/TCU mgr hit/manager -Registered Nurse hat R104 had gone shopping by was staff aware. This writer I details and he stated the 1st floor male honcho. Talked				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
CENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEN L, MN 55422	IUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21995	about rides availabl [grocery store] for s she sticking her nos people.' Gave him r floor and then he sa is on a plaque in the p.m. "Writer noticed is not in his room. S family member carr [R104] on first floor the smoking area a [R104] was not ther "Resident was repor this morning by the [sic] about 350 met went to get him bac and insisted that her redirected several t and kept on walking Staff called the faci After about 10 minu- then talked to him a Vital signs were cor denied having pain noted at the time m administered and a initiated. All parties gave new orders fo out with [family]. Sta monitor the residen A care conference in R104 and family rea- required supervisio medical record and evidence of any acc regarding R104 mis	e. Cab was ok. Went to Cub ome fruit and stuff. Why is se in? Why is she calling names of men working on 1st aid 'The one who's [sic] name e front.''' On 11/19/16, at 6:13 d at 1800 res [resident - R104] South nurse told writer that a ne to visit and went with res . Writer checked on 1st floor, nd front of the building res re. On 12/16/16, at 2:04 p.m. rted to be walking on the road staff along vera cruz ave n ers from the facility. Writer ek to the facility but he refused was going to cub he was ime back but still he refused g with the walker towards 36th. lity who in turn called 911. utes, the police arrived who and he accepted to comeback. mpleted see vital section he no SOB [shortness of breath] orning medication 15 minutes check was were notified hospice nurse r see orders. He is currently aff will cont. [continue] to	21995			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		12/	22/2010
		3245 VE	RA CRUZ AVE			
ENTEN	NIAL GARDENS FOR	NUBSING & REF	L, MN 55422			
X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
REFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	THE APPROPRIATE	COMPLET DATE
				DEFICIEN	CY)	
21995	Continued From pa	age 42	21995			
	RN-A was interview	ved on 12/20/16, at 3:12 p.m.				
		called police on 12/16/16,				
		utside of the facility. RN-A				
		to be "totally wonderful one confused, and he was				
		orning, it took police another				
		nim into coming back here."				
		04 was discovered missing				
		nds around 6:30 a.m. RN-A				
:		the nurse working and				
		ng after R104 was not in his				
		ed someone outside the ff that R104 was walking dowr				
		C went outside to redirect				
		ing. LPN-C could not redirect				
		N-A from his cell phone. RN-A				
	•	ce who were able to bring				
		building. When R104 was				
		y, the facility began every 15				
		updated family, hospice, the RN-A indicated the DON did				
		SA and believed the incident				
		en asked about the 11/8/16,				
	Progress Note which	ch indicated R104 left the				
		I-A stated the incident did not				
		staff knew he wanted to call a				
		I before anything occurred. liar with R104 missing from the				
		time and not familiar with the	7			
		Note entry. RN-A stated she				
		wandering assessment for				
		"this one little trip outside the				
		elopement; he had a				
		rther indicated the incident				
	really was not dan	gerous in any way."				
	The DON was inter	rviewed on 12/20/16, at 3:30				
		ed R104 "goes for walks and				
		and smokes." The DON did				
			ii			1

	T OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00055	B. WING		10/00/0010		
		00255			12/2	22/2016	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST RA CRUZ AVEI				
ENTEN	NIAL GARDENS FOR	R NURSING & REF	L, MN 55422				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLE DATE	
				DEFICIENC	;Y)		
21995	Continued From pa	age 43	21995				
	smoking. The DON stated R104 was dressed						
		e weather on 12/16/16, and					
		used. The DON confirmed					
		acility grounds when he was					
	2	2/16/16, and she did not					
		ent an elopement. The DON 04 has been trying to go out					
		e did not think R104 had a					
		they had tried on in the past					
		ally close eye on him. The DON	N				
		ement assessment or					
		ment had not been completed					
		d there was a difference					
		and going for a walk. The					
		med R104 was not on the					
		ard list and stated "he shouldn't	I I				
		the time." The DON further					
		d the right to wander and e incident was not reported					
		ot view the incident as an					
		as found immediately by staff.					
		an elopement a "someone who					
		rd but is gone, and cannot be					
	found."	0					
	$O_{\rm P}$ 12/21/16 at 2.0	21 p.m. LPN-C was					
		C stated he was the nurse					
		6, and during morning report a	4				
		mber who had left for the	`				
	0	to the facility and stated R104					
		street. LPN-C confirmed no					
	staff was aware R1	104 had left the building.					
		outside the facility to bring R104	4				
		ated it was freezing outside					
		s dressed in a coat and had					
		approximately 300 meters					
		PN-C stated he was unable to					
		o the building and called RN-A					
		C stated police arrived and					

STATE FORM

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00255	- B. WING		12/	22/2016
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOR	SNUBSING & REF 3245 VEF	RA CRUZ AVEI	NUE NORTH		
	MAE GANDENS I ON	CRYSTAI	, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	uge 44	21995			
	facility. LPN-C state they returned to the and F-B. LPN-C state every 15 minute ch any other time R10 unsupervised. LPN how long R104 had RN-B was interview who stated she new F-B on 11/8/16. RN office and asked he a cab to Cub Foods unaware of that and DON about what wa F-B. RN-B stated si further regarding th RN-A. RN-B was not the facility unsuper aware of the 12/16/	d LPN-C a ride back to the ed he assessed R104 when a facility and updated Hospice ated they then implemented ecks. LPN-C was unaware of 4 had left the building -C stated he was unaware at 8 been outside. wed on 12/21/16, at 12:06 p.m. ver received a call from R104's I-B stated F-B stopped in her er if she had heard R104 left in s yesterday. RN-B was d contacted RN-A and the as told to her about R104 from he did not hear anything ue situation from the DON or ot aware of R104 ever leaving vised. RN-B stated she was (16, incident however, was not the incident occurred.				
	interviewed on 12/2 12/22/16, at 2:23 p. leave from the facil of the incident and reporting the incide was not reported be the resident and he safely and appropri vacation during the know if R104 actua familiar with any oth missing or left the f	ial services (DSS) was 21/16, at 8:42 a.m. and on .m. regarding R104's 12/16/16, ity. DSS stated she was aware stated there was discussion of nt later in the day however, it ecause there was no harm to a was returned to the facility ately. DSS stated she was on week of 11/8/16, and did not .lly left the facility. DSS was not her time R104 had been acility without supervision.				
		Iministrator stated he was 5, R104 was outside and to his				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00055	B. WING				
		00255			12/	12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
CENTEN	NIAL GARDENS FOR	R NURSING & REF	RA CRUZ AVE L, MN 55422				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
21995	Continued From pa	age 45	21995				
	understanding staf	f had let him out front and he					
		the side walk and a nurse					
		de. The administrator					
		lent was not reported and as aware of the incident and					
		he had taken care of the					
		inistrator confirmed he was					
		elopement was and if that was					
		to him it would have been					
		inistrator was interviewed					
		(16, Progress Note and stated R104 that he could call a cab to					
		he administrator was unaware					
	if R104 left the faci	lity. The administrator was not					
		/18/16, Progress Note or					
	incident.						
	An undated elonen	nent policy included "staff shall					
		port all cases of missing					
		licy further indicated when a					
		I returns to the facility the DON	1				
	or Charge Nurse s						
	"a. Examine the re						
	b. Notify the Attend	nt's legal representative of the					
	incident;						
		le Report of Incident/Accident;					
	and						
	e. Document the er record."	vent in the resident's medical					
	SUGGESTED ME	THOD FOR CORRECTION:					
		DON, social services or					
		review and revise as					
		cies and procedures regarding					
		s of reporting/investigating the or maltreatment. The					
		I, social services or					
	designee(s) could	provide training for all					
		n these policies and					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00255	B. WING		12/22/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
ENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	ge 46	21995			
	services or designe all reports of abuse investigated. TIME PERIOD FOR	Iministrator, DON, social e(s) could monitor to assure are being reported and R CORRECTION: Twenty-one				
22000		6.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			2/10/17
	facility, except hom personal care atten establish and enfor- prevention plan. The assessment of the environment, and it factors which may ea and a statement of to minimize the risk comply with any rul- promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or rea The plan shall conta assessment of: (1) abuse by other indi- vulnerable adults; (2) other vulnerable ad specific measures to risk of abuse to tha	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. including a home health care al care attendant services relop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the				
		except home health agencies				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING		12/22/2016		
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/	12/22/2010	
-		3245 VE		ENUE NORTH			
ENTEN	NIAL GARDENS FOR	NURSING & REF	L, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	age 47	22000				
	violent crime or an toward others, the i plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Unc of a vulnerable adu misconduct or phy such information fre authority or through another facility, and	herable adult has committed a act of physical aggression individual abuse prevention e measures to be taken to nat the vulnerable adult might ected to pose to visitors to the soutside the facility, if der this section, a facility knows lit's history of criminal sical aggression if it receives om a law enforcement n a medical record prepared by other health care provider, or g assessments of the	3				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document ailed to operationalize their policy for 2 of 4 residents (R77, abuse.		Corrected			
	Investigation dated will thoroughly inve suspected or allege financial exploitatio will be investigated	or Abuse Reporting and 11/28/16, indicated the facility stigated all reports of ed abuse, neglect, and n. Injuries of unknown origin to rule out potential abuse. staff to immediately report					
	abuse or neglect to	the supervisor and the supervisor should immediately					

65E811

If continuation sheet 48 of 57

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00255	B. WING		12/	22/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ENTEN	INIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
22000	Continued From pa	age 48	22000			
	report to the state agency (SA) if there was a suspicion that abuse occurred.					
	noted R77 to have memory impairmer assist of one for all with the exception ambulate. The corr 11/8/16, noted R77	ta Set (MDS) dated 10/26/16, both long term and short nt. In addition, R77 required activities of daily living (ADLs) of eating and R77 did not nprehensive care plan dated 's diagnoses to include avioral disturbance and muscle				
	R77 had a bruise to left forearm, a bruise knee. An Incident F the resident had be wheelchair and said doorway going into dated 12/10/16, inc bruise to the face a the left forearm, the left elbow or upper 12/18/16, at 4:00 p	te dated 12/3/16, indicated o the face, a skin tear on the se on the left wrist, and left Report dated 12/3/16, noted een propelling himself in the d he hit his arm on the his room. The bath skin check dicated R77 noted a dark und left wrist, and a skin tear to ere was no note of injury to the arm. A Progress Note dated .m. indicated R77 complained ad could not move the arm on				
	his room laying in h elbow was observe approximately the s grimacing and state injured left arm had sling or wrap on the side to side and the the pillow. R77 stat wrong with his arm	on 12/19/16, at 2:00 p.m. in his bed. The resident's left ed to be reddened and swollen, size of a baseball. R77 was ed, "I can't stand the pain." The d a pillow under it, there was no e arm. R77 was moving from e arm was not supported by red he did not know what was . Nursing assistant (NA)-E and said, "He hurt his arm				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00255	B. WING		12/22/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE. ZIP CODE	•	
		3245 VE	RA CRUZ AVE			
ENTEN	NIAL GARDENS FOF	CRYSTA	L, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		MUST BE PRECEDED BY FULL PREFIX		CORRECTION FION SHOULD BE THE APPROPRIATE CY)	(X5) COMPLETE DATE
22000	Continued From pa	age 49	22000			
	had a complete fra arm bone) by the e separated by 5 mill indicated the x-ray 12/19/16, at 10:45 called to the physic A Progress Note at indicated R77 cont could not move the left elbow was "red warm to touch."	ed 12/19/16, indicated R77 cture of the humerus (upper blow and the bones were limeters. The progress notes results had been received on p.m. and the results were cian and the family. t 6:30 a.m. on 12/19/16, inued to complain of pain, and e left arm. The nurse noted the idened, a bit inflamed and RN)-A was interviewed on				
	12/19/16, at 4:00 p	.m. and stated the resident wall on 12/3/16, but had not				
	on $12/20/16$, at 2:1 the hospital emerg 12/20/16, to treat a	nurse (LPN)-A was interviewed 5 p.m. and stated R77 went to ency room at lunch time on a left arm fracture. LPN-A said, what happened to the arm, it ' (12/18/16).				
	and stated R77 had the left arm on Sur reported to the nur afternoon shift. NA	20 p.m. NA-A was interviewed d complained of severe pain in nday, and that he (NA-A) had se on 12/18/16, during the -A said R77 remained on bed R77 was up and about with no week before.				
	12/21/16, at 9:20 a been made to her, a serious injury of u	sing (DON) was interviewed or m. and stated no report had the administrator or the SA of unknown origin until 12/20/16. report had been submitted to				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING		12/	12/22/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE			
ENTEN	NIAL GARDENS FOF		RA CRUZ AVEN L, MN 55422	IUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	age 50	22000				
	12/20/16, at about investigation was n the injury to an inci- bumped into the wa experienced a char that the appearanc 12/19/16, which wa the nurse practition no known injury sin whether the fractu- injury, she stated n On 12/21/16, at 10 interviewed and sta for R77 on 12/3/16 more on Monday 1 had been diagnose that nursing was lo report to the SA ha	estigation was initiated on 4:00 p.m The DON stated the lot complete but she attributed dent on 12/3/16, when R77 all. She confirmed R77 had nge in pain on 12/18/16, and e of the arm changed on as subsequently checked by her (NP). She stated there was nce 12/3/16. When asked re was considered a new to. :30 a.m. the administrator was ated he'd heard about the injury , and was told the arm hurt 2/19/16, and that the resident ed with a fracture. He stated oking into it, but confirmed a d not been made until d he assumed the injury was					
	and stated she saw R77 had an acute in not move the arm. cannot imagine tha 12/3/16 due to the felt the fracture was know the cause ho	wed on 12/21/16, at 12:07 p.m. v R77 on 12/19/16. NP-D said injury to the left arm and could She stated medically she at was from an injury on severity of the fracture. She s a new injury and did not wever, stated it could not be he fracture occurred.					
	investigate and rep residents." The pol	sident for injuries;					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING		12/22/2016		
AME OF F	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
ENTEN	NIAL GARDENS FOF	R NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
22000	Continued From pa	age 51	22000				
	incident; d. Complete and fil and e. Document the ev record." R104's care plan d had limited physica use his walker, and going out of the bu 9/29/16, noted R10 impairment and wa diagnoses of hepat with ascites and re- care plan also inclu indicated R104 was supervision with sn designated area. T the use of R104's V	nt's legal representative of the le Report of Incident/Accident; vent in the resident's medical ated 7/31/16, indicated R104 al mobility, needed reminders to d may need a wheelchair when ilding. R104's MDS dated 04 had severe cognitive as admitted to the facility with a tic failure, cirrhosis of the liver ceived hospice services. The uded a date of 9/30/16, which s a smoker who required noking in the outside the care plan did not include WanderGuard or the ne facility. R104's Physician					
	WanderGuard." Review of R104's F following entries: C family member (F)- [transitional care un (RN)-B] to report th cab yesterday and asked R104 for the following ' Talked to Talked about rides	(16, included "OK for Progress Notes included the On 11/8/16, at 5:54 p.m. A -B "had called 1st floor/Tcu mginit/manager -Registered Nurse hat R104 had gone shopping by was staff aware. This writer e details and he stated the to 1st floor male honcho. available. Cab was ok. Went					
	to Cub for some fru sticking her nose in Gave him names of then he said ' The plaque in the front. -"Writer noticed at	uit and stuff. Why is she n? Why is she calling people. ' of men working on 1st floor and one who's [sic] name is on a ' " On 11/19/16, at 6:13 p.m. 1800 res [resident - R104] is uth nurse told writer that a					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00255	B. WING	B. WING		12/22/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
	NIAL GARDENS FOF	3245 VE	RA CRUZ AVEI L, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	[R104] on first floor	ne to visit and went with res r. Writer checked on 1st floor,	22000				
	[R104] was not the "Resident was repor- this morning by the [sic] about 350 met went to get him bac and insisted that he redirected several and kept on walkin Staff called the fac After about 10 min then talked to him Vital signs were co denied having pain	and front of the building res re. On 12/16/16, at 2:04 p.m. orted to be walking on the road e staff along vera cruz ave n ters from the facility. Writer ck to the facility but he refused e was going to cub he was time back but still he refused g with the walker towards 36th ility who in turn called 911. utes, the police arrived who and he accepted to comeback mpleted see vital section he no SOB [shortness of breath]					
	initiated. All parties gave new orders for out with [family]. St monitor the resider A care conference R104 and family re required supervisio	a 15 minutes check was were notified hospice nurse or see orders. He is currently aff will cont. [continue] to					
	evidence of any ac regarding R104 mi 12/16/16, R104 mi leave on 11/7/16.	cident/incident reports ssing from the facility on ssing on 11/19/16 or R104's					
	who confirmed she when R104 went o indicated R104 car moment and then o confused on this m 10 minutes to talk I	ved on 12/20/16, at 3:12 p.m. e called police on 12/16/16, utside of the facility. RN-A n be "totally wonderful one confused, and he was iorning, it took police another him into coming back here." 04 was discovered missing					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00255	B. WING	B. WING		12/22/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR	NURSING & REF	RA CRUZ AVEI L, MN 55422	NUE NORTH			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
22000	Continued From pa	age 53	22000				
	during morning rounds around 6:30 a.m. RN-A						
		ctical nurse (LPN)-C was the					
		searched the building after					
		s room. RN-A indicated					
		he building alerted staff R104					
	0	the road and LPN-C went					
		R104 into the building. LPN-C R104 and called RN-A from his					
		nen called the police who were					
		back into the building. When					
	5	the building, the facility began					
		ecks and updated family,					
		d the DON. RN-A indicated the)				
		ing to the SA and believed the					
		ed. When asked about the					
		Note which indicated R104 left					
		, RN-A stated the incident did					
		ated staff knew he wanted to					
		vened before anything s not familiar with R104					
		acility at any other time and not					
		/19/16, Progress Note entry.					
		d not complete a wandering					
		04. RN-A stated "this one little					
		ding was not an elopement; he					
		and further indicated the					
	incident "really was	not dangerous in any way."					
		rviewed on 12/20/16, at 3:30					
		ed R104 "goes for walks and					
		and smokes." The DON did					
		equired supervision for					
		I stated R104 was dressed					
		e weather on 12/16/16, and used. The DON confirmed					
		acility grounds when he was					
		2/16/16, and she did not					
		nt an elopement. The DON					
		04 has been trying to go out					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00255	B. WING		12/22/2016	
					12/	22/2010
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ENTEN	NIAL GARDENS FOF	R NURSING & REF	RA CRUZ AVE L, MN 55422	NUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 54	22000			
	but staff keep a reaconfirmed an elope wandering assess for R104 and state between going out DON further confirm facility WanderGua be, he goes out all indicated R104 had confirmed again the because she did no elopement as he w The DON defined a	they had tried on in the past ally close eye on him. The DON ement assessment or nent had not been completed d there was a difference and going for a walk. The med R104 was not on the ard list and stated "he shouldn't the time." The DON further d the right to wander and e incident was not reported of view the incident as an vas found immediately by staff. an elopement a "someone who rd but is gone, and cannot be				
	interviewed. LPN-C working on 12/16/1 night shift staff mer morning, returned t was outside on the staff was aware R1 LPN-C then went of back in. LPN-C sta however R104 was shoes on and was from the building. L persuade R104 into to call police. LPN- persuaded R104 ba gave both R104 and facility. LPN-C stat they returned to the and F-B. LPN-C stat every 15 minute ch any other time R10	21 p.m. LPN-C was C stated he was the nurse 6, and during morning report a mber who had left for the to the facility and stated R104 street. LPN-C confirmed no 04 had left the building. butside the facility to bring R104 ted it was freezing outside a dressed in a coat and had approximately 300 meters .PN-C stated he was unable to o the building and called RN-A C stated police arrived and ack into the building and police ted he assessed R104 when e facility and updated Hospice ated they then implemented necks. LPN-C was unaware of 04 had left the building I-C stated he was unaware at	1			

Minnesota Department of Hea STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/22/2016		
		00255					
IAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S		· ·/		
		3245 VEI	RA CRUZ AVEI				
ENTEN	NIAL GARDENS FOR	R NURSING & REF	L, MN 55422				
(X4) ID			ID			(X5) COMPLET	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	DATE	
				DEFICIENC	CY)		
22000	Continued From page 55		22000				
	RN-B was interviewed on 12/21/16, at 12:06 p.m.						
	who stated she never received a call from R104's						
	F-B on 11/8/16. RN-B stated F-B stopped in her						
		er if she had heard R104 left in					
	a cab to Cub Foods yesterday. RN-B was unaware of that and contacted RN-A and the						
		as told to her about R104 from					
		he did not hear anything					
		e situation from the DON or					
		ot aware of R104 ever leaving					
		vised. RN-B stated she was					
		/16, incident however, was not					
	working at the time	the incident occurred.					
	The director of soc	ial services (DSS) was					
	interviewed on 12/21/16, at 8:42 a.m. and on						
	12/22/16, at 2:23 p.m. regarding R104's 12/16/16,						
		ity. DSS stated she was aware					
		stated there was discussion of					
	reporting the incident later in the day however, it						
	was not reported because there was no harm to the resident and he was returned to the facility						
		iately. DSS stated she was on					
		week of 11/8/16, and did not					
		Ily left the facility. DSS was no	t				
		her time R104 had been					
	missing or left the t	acility without supervision.					
	The administrator v	was interviewed on 12/21/16,					
		dministrator stated he was					
	notified on 12/16/16, R104 was outside and to his						
		f had let him out front and he					
		the side walk and a nurse					
		le. The administrator					
	confirmed the incident was not reported and stated the DON was aware of the incident and						
		he had taken care of the					
		inistrator confirmed he was					
	aware of what an e					1	

Minneso	ta Department of He	ealth				APPROVE	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00255	B. WING		12/2	22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
CENTEN	NIAL GARDENS FOR			NUE NORTH			
	SUMMARY ST		L, MN 55422	PROVIDER'S PLAN OF CO		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE	
22000	Continued From page 56		22000				
	what had been told reported. The admir regarding the 11/8/ he did not tell the F leave the facility. Th if R104 left the faci familiar with the 11/ incident. SUGGESTED MET The administrator of need to follow the f immediately reporti	I to him it would have been inistrator was interviewed 16, Progress Note and stated 104 that he could call a cab to he administrator was unaware lity. The administrator was not /18/16, Progress Note or THOD OF CORRECTION: could in-service all staff on the facility policy in regards to ing suspected abuse to the gency/common entry point.					
	TIME PERIOD FOI One (21) days.	R CORRECTION: Twenty-					
mesota D	epartment of Health						
TE FORI	-		6899 6	5E811	lf continuati	on sheet 57 o	