MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 65E8
Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245289**

2. STATE VENDOR OR MEDICAID NO. (L2) **604140000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTENNIAL GARDENS FOR NURSING & REHABILITATION**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/31/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **115** (L18)

13.Total Certified Beds **115** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

___ 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	115			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jares Magdalene, HFE NE II 08/25/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 09/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2017
(L33)

DETERMINATION APPROVAL

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.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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 one 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, **in writing**, 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 RO5LTCHearingWaivers@cms.hhs.gov. **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 not 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 must 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, 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

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 https://dab.efile.hhs.gov/. 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 https://dab.efile.hhs.gov/user_sessions/new 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 **all** 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 no later than 60 days 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 HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 65E8
Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245289**

2. STATE VENDOR OR MEDICAID NO. (L2) **604140000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTENNIAL GARDENS FOR NURSING & REHABILITATIC**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **03/01/2016**

6. DATE OF SURVEY **02/17/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **115** (L18)

13.Total Certified Beds **115** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	115			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 03/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1984** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

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;

- 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

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

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

Feel free to contact me if you have questions.

Sincerely,

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: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	R 02/17/2017

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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 2/16 and 2/17/17. The certification tags that were corrected can be found on the CMS2567B. Tag/s that were not found corrected at the time of onsite PCR are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 225} SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	{F 225}		3/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 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.

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{F 225}	Continued From page 1	{F 225}		

body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the

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{F 225}	Continued From page 2 administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an alleged violation of neglect to the administrator and State agency, and to investigate the allegation for one of three residents (R43) reviewed. R43 sustained a fall in the tub room when a nursing assistant (NA) had attempted to transfer the resident independently even though she had been assessed to require two staff and a mechanical lift for transfers. Findings include: R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on the MDS included: arthritis and generalized muscle weakness. The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA) Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed	{F 225}	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 violations 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 trained in the new Minnesota Department of Health Nursing Home Incident Reporting system. Facility policy regarding investigating and reporting alleged	

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{F 225} Continued From page 3
to decrease the potential for falls.

R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing.

The NAR (nursing assistant registered) Sheets (included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk.

A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall. The 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."

An undated hand written note from tranined medication aide (TMA)-A included a description of R43's 2/15/17 fall. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were

{F 225}

violations has been reviewed. In addition, we have created an Incident Report Guide tool and have adopted the Care Providers of Minnesota, Abuse, Neglect, or Unexplained Injury Incident Reporting Decision Tree. The tool is based on the CMS NF/SNF Requirements of Participation. The Administrator or designee will notify allegations of neglect to the State Agency (SA) in a timely manner that follow facility policy, State, and Federal guidelines.

The Administrator or designee will review and audit incident reports daily x 2 weeks, then weekly thereafter to ensure facility sustains compliance with State and Federal guidelines. The Administrator or designee will report audit results monthly to the Quality Assurance Committee.

The correction date for completion is March 21, 2017.

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{F 225}	Continued From page 4	{F 225}		

busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had 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."

During interview on 2/17/17, at 11:00 a.m. clinical manager (CM)-A said, "She [R43] is essentially an assist of two but can vary because she goes in and out of therapy a great deal. The care sheet says she is an assist of two." CM-A also said, "There were not two staff members present for her bath" and added, "The circumstances of the fall were because she has been in and out of therapy. One of the therapy guys has been working with her in the hall and has had her taking a few steps. She is very proud and wanted to show the aide what she could do."

During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. They told me what happened. I knew there was only one aide present instead of two. We did not report this to OHFC [State agency] because there was no injury. We do not have to report falls without an injury, even though the aide did not follow the care plan."

During interview on 2/17/17, at 1:25 p.m. the facility's executive director verified the facility staff

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{F 225}	Continued From page 5 were aware R43 had complained of pain at the time of the fall, and that R43's care plan had not been followed for safe transfer. During interview on 2/17/17, at 2:15 p.m. nursing assistant (NA)-I said it had taken three to four staff to transfer R43 from the floor back into her chair after the fall. During interview on 2/17/17, at 2:23 p.m. licensed practical nurse (LPN)-D said, "It takes two people to turn and two people to transfer [R43] with a lift, and sometimes more. I would use two people to keep her safe." The facility's policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigate all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse. The policy also directed staff to immediately report abuse or neglect to the supervisor and the administrator, and indicated the supervisor should immediately report to the state agency (SA) if there was a suspicion that abuse occurred.	{F 225}		
{F 226} SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	{F 226}		3/21/17

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{F 226} Continued From page 6 {F 226}

(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95
(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to operationalize their abuse prevention policy for 1 of 3 residents (R43) reviewed for an allegation of neglect.

Findings include:

The facility's policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigate all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse. The policy also directed staff to immediately report

F226 Develop/Implement Abuse/Neglect Policies

The incident involving R43 has been investigated for an alleged violation of neglect and has been reported to the State agency.

Residents were reviewed for injuries and incidents that were potentially reportable. Corrections have been made where necessary.

The Administrator, Director of Nursing,

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{F 226}	Continued From page 7 abuse or neglect to the supervisor and the administrator, and indicated the supervisor should immediately report to the state agency (SA) if there was a suspicion that abuse occurred. A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall. The 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." An undated hand written note from tranined medication aide (TMA)-A included a description of R43's 2/15/17 fall. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had 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 226}	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 violations 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 trained in the new Minnesota Department of Health Nursing Home Incident Reporting system. Facility policy regarding investigating and reporting alleged violations has been reviewed. In addition, we have created an Incident Report Guide tool and have adopted the Care Providers of Minnesota, Abuse, Neglect, or Unexplained Injury Incident Reporting Decision Tree. The tool is based on the CMS NF/SNF Requirements of Participation. The Administrator or designee will notify allegations of neglect to the State Agency (SA) in a timely manner that follow facility policy, State, and Federal guidelines. The Administrator or designee will review and audit incident reports daily x 2 weeks, then weekly thereafter to ensure facility sustains compliance with State and Federal guidelines. The Administrator or designee will report audit results monthly to the Quality Assurance Committee.	

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{F 226}	Continued From page 8 R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on the MDS included: arthritis and generalized muscle weakness. The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA) Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed to decrease the potential for falls. R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing. The NAR (nursing assistant registered) Sheets (included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk. During interview on 2/17/17, at 11:00 a.m. clinical	{F 226}	The correction date for completion is March 21, 2017.	

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CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

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{F 226}	Continued From page 9 manager (CM)-A said, "She [R43] is essentially an assist of two but can vary because she goes in and out of therapy a great deal. The care sheet says she is an assist of two." CM-A also said, "There were not two staff members present for her bath" and added, "The circumstances of the fall were because she has been in and out of therapy. One of the therapy guys has been working with her in the hall and has had her taking a few steps. She is very proud and wanted to show the aide what she could do." During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. They told me what happened. I knew there was only one aide present instead of two. We did not report this to OHFC [State agency] because there was no injury. We do not have to report falls without an injury, even though the aide did not follow the care plan." During interview on 2/17/17, at 1:25 p.m. the facility's executive director verified the facility staff were aware R43 had complained of pain at the time of the fall, and that R43's care plan had not been followed for safe transfer. During interview on 2/17/17, at 2:15 p.m. nursing assistant (NA)-I said it had taken three to four staff to transfer R43 from the floor back into her chair after the fall. During interview on 2/17/17, at 2:23 p.m. licensed practical nurse (LPN)-D said, "It takes two people to turn and two people to transfer [R43] with a lift, and sometimes more. I would use two people to keep her safe."	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	R 02/17/2017

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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10	F 282		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 1 of 4 residents (R43) reviewed for accidents resulting in R43 falling. Findings include: An undated hand written note from tranined medication aide (TMA)-A included a description of a fall R43 had sustained on 2/15/17l. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had 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	F 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 updating that occurs as part of resident care and change of condition care planning. Under this program, resident	3/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	R 02/17/2017

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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11 wheelpool (sic) chair and got her shower." On 2/16/17, at 3:20 p.m. R43 was observed 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 could do it myself but I slid and lowered myself to the floor. I hurt my arm. I am ok now." R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on the MDS included: arthritis and generalized muscle weakness. The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA) Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed to decrease the potential for falls. R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing. The NAR (nursing assistant registered) Sheets	F 282	care plans and care sheets are reviewed for updating as needed at quarterly care conferences and or when there is a change in condition that would warrant a care plan change. This is a purposeful addition to the care conferences, called “care plan update review”. The Care Plan Update Review is also completed routinely at annual reviews. In addition, we have revised our incident /accident reporting form to include the question, Was the care plan followed at the time of the incident? Unit Nurse Managers will be responsible to audit 5% of resident care plans and nursing care sheets monthly. Nurse Managers will report audit data to the Director of Nursing. Director of Nursing or her designee will report on this program routinely to the monthly Quality Assurance Committee. The correction date for completion is March 21st, 2017	

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CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

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F 282	Continued From page 12 (included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk. During interview on 2/17/17, at 11:00 a.m. clinical manager CM-A said, "She is essentially an assist of two but can vary because she goes in and out of therapy a great deal. Care sheet says she is an assist of two." CM-A said, "There were not two staff members present for her bath." CM-A said, "The circumstances of the fall were she has been in and out of therapy. One of the therapy guys has her in the hall and taking a few steps. She is very proud and wanted to show the aide what she could do." During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. The DON said. "They told me what happened. I knew that there was only one aide not two." During interview on 2/17/17, at 1:25 p.m. executive director verified facility were aware R43 complained of pain at time of fall, and that care plan was not followed for transfer.	F 282		
{F 323} SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	{F 323}		3/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	R 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

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{F 323}	Continued From page 13 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to prevent a fall for for 1 of 4 residents (R43) reviewed for accidents. Findings include: An undated hand written note from tranined medication aide (TMA)-A included a description of a fall R43 had sustained on 2/15/17l. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had	{F 323}	F323 Free of Accident Hazards/Supervision/Devices Interventions have been developed and care planned to reduce the risk of falls for resident 43. Residents throughout the facility were reviewed and care plans updated as needed for proper interventions regarding falls. Nursing staff will be trained on the Supervision/Intervention program as explained below by March 21st, 2017. The facility has developed a new Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{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." A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall. The 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." On 2/16/17, at 3:20 p.m. R43 was observed 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 could do it myself but I slid and lowered myself to the floor. I hurt my arm. I am ok now." R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on	{F 323}	Supervision/Intervention program that identifies residents that are at risk for falls. The Resident Supervision/Intervention program will utilize the Resident Supervision/Intervention Checklist tool to identify residents that are or may be at risk so appropriate interventions can be implemented. New admissions will be screened and assessed when necessary for risks related to falls. If the resident has been identified with a fall, appropriate interventions/supervision will be implemented and reflected in the care plan and nursing care sheets. The Resident Supervision/Intervention Checklist tool will be initiated in the event of resident change of condition and or an applicable incident that relates to falls. The tool used for this program is designed to identify residents at risk for falls, supervision needs, then, interventions for supervision are identified, followed by implementation of the intervention. Using this tool, nursing can be assured of identification of residents that are at risk for falls, interventions for preventing falls being developed, implemented, and communicated to appropriate staff. The Director of Nursing or designee will audit the Resident Supervision/Intervention Checklist weekly 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 is 03/21/2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	R 02/17/2017

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{F 323}	Continued From page 15 the MDS included: arthritis and generalized muscle weakness. The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA) Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed to decrease the potential for falls. R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing. The NAR (nursing assistant registered) Sheets (included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk. During interview on 2/17/17, at 11:00 a.m. clinical manager (CM)-A said, "She [R43] is essentially an assist of two but can vary because she goes in and out of therapy a great deal. The care sheet says she is an assist of two." CM-A also said, "There were not two staff members present for her bath" and added, "The circumstances of the fall were because she has been in and out of therapy. One of the therapy guys has been	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	R 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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{F 323}	Continued From page 16	{F 323}		

working with her in the hall and has had her taking a few steps. She is very proud and wanted to show the aide what she could do."

During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. They told me what happened. I knew there was only one aide present instead of two. We did not report this to OHFC [State agency] because there was no injury. We do not have to report falls without an injury, even though the aide did not follow the care plan."

During interview on 2/17/17, at 1:25 p.m. the facility's executive director verified the facility staff were aware R43 had complained of pain at the time of the fall, and that R43's care plan had not been followed for safe transfer.

During interview on 2/17/17, at 2:15 p.m. nursing assistant (NA)-I said it had taken three to four staff to transfer R43 from the floor back into her chair after the fall.

During interview on 2/17/17, at 2:23 p.m. licensed practical nurse (LPN)-D said, "It takes two people to turn and two people to transfer [R43] with a lift, and sometimes more. I would use two people to keep her safe."

During interview on 2/17/17, at 3:07 p.m. the physical therapy director said, "[R43] can if everything is right, do a step, step transfer, but I would have two staff people there at this time. If she is tired or sad it does not always work. By the end of the day she can be tired. I worked with the staff yesterday on a lift transfer it took three of us but when she was in the chair she was sitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	R **02/17/2017**

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{F 323}	Continued From page 17 right."	{F 323}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245289		2/17/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	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
ID Prefix F0250 Reg. # 483.40(d) LSC	Correction Completed 02/10/2017	ID Prefix F0280 Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) LSC	Correction Completed 02/10/2017	ID Prefix F0334 Reg. # 483.80(d)(1)(2) LSC	Correction Completed 02/10/2017
ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 02/10/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 3/10/2017	SIGNATURE OF SURVEYOR 35993	DATE 2/17/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245289	A. Building 01 - MAIN BUILDING 01 B. Wing	2/14/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	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
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 02/10/2017	ID Prefix Reg. # NFPA 101 LSC K0523	Correction Completed 02/10/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 3/10/2017	SIGNATURE OF SURVEYOR 37009	DATE 2/14/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ 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. 1--Adequate 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.

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.

Sincerely,

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: Kamala.Fiske-Downing@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	R 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REH	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 2/16 and 2/17/17. During this onsite visit it was determined that the following corrections orders/s # 570, 830, 1995, and 2000 were NOT corrected. The uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Uncorrected order/s will be reviewed for possible	{2 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 000}	Continued From page 1 penalty assessment.	{2 000}		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 1 of 4 residents (R43) reviewed for accidents resulting in R43 falling. Findings include: An undated hand written note from tranined medication aide (TMA)-A included a description of a fall R43 had sustained on 2/15/17l. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had 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	2 565	Corrected	3/21/17

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2 565	Continued From page 2	2 565		

to help. Then she was helped back to the wheelpool (sic) chair and got her shower."

On 2/16/17, at 3:20 p.m. R43 was observed 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 could do it myself but I slid and lowered myself to the floor. I hurt my arm. I am ok now."

R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on the MDS included: arthritis and generalized muscle weakness.

The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA) Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed to decrease the potential for falls.

R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing.

The NAR (nursing assistant registered) Sheets

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2 565	Continued From page 3	2 565		

(included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk.

During interview on 2/17/17, at 11:00 a.m. clinical manager CM-A said, "She is essentially an assist of two but can vary because she goes in and out of therapy a great deal. Care sheet says she is an assist of two." CM-A said, "There were not two staff members present for her bath." CM-A said, "The circumstances of the fall were she has been in and out of therapy. One of the therapy guys has her in the hall and taking a few steps. She is very proud and wanted to show the aide what she could do."

During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. The DON said. "They told me what happened. I knew that there was only one aide not two."

During interview on 2/17/17, at 1:25 p.m. executive director verified facility were aware R43 complained of pain at time of fall, and that care plan was not followed for transfer.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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{2 830}	Continued From page 4	{2 830}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to prevent a fall for for 1 of 4 residents (R43) reviewed for accidents. Findings include: An undated hand written note from tranined medication aide (TMA)-A included a description of a fall R43 had sustained on 2/15/17l. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had insisted she would be able to stand and sit on the whirlpool chair and included, "The writter (sic)	{2 830}	Corrected	3/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 830}	Continued From page 5	{2 830}		

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."

A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall. The 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."

On 2/16/17, at 3:20 p.m. R43 was observed 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 could do it myself but I slid and lowered myself to the floor. I hurt my arm. I am ok now."

R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on the MDS included: arthritis and generalized muscle weakness.

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{2 830}	Continued From page 6 The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA) Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed to decrease the potential for falls. R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing. The NAR (nursing assistant registered) Sheets (included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk. During interview on 2/17/17, at 11:00 a.m. clinical manager (CM)-A said, "She [R43] is essentially an assist of two but can vary because she goes in and out of therapy a great deal. The care sheet says she is an assist of two." CM-A also said, "There were not two staff members present for her bath" and added, "The circumstances of the fall were because she has been in and out of therapy. One of the therapy guys has been working with her in the hall and has had her taking a few steps. She is very proud and wanted to show the aide what she could do."	{2 830}		

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{2 830}	Continued From page 7 During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. They told me what happened. I knew there was only one aide present instead of two. We did not report this to OHFC [State agency] because there was no injury. We do not have to report falls without an injury, even though the aide did not follow the care plan." During interview on 2/17/17, at 1:25 p.m. the facility's executive director verified the facility staff were aware R43 had complained of pain at the time of the fall, and that R43's care plan had not been followed for safe transfer. During interview on 2/17/17, at 2:15 p.m. nursing assistant (NA)-I said it had taken three to four staff to transfer R43 from the floor back into her chair after the fall. During interview on 2/17/17, at 2:23 p.m. licensed practical nurse (LPN)-D said, "It takes two people to turn and two people to transfer [R43] with a lift, and sometimes more. I would use two people to keep her safe." During interview on 2/17/17, at 3:07 p.m. the physical therapy director said, "[R43] can if everything is right, do a step, step transfer, but I would have two staff people there at this time. If she is tired or sad it does not always work. By the end of the day she can be tired. I worked with the staff yesterday on a lift transfer it took three of us but when she was in the chair she was sitting right."	{2 830}		
{21995}	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults	{21995}		3/21/17

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{21995}	Continued From page 8	{21995}		

Subd. 4a. Internal reporting of maltreatment.
(a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to report an alleged violation of neglect to the administrator and State agency, and to investigate the allegation for one of three residents (R43) reviewed. R43 sustained a fall in the tub room when a nursing assistant (NA) had attempted to transfer the resident independently even though she had been assessed to require two staff and a mechanical lift for transfers.

Corrected

Findings include:

R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on the MDS included: arthritis and generalized muscle weakness.

The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA)

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{21995}	Continued From page 9 Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed to decrease the potential for falls. R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing. The NAR (nursing assistant registered) Sheets (included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk. A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall. The 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." An undated hand written note from tranined	{21995}		

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{21995}	Continued From page 10	{21995}		

medication aide (TMA)-A included a description of R43's 2/15/17 fall. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had 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."

During interview on 2/17/17, at 11:00 a.m. clinical manager (CM)-A said, "She [R43] is essentially an assist of two but can vary because she goes in and out of therapy a great deal. The care sheet says she is an assist of two." CM-A also said, "There were not two staff members present for her bath" and added, "The circumstances of the fall were because she has been in and out of therapy. One of the therapy guys has been working with her in the hall and has had her taking a few steps. She is very proud and wanted to show the aide what she could do."

During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. They told me what happened. I knew there was only one aide present instead of two. We did not report this to OHFC [State agency] because there was no injury. We do not have to report falls without an injury, even though the aide did not follow the

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CENTENNIAL GARDENS FOR NURSING & REH	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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{21995}	Continued From page 11 care plan." During interview on 2/17/17, at 1:25 p.m. the facility's executive director verified the facility staff were aware R43 had complained of pain at the time of the fall, and that R43's care plan had not been followed for safe transfer. During interview on 2/17/17, at 2:15 p.m. nursing assistant (NA)-I said it had taken three to four staff to transfer R43 from the floor back into her chair after the fall. During interview on 2/17/17, at 2:23 p.m. licensed practical nurse (LPN)-D said, "It takes two people to turn and two people to transfer [R43] with a lift, and sometimes more. I would use two people to keep her safe." The facility's policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigate all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse. The policy also directed staff to immediately report abuse or neglect to the supervisor and the administrator, and indicated the supervisor should immediately report to the state agency (SA) if there was a suspicion that abuse occurred.	{21995}		
{22000}	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an	{22000}		3/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	R 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REH	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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
{22000}	Continued From page 12 assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	{22000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ____ B. WING ____	R 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REH	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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
{22000}	Continued From page 13	{22000}		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to operationalize their abuse prevention policy for 1 of 3 residents (R43) reviewed for an allegation of neglect.

Corrected

Findings include:

The facility's policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigate all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse. The policy also directed staff to immediately report abuse or neglect to the supervisor and the administrator, and indicated the supervisor should immediately report to the state agency (SA) if there was a suspicion that abuse occurred.

A facility Incident Post Fall Scene Investigation dated 2/15/17, identified R43 had sustained a fall. The 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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	R 02/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REH	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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
{22000}	Continued From page 14 An undated hand written note from tranined medication aide (TMA)-A included a description of R43's 2/15/17 fall. The note indicated that at 7 p.m. on 2/15/17, R43 had put on the call light and requested a shower. TMA-A documented she'd explained to R43 that the other staff were busy and that R43 would need to wait until the other staff were available to help her shower because she required a two person transfer. The note further indicated R43 had 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." R43's annual Minimum Data Set (MDS) dated 2/1/17, indicated R43 was cognitively intact and required assistance with all activities of daily living (ADLs), except eating. The MDS indicated R43 required two persons for physical assist with bathing and that R43's balance when changing positions or walking was unstable, so R43 required physical assistance. R43's diagnoses on the MDS included: arthritis and generalized muscle weakness. The corresponding ADL Functional/ Rehabilitation Potential Care Area Assessment (CAA) Worksheet dated 2/6/17, included: "[R43] requires extensive to total assistance with ADL." The Falls CAA dated 2/6/17, included: "[R43] has a history of falls and has had two falls without injury during the quarter." The CAA also indicated there had been care plan interventions developed to decrease the potential for falls.	{22000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{22000}	Continued From page 15	{22000}		

R43's fall care plan revised 11/11/16, and reviewed 2/8/17, indicated R43 was at high risk for falls and was obese with limited mobility. The care plan indicated R43 had a history of falls when leaning forward and interventions included for R43 to have assist of two staff and EZ stand (mechanical lift) for all transfers, and bathing.

The NAR (nursing assistant registered) Sheets (included directions for assigned duties) dated 2/13/17, instructed staff that R43 required assist of two staff for turning and repositioning, and transfered using a mechanical standing lift. The NAR sheets also indicated two staff were to be in room at all times during cares and that R43 was a fall risk.

During interview on 2/17/17, at 11:00 a.m. clinical manager (CM)-A said, "She [R43] is essentially an assist of two but can vary because she goes in and out of therapy a great deal. The care sheet says she is an assist of two." CM-A also said, "There were not two staff members present for her bath" and added, "The circumstances of the fall were because she has been in and out of therapy. One of the therapy guys has been working with her in the hall and has had her taking a few steps. She is very proud and wanted to show the aide what she could do."

During interview on 2/17/17, at 11:08 a.m. the director of nurses (DON) stated, "I was informed of the fall right away. They told me what happened. I knew there was only one aide present instead of two. We did not report this to OHFC [State agency] because there was no injury. We do not have to report falls without an injury, even though the aide did not follow the care plan."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{22000}	Continued From page 16 During interview on 2/17/17, at 1:25 p.m. the facility's executive director verified the facility staff were aware R43 had complained of pain at the time of the fall, and that R43's care plan had not been followed for safe transfer. During interview on 2/17/17, at 2:15 p.m. nursing assistant (NA)-I said it had taken three to four staff to transfer R43 from the floor back into her chair after the fall. During interview on 2/17/17, at 2:23 p.m. licensed practical nurse (LPN)-D said, "It takes two people to turn and two people to transfer [R43] with a lift, and sometimes more. I would use two people to keep her safe."	{22000}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00255 Y1	Y2	2/17/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 02/10/2017	ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 02/10/2017	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 02/10/2017
ID Prefix 21495 Reg. # MN Rule 4658.1005 Subp. 5 LSC	Correction Completed 02/10/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 3/10/2017	SIGNATURE OF SURVEYOR 35993	DATE 2/17/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 65E812

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,

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 https://dab.efile.hhs.gov 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

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

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

dates specified for compliance or the imposition of remedies.

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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: Kamala.Fiske-Downing@state.mn.us

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.

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,

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 HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 65E8
Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245289**

2. STATE VENDOR OR MEDICAID NO. (L2) **604140000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTENNIAL GARDENS FOR NURSING & REHABILITATIC**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **03/01/2016**

6. DATE OF SURVEY **12/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **115** (L18)

13.Total Certified Beds **115** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	115			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Barbara White, HFE NE II 01/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/31/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1984** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

> **No Opportunity to Correct** - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> **Remedies** - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> **Plan of Correction** - when a plan of correction will be due and the information to be contained in that document;
>
> **Potential Consequences** - the consequences of not attaining substantial compliance 6 months after the survey date; and
>
> **Informal Dispute Resolution** - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

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;

- 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

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

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

dates specified for compliance or the imposition of remedies.

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	12/22/2016

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) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. During the survey compalint H5289051 was investigated and not substantiated.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225		2/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | 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.

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F 225	Continued From page 1 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and	F 225		

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F 225	Continued From page 2 if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to immediately notify the administrator, investigate and report allegations of mistreatment/elopement(s) to the State agency (SA) timely for 2 of 4 residents (R77, R104). Findings include: R77's Minimum Data Set (MDS) dated 10/26/16, noted R77 to have both long term and short memory impairment. In addition, R77 required assist of one for all activities of daily living (ADLs) with the exception of eating and R77 did not ambulate. The comprehensive care plan dated 11/8/16, noted R77's diagnoses to include dementia with behavioral disturbance and muscle weakness. R77's Progress Note dated 12/3/16, indicated R77 had a bruise to the face, a skin tear on the left forearm, a bruise on the left wrist, and left knee. An Incident Report dated 12/3/16, noted the resident had been propelling himself in the wheelchair and said he hit his arm on the doorway going into his room. The bath skin check dated 12/10/16, indicated R77 noted a dark bruise to the face and left wrist, and a skin tear to the left forearm, there was no note of injury to the left elbow or upper arm. A Progress Note dated 12/18/16, at 4:00 p.m. indicated R77 complained his left arm hurt, and could not move the arm on his own. R77 was observed on 12/19/16, at 2:00 p.m. in his room laying in his bed. The resident's left	F 225	F225 Resident Supervision Resident 77 has been reviewed by a physician and care has been given as needed. Resident 104 has been reviewed and screened for elopement risk and care plan has been updated. Residents were reviewed for injuries, incidents, and elopements that were reportable. Corrections have been made where necessary. Nurses will be trained on the modifications to the shift-to-shift notification form by February 10th, 2017. Facility has modified the shift-to-shift report form to trigger an immediate notification of any injuries or elopement that may be reportable to the DON or designee. DON or designee will notify allegations of mistreatment/elopement(s) to the State Agency (SA) in a timely manner. Two questions have been added to the shift-to-shift form to prompt the nurses at the end of the shift to determine if an incident has occurred including injury or elopement that should be reported. Those questions are: 1. Has an elopement occurred this shift that should be reported? 2. Has an injury that is reportable occurred this shift? Any reportable incident will be reviewed by the Interdisciplinary Team (IDT).	

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F 225	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 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 started on Sunday" (12/18/16). On 12/20/16, at 3:20 p.m. NA-A was interviewed and stated R77 had complained of severe pain in	F 225	Audits of the shift-to-shift forms will be performed by the nurse managers or designee weekly x 4, then monthly thereafter. The Director of Nursing will report audit results monthly to the Quality Assurance Committee. The correction date for completion is February 10th, 2017.	

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F 225	Continued From page 4	F 225		

the left arm on Sunday, and that he (NA-A) had reported to the nurse on 12/18/16, during the afternoon shift. NA-A said R77 remained on bed rest. NA-A stated R77 was up and about with no arm problems the week before.

The director of nursing (DON) was interviewed on 12/21/16, at 9:20 a.m. and stated no report had been made to her, the administrator or the SA of a serious injury of unknown origin until 12/20/16. The DON stated a report had been submitted to the SA and an investigation was initiated on 12/20/16, at about 4:00 p.m.. The DON stated the investigation was not complete but she attributed the injury to an incident on 12/3/16, when R77 bumped into the wall. She confirmed R77 had experienced a change in pain on 12/18/16, and that the appearance of the arm changed on 12/19/16, which was subsequently checked by the nurse practitioner (NP). She stated there was no known injury since 12/3/16. When asked whether the fracture was considered a new injury, she stated no.

On 12/21/16, at 10:30 a.m. the administrator was interviewed and stated he'd heard about the injury for R77 on 12/3/16, and was told the arm hurt more on Monday 12/19/16, and that the resident had been diagnosed with a fracture. He stated that nursing was looking into it, but confirmed a report to the SA had not been made until 12/20/16. He stated he assumed the injury was not new.

NP-D was interviewed on 12/21/16, at 12:07 p.m. and stated she saw R77 on 12/19/16. NP-D said R77 had an acute injury to the left arm and could not move the arm. She stated medically she cannot imagine that was from an injury on

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F 225	Continued From page 5	F 225		

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.

The facility policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigate all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse.

The policy directed staff to immediately report abuse or neglect to the supervisor and the administrator. The supervisor should immediately report to the state agency (SA) if there was a suspicion that abuse occurred.
R104's care plan dated 7/31/16, indicated R104 had limited physical mobility, needed reminders to use his walker, and may need a wheelchair when going out of the building. R104's MDS dated 9/29/16, noted R104 had severe cognitive impairment and was admitted to the facility with a diagnoses of hepatic failure, cirrhosis of the liver with ascites and received hospice services. The care plan also included a date of 9/30/16, which indicated R104 was a smoker who required supervision with smoking in the outside designated area. R104's Physician Orders dated 10/8/16, included "OK for WanderGuard."

Review of R104's Progress Notes included the following entries: On 11/8/16, at 5:54 p.m. family member (F)-B "had called 1st floor/TCU mgr [transitional care unit/manager -Registered Nurse (RN)-B] to report that R104 had gone shopping by cab yesterday and was staff aware. This writer asked R104 for the details and he stated the following 'Talked to 1st floor male honcho. Talked

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F 225	Continued From page 6 about rides available. Cab was ok. Went to Cub [grocery store] for some fruit and stuff. Why is she sticking her nose in? Why is she calling people.' Gave him names of men working on 1st floor and then he said 'The one who's [sic] name is on a plaque in the front.'" On 11/19/16, at 6:13 p.m. "Writer noticed at 1800 res [resident - R104] is not in his room. South nurse told writer that a family member came to visit and went with res [R104] on first floor. Writer checked on 1st floor, the smoking area and front of the building res [R104] was not there. On 12/16/16, at 2:04 p.m. "Resident was reported to be walking on the road this morning by the staff along vera cruz ave n [sic] about 350 meters from the facility. Writer went to get him back to the facility but he refused and insisted that he was going to cub he was redirected several time back but still he refused and kept on walking with the walker towards 36th. Staff called the facility who in turn called 911. After about 10 minutes, the police arrived who then talked to him and he accepted to comeback. Vital signs were completed see vital section he denied having pain no SOB [shortness of breath] noted at the time morning medication administered and a 15 minutes check was initiated. All parties were notified hospice nurse gave new orders for see orders. He is currently out with [family]. Staff will cont. [continue] to monitor the resident." A care conference note dated 11/17/16, indicated R104 and family received re-clarification R104 required supervision out of the building. R104's medical record and facility documentation lacked evidence of any accident/incident reports regarding R104 missing from the facility on 12/16/16, R104 missing on 11/19/16 or R104's leave on 11/7/16.	F 225		

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F 225	Continued From page 7	F 225		

RN-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 not in his room. RN-A indicated someone outside the building alerted staff that R104 was walking 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 minute checks and updated family, hospice, the NP and the DON. RN-A indicated the DON did the reporting to the SA and believed the incident was reported. When asked about the 11/8/16, Progress Note which indicated R104 left the facility in a cab, RN-A stated the incident did not occur. RN-A stated staff knew he wanted to call a cab and intervened before anything occurred. RN-A was not familiar with R104 missing from the 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

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CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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) COMPLETION DATE
F 225	Continued From page 8 goes out every day and smokes." The DON did not know if R104 required supervision for smoking. The DON stated R104 was dressed appropriately for the weather on 12/16/16, and R104 was not confused. The DON confirmed R104 was not on facility grounds when he was found by staff on 12/16/16, and she did not consider the incident an elopement. The DON went on to say R104 has been trying to go out and smoke and she did not think R104 had a WanderGuard, but they had tried on in the past but staff keep a really close eye on him. The DON confirmed an elopement assessment or wandering assessment had not been completed for R104 and stated there was a difference between going out and going for a walk. The DON further confirmed R104 was not on the facility WanderGuard list and stated "he shouldn't be, he goes out all the time." The DON further indicated R104 had the right to wander and confirmed again the incident was not reported because she did not view the incident as an elopement as he was found immediately by staff. The DON defined an elopement a "someone who has a WanderGuard but is gone, and cannot be found." On 12/21/16, at 3:21 p.m. LPN-C was interviewed. LPN-C stated he was the nurse working on 12/16/16, and during morning report a night shift staff member who had left for the morning, returned to the facility and stated R104 was outside on the street. LPN-C confirmed no staff was aware R104 had left the building. LPN-C then went outside the facility to bring R104 back in. LPN-C stated it was freezing outside however R104 was dressed in a coat and had shoes on and was approximately 300 meters from the building. LPN-C stated he was unable to	F 225		

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persuade R104 into the building and called RN-A to call police. LPN-C stated police arrived and persuaded R104 back into the building and police gave both R104 and LPN-C a ride back to the facility. LPN-C stated he assessed R104 when they returned to the facility and updated Hospice and F-B. LPN-C stated they then implemented every 15 minute checks. LPN-C was unaware of any other time R104 had left the building unsupervised. LPN-C stated he was unaware at how long R104 had been outside.

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 office and asked her 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 DON about what was told to her about R104 from F-B. RN-B stated she did not hear anything further regarding the situation from the DON or RN-A. RN-B was not aware of R104 ever leaving the facility unsupervised. RN-B stated she was aware of the 12/16/16, incident however, was not working at the time the incident occurred.

The director of social 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, leave from the facility. DSS stated she was aware of the incident and 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 safely and appropriately. DSS stated she was on vacation during the week of 11/8/16, and did not know if R104 actually left the facility. DSS was not familiar with any other time R104 had been missing or left the facility without supervision.

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F 225	Continued From page 10 The administrator was interviewed on 12/21/16, at 1:04 p.m. The administrator stated he was notified on 12/16/16, R104 was outside and to his understanding staff had let him out front and he was walking down the side walk and a nurse followed him outside. The administrator confirmed the incident was not reported and stated the DON was aware of the incident and she had told him she had taken care of the situation. The administrator confirmed he was aware of what an elopement was and if that was what had been told to him it would have been reported. The administrator was interviewed regarding the 11/8/16, Progress Note and stated he did not tell the R104 that he could call a cab to leave the facility. The administrator was unaware if R104 left the facility. The administrator was not familiar with the 11/18/16, Progress Note or incident. An undated elopement policy included "staff shall investigate and report all cases of missing residents." The policy further indicated when a departing individual returns to the facility the DON or Charge Nurse shall: "a. Examine the resident for injuries; b. Notify the Attending Physician; c. Notify the resident's legal representative of the incident; d. Complete and file Report of Incident/Accident; and e. Document the event in the resident's medical record."	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		2/10/17

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F 226	Continued From page 11 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to operationalize their abuse prevention policy for 2 of 4 residents (R77, R104) reviewed for abuse. Findings include:	F 226	F226 Resident Investigations Any investigations or related concerns regarding resident 77 and resident 104 have been reviewed by the Interdisciplinary Team (IDT) and closed	

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The facility policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigated all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse.

The policy directs staff to immediately report abuse or neglect to the supervisor and the administrator. The supervisor should immediately report to the state agency (SA) if there was a suspicion that abuse occurred.

R77's Minimum Data Set (MDS) dated 10/26/16, noted R77 to have both long term and short memory impairment. In addition, R77 required assist of one for all activities of daily living (ADLs) with the exception of eating and R77 did not ambulate. The comprehensive care plan dated 11/8/16, noted R77's diagnoses to include dementia with behavioral disturbance and muscle weakness.

R77's Progress Note dated 12/3/16, indicated R77 had a bruise to the face, a skin tear on the left forearm, a bruise on the left wrist, and left knee. An Incident Report dated 12/3/16, noted the resident had been propelling himself in the wheelchair and said he hit his arm on the doorway going into his room. The bath skin check dated 12/10/16, indicated R77 noted a dark bruise to the face and left wrist, and a skin tear to the left forearm, there was no note of injury to the left elbow or upper arm. A Progress Note dated 12/18/16, at 4:00 p.m. indicated R77 complained his left arm hurt, and could not move the arm on his own.

F 226

out. Both residents have been seen by their physicians and any concerns have been resolved. Care plans for resident 77 and resident 104 have been reviewed and updated as necessary.

Residents with investigations over the past 30 days that may be incomplete have now been reviewed and resolved.

Nursing staff will be in-serviced by February 10th, 2017 on the new incident/accident reporting program stated below to ensure timely reporting.

As a function of IDT, a record – new form - of incidents/investigations will be kept by a designated monitor indicating the resident, the date, description of the incident, and the status of the case under investigation. The designated monitor will be responsible to track and notify appropriate team members of completion of the incident/investigation. IDT will establish timeframes regarding completion and compliance for timely reporting and investigating for each type of incident (e.g. serious injury of unknown origin, resident-to-resident incident, alleged resident abuse.).

Administrator or his designee will audit the monitoring log weekly x 4 to ensure that the program has been operationalized and it functioning appropriately. Audits will continue monthly thereafter. The Administrator or designee will present monthly to the Quality Assurance Committee.

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F 226	Continued From page 13 R77 was observed on 12/19/16, at 2:00 p.m. in his room laying in his bed. The resident's left 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 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 started on Sunday" (12/18/16).	F 226	The correction date for completion is February 10th, 2017.	

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On 12/20/16, at 3:20 p.m. NA-A was interviewed and stated R77 had complained of severe pain in the left arm on Sunday, and that he (NA-A) had reported to the nurse on 12/18/16, during the afternoon shift. NA-A said R77 remained on bed rest. NA-A stated R77 was up and about with no arm problems the week before.

The director of nursing (DON) was interviewed on 12/21/16, at 9:20 a.m. and stated no report had been made to her, the administrator or the SA of a serious injury of unknown origin until 12/20/16. The DON stated a report had been submitted to the SA and an investigation was initiated on 12/20/16, at about 4:00 p.m.. The DON stated the investigation was not complete but she attributed the injury to an incident on 12/3/16, when R77 bumped into the wall. She confirmed R77 had experienced a change in pain on 12/18/16, and that the appearance of the arm changed on 12/19/16, which was subsequently checked by the nurse practitioner (NP). She stated there was no known injury since 12/3/16. When asked whether the fracture was considered a new injury, she stated no.

On 12/21/16, at 10:30 a.m. the administrator was interviewed and stated he'd heard about the injury for R77 on 12/3/16, and was told the arm hurt more on Monday 12/19/16, and that the resident had been diagnosed with a fracture. He stated that nursing was looking into it, but confirmed a report to the SA had not been made until 12/20/16. He stated he assumed the injury was not new.

NP-D was interviewed on 12/21/16, at 12:07 p.m. and stated she saw R77 on 12/19/16. NP-D said R77 had an acute injury to the left arm and could

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not move the arm. She stated medically she cannot imagine that was from an injury on 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.

R104:
An undated elopement policy included "staff shall investigate and report all cases of missing residents." The policy further indicated when a departing individual returns to the facility the DON or Charge Nurse shall:
"a. Examine the resident for injuries;
b. Notify the Attending Physician;
c. Notify the resident's legal representative of the incident;
d. Complete and file Report of Incident/Accident; and
e. Document the event in the resident's medical record."

R104's care plan dated 7/31/16, indicated R104 had limited physical mobility, needed reminders to use his walker, and may need a wheelchair when going out of the building. R104's MDS dated 9/29/16, noted R104 had severe cognitive impairment and was admitted to the facility with a diagnoses of hepatic failure, cirrhosis of the liver with ascites and received hospice services. The care plan also included a date of 9/30/16, which indicated R104 was a smoker who required supervision with smoking in the outside designated area. R104's Physician Orders dated 10/8/16, included "OK for WanderGuard."

Review of R104's Progress Notes included the following entries: On 11/8/16, at 5:54 p.m. A

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family member (F)-B "had called 1st floor/TCU mgr [transitional care unit/manager -Registered Nurse (RN)-B] to report that R104 had gone shopping by cab yesterday and was staff aware. This writer asked R104 for the details and he stated the following 'Talked to 1st floor male honcho. Talked about rides available. Cab was ok. Went to Cub [grocery store] for some fruit and stuff. Why is she sticking her nose in? Why is she calling people.' Gave him names of men working on 1st floor and then he said 'The one who's [sic] name is on a plaque in the front.'" On 11/19/16, at 6:13 p.m. "Writer noticed at 1800 res [resident - R104] is not in his room. South nurse told writer that a family member came to visit and went with res [R104] on first floor. Writer checked on 1st floor, the smoking area and front of the building res [R104] was not there. On 12/16/16, at 2:04 p.m. "Resident was reported to be walking on the road this morning by the staff along vera cruz ave n [sic] about 350 meters from the facility. Writer went to get him back to the facility but he refused and insisted that he was going to cub he was redirected several time back but still he refused and kept on walking with the walker towards 36th. Staff called the facility who in turn called 911. After about 10 minutes, the police arrived who then talked to him and he accepted to comeback. Vital signs were completed see vital section he denied having pain no SOB [shortness of breath] noted at the time morning medication administered and a 15 minutes check was initiated. All parties were notified hospice nurse gave new orders for see orders. He is currently out with [family]. Staff will cont. [continue] to monitor the resident."

A care conference note dated 11/17/16, indicated R104 and family received re-clarification R104

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required supervision out of the building. R104's medical record and facility documentation lacked evidence of any accident/incident reports regarding R104 missing from the facility on 12/16/16, R104 missing on 11/19/16 or R104's leave on 11/7/16.

RN-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 licensed practical nurse (LPN)-C was the nurse working and searched the building after R104 was not in his room. RN-A indicated someone outside the building alerted staff R104 was walking 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 minute checks and updated family, hospice, the NP and the DON. RN-A indicated the DON did the reporting to the SA and believed the incident was reported. When asked about the 11/8/16, Progress Note which indicated R104 left the facility in a cab, RN-A stated the incident did not occur. RN-A stated staff knew he wanted to call a cab and intervened before anything occurred. RN-A was not familiar with R104 missing from the 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

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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 goes out every day and smokes." The DON did not know if R104 required supervision for smoking. The DON stated R104 was dressed appropriately for the weather on 12/16/16, and R104 was not confused. The DON confirmed R104 was not on facility grounds when he was found by staff on 12/16/16, and she did not consider the incident an elopement. The DON went on to say R104 has been trying to go out and smoke and she did not think R104 had a WanderGuard, but they had tried on in the past but staff keep a really close eye on him. The DON confirmed an elopement assessment or wandering assessment had not been completed for R104 and stated there was a difference between going out and going for a walk. The DON further confirmed R104 was not on the facility WanderGuard list and stated "he shouldn't be, he goes out all the time." The DON further indicated R104 had the right to wander and confirmed again the incident was not reported because she did not view the incident as an elopement as he was found immediately by staff. The DON defined an elopement a "someone who has a WanderGuard but is gone, and cannot be found."

On 12/21/16, at 3:21 p.m. LPN-C was interviewed. LPN-C stated he was the nurse working on 12/16/16, and during morning report a night shift staff member who had left for the morning, returned to the facility and stated R104 was outside on the street. LPN-C confirmed no

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CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH** **CRYSTAL, 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) COMPLETION DATE
F 226	Continued From page 19 staff was aware R104 had left the building. LPN-C then went outside the facility to bring R104 back in. LPN-C stated it was freezing outside however R104 was dressed in a coat and had shoes on and was approximately 300 meters from the building. LPN-C stated he was unable to persuade R104 into the building and called RN-A to call police. LPN-C stated police arrived and persuaded R104 back into the building and police gave both R104 and LPN-C a ride back to the facility. LPN-C stated he assessed R104 when they returned to the facility and updated Hospice and F-B. LPN-C stated they then implemented every 15 minute checks. LPN-C was unaware of any other time R104 had left the building unsupervised. LPN-C stated he was unaware at how long R104 had been outside. 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 office and asked her 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 DON about what was told to her about R104 from F-B. RN-B stated she did not hear anything further regarding the situation from the DON or RN-A. RN-B was not aware of R104 ever leaving the facility unsupervised. RN-B stated she was aware of the 12/16/16, incident however, was not working at the time the incident occurred. The director of social 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, leave from the facility. DSS stated she was aware of the incident and stated there was discussion of reporting the incident later in the day however, it was not reported because there was no harm to	F 226		

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F 226	Continued From page 20 the resident and he was returned to the facility safely and appropriately. DSS stated she was on vacation during the week of 11/8/16, and did not know if R104 actually left the facility. DSS was not familiar with any other time R104 had been missing or left the facility without supervision. The administrator was interviewed on 12/21/16, at 1:04 p.m. The administrator stated he was notified on 12/16/16, R104 was outside and to his understanding staff had let him out front and he was walking down the side walk and a nurse followed him outside. The administrator confirmed the incident was not reported and stated the DON was aware of the incident and she had told him she had taken care of the situation. The administrator confirmed he was aware of what an elopement was and if that was what had been told to him it would have been reported. The administrator was interviewed regarding the 11/8/16, Progress Note and stated he did not tell the R104 that he could call a cab to leave the facility. The administrator was unaware if R104 left the facility. The administrator was not familiar with the 11/18/16, Progress Note or incident.	F 226		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide medically necessary equipment for 1 of 1 resident (R78)	F 250	F250 Acquiring Medical Equipment for Residents	2/10/17

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F 250	Continued From page 21 reviewed who required a specialized wheel chair in order to get up and remain out of bed. 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. A review of R78's Nursing and Rehabilitation Progress Notes dated 12/12 through 12/20/16, indicated the following: - 12/12/16 - Has new orders for Broda chair. - 12/13/16 through 12/19/16 - Broda chair, every shift for hip fracture, on order or not available. - 12/20/16 - Resident was in bed during holiday party on unit. During continuous observation on 12/20/16, at 2:20 p.m., R78 was lying awake in her bed. In the common area of the adjoining unit, a resident holiday party was beginning. At 2:33 p.m. the party continued with live music, a visit from Santa and presents for each resident. At 2:47 p.m., R78 remained in bed and was observed to be awake. Music could be heard from the party down the hall. At 3:10 p.m., R78 continued to lay awake in her bed. R78 continued to lay awake in her bed throughout the party.	F 250	Resident 78 has received the medically necessary equipment per physician orders. Residents were reviewed for any physician ordered medically necessary equipment or supplies to ensure compliance. All associated needs have been satisfied. Staff will be trained on the new policy and procedure regarding the Fast Track Resident Equipment and Supplies Requisition Program for obtaining medically necessary equipment and supplies that can't be obtained immediately in the facility. This program is explained below. To ensure timely procurement of medically necessary equipment or supplies, the facility has updated the policy and procedure to ensure compliance. The facility has initiated a program named the Fast Track Resident Equipment and Supplies Requisition Program. If physician ordered medically necessary equipment or supplies can't be immediately supplied by the facility, nursing staff will fill out a Fast Track requisition form and give it to the Administrator or designee. Then Administrator or designee will then work on procuring in a reasonable period of time the medically necessary equipment or supplies ordered by the physician. The physician ordered medically necessary equipment or supplies will be tracked on a designated calendar to ensure timely resolution and receipt by the	

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F 250	Continued From page 22	F 250		

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During an interview on 12/20/16, at 3:11 p.m., registered nurse (RN)-D stated R78 had been on bed rest and that the therapy department was looking into a chair for her. She stated the chair ordered by the physician was not readily available in the facility so they had to either rent one or buy one.

During an interview on 12/20/16 at 3:17 p.m., physical therapist (PT)-A stated the nursing department was supposed to be ordering a Broda chair for R78. During the same interview the therapy director stated she'd recommended the chair last week, when the physician had released R78 from bed rest.

During an interview on 12/20/16, at 7:44 a.m., the director of nursing (DON) stated she was ordering the Broda chair for R78 that day.

During an observation on 2/21/16, at 7:44 a.m., a Broda chair was availalble for use in R78's room.

The DON stated during a follow up interview on 12/21/16, at 11:06 a.m., that she had been trying to find a vendor that could provide the chair for R78 as a rental. She stated because R78 would only require the chair for about a month, the facility did not want to spend two thousand dollars to purchase one. The DON acknowledged she'd first ordered the chair the day prior.

The Broda chair was received in the facility less than twenty four hours after it had finally been ordered. R78 had remained in bed for eight days while waiting for the chair, unable to attend activities including the holiday party, due to the facility's failure to obtain physician ordered

Provider's Plan of Correction (F 250):

Administrator, entering the date the requisition was received from staff and the date the item was received.

The Interdisciplinary Team will audit the program including reviewing the Administrators Fast Track calendar weekly x 4 and monthly thereafter. The Administrator will report to the Quality Assurance Committee monthly on this program.

The correction date for compliance is February 10th, 2017.

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F 250	Continued From page 23 medical equipment in a timely manner. A facility policy regarding timeliness of following up on Physician's Orders was requested but not received.	F 250		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or	F 280		2/10/17

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F 280	Continued From page 24 resident representative. (ii) Include an assessment of the resident’s strengths and needs. (iii) Incorporate the resident’s personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan. (F) Other appropriate staff or professionals in	F 280		

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F 280	Continued From page 25 disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise care planned interventions for 3 of 4 residents (R77, R78, R66) who had a change in care needs. Findings include: R77's Minimum Data Set (MDS) dated 10/26/16, noted R77 to have both long term and short memory impairment. In addition, R77 required assist of one for all activities of daily living (ADLs) with the exception of eating and R77 did not ambulate. The comprehensive care plan dated 11/8/16, noted R77's diagnoses to include dementia with behavioral disturbance and muscle weakness. R77 had an injury to the arm that was not included on the care plan. The comprehensive care plan lacked interventions on how to care for the injured left arm. R77 was observed on 12/19/16, at 2:00 p.m. in his room with the left elbow swollen the size of a baseball, and reddened. An x-ray was just completed of the arm. R77 was grimacing and stated, "I can't stand the pain." The injured left arm was not supported in the bed nor was it in a sling. 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."	F 280	F280 Updating Resident Care Plans Care plans for residents 77, 78, 66 have been reviewed and updated as necessary. Residents throughout the facility have had their care plans reviewed and updated as necessary. Nursing staff and other facility personnel 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 to review and monitor resident care plans to ensure appropriate interventions are revised when appropriate. This is a new program in addition to updating that occurs as part of resident care and change of condition care planning. Under the new program, Resident care plans will be reviewed for updating as needed at quarterly care conferences and or when there is a change in condition that would warrant a care plan change. This is a purposeful addition to the care conferences, called “care plan update review”. The Care Plan Update Review is also to be done routinely at annual reviews.	

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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 lunchtime on 12/20/16, to treat a left arm fracture. LPN-A said, "No one could tell what happened to the arm, it started on Sunday" (12/18/16).
- At 3:20 p.m. NA-A was interviewed and stated R77 had complained of severe pain in the left arm on Sunday (12/18/16) afternoon shift, and remained on bedrest. NA-A stated the nurse told him to have R77 rest.

The NA Care Sheet dated 12/20/16, did not have any direction to keep on bedrest or to support the arm, and did not mention a fracture to the arm.

The director of nursing (DON) was interviewed on 12/21/16, at 9:20 a.m. and stated care plans should be updated with changes to the resident's care needs. She verified R77's care plan had not been updated since R77 had complained of pain on 12/18/16. The x-ray on 12/19/16, had noted a complete fracture of the humerus (arm bone).

R78's MDS dated 10/4/16, indicated she was independent with ambulation and required only one staff assistance for all other ADLs. R78's significant change MDS 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. A Care Area Assessment (CAA) dated 11/28/16, identified a risk for falls based on an actual fall on 11/15/16, and indicated R78 was at moderate risk for falls. R78's care plan dated 12/7/16, indicated a potential for falls due to cognitive deficit and identified a right hip fracture sustained on 11/15/16, as a result of a

F 280

Unit Nurse Managers will be responsible to audit 5% of resident care plans monthly. Nurse Managers will report audit data to the Director of Nursing. Director of Nursing or her designee will report on this program routinely to the monthly Quality Assurance Committee.

The correction date for completion is February 10th, 2017

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F 280	Continued From page 27 fall. A review of Centennial Gardens for Nursing and Rehabilitation - SNF (Skilled Nursing facility) Progress Notes along with correlating Incident Post Fall Scene Investigation Tools indicated R78 sustained nine falls between 2/5/16 and 2/22/16. The most recent fall on 1/18/16, resulted in a fracture. R78's care plan dated 12/7/16, identified the following fall interventions: 1/23/15 - fall assessment per policy, 1/23/15 - anticipate and meet the resident's needs, 1/23/15 - the resident needs a safe environment, 1/29/16 - offer diversional activities, 1/29/16 - proper footwear (currently on hold) 4/20/16 - check and change and reposition the resident every two hours. The care plan did not include 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 had a history of falls but she was not sure how many. She stated she used to walk very fast on the unit. NA-B further stated she was not aware of any fall prevention interventions and stated she was told to watch R78. During an interview on 12/21/16, at 2:19 p.m., registered nurse (RN)-D stated when a resident falls, the nurse on duty fills out a risk management report. She stated the nurse will put an immediate intervention in place. During an interview on 12/21/16, at 2:37 p.m., the DON stated when R78 fell, "It wasn't a surprise." She stated she walked very fast and did not understand when staff told her to slow down. The DON stated falls were reviewed by a fall committee and stated the fall committee was	F 280		

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F 280	Continued From page 28	F 280		

"trying" to meet every two months. She stated the committee looks at the incident reports and tries to determine causes of falls. During a subsequent interview at 3:12 p.m., the DON stated there was no review of R78's fall history in the falls meeting minutes and stated "we were going to look at her this week."

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."

During observation on 12/21/16, at 7:27 a.m. R66 was observed coming out of his room. There was fresh blood on the right side of chin and jaw. R66 said, "It is just from shaving and wiped at the blood. It will go away soon. I just cut myself shaving." Surveyor notified unknown nursing assistant of R66's bleeding. At 8:13 a.m. R66 observed in dining room, blood had been washed off R66's face. There was a 1 centimeter (cm) to 1.5 cm longitudinal cut on right side of the jaw.

R66's quarterly MDS dated 10/5/16, indicated R66 had moderate cognitively impaired and required assistance with personal hygiene. R66's MDS indicated R66's had diagnoses of dementia, hemiplegia and atrial fibrillation (irregular heart beat) on chronic Coumadin (blood thinner).

The ADLs Function/Rehabilitation Potential CAA dated 7/8/16, indicated R66 required, "Assist with dressing grooming and personal hygiene with set up and supervision to ensure tasks have been completed." Staff were to continue with current care plan and monitor for decline in self-care.

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The ADL care plan revised 7/15/15, indicated R66 had altered status in ADLs related to alteration in decision making and thought process. The ADL care plan instructed staff, R66 was independent with shaving. The cardiac care plan revised 10/7/16, indicated R66 was on Coumadin and at risk for bruising and bleeding and instructed nursing assistants to observe and report blood in urine or pad tarry stools, bruises skin discolorations prolong bleeding from nose, gums or lab draw sites. The nurses were instructed to report to medical doctor or nurse practitioner and family bruises and symptoms of bleeding. The care plan did not address how to minimize bleeding risks while shaving, effect of hemiplegia on R66's safety to shave self with a disposable razor, or other interventions for staff to take to prevent bleeding.

Review of Progress Notes from 11/1/16, to 12/22/16, indicated
- On 11/12/16, R66 was noted to be bleeding from right thumb. Staff cleaned area applied triple antibiotic cream and a band-aid. The note indicated R66 stated," to have injured self from trying to shave. Will continue to be monitored."
- On 12/5/16, R66 was noted to have scratches on head with a small amount of bleeding. Note indicated staff cleaned up the area and warned R66 not to use razor on his own. Per progress note, "[R66] stated it was a result of him shaving himself. Writer [sic] took all razors from his drawers as well. Will continue to be monitored."
- On 12/19/16, progress note indicated, "Resident noted to have blood to nose when walking to the dining room for lunch. Resident's nasal was cleaned and two spots noted like from a scratch. Resident stated did not know how it happened.

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F 280	Continued From page 30 Will continue to monitor." - On 12/21/16, progress note indicated, "Resident noted to have blood to his cheek this morning. Scratches noted to the area. Resident stated no idea where it came from. Will continue to be monitored." The 3rd Floor NA sheets dated 12/13/16, indicated R66 was independent with shaving. During interview on 12/21/16, at 2:19 p.m. RN-A said, "I do not update the care plan the Nurse Managers do." During interview on 12/21/16, at 2:34 p.m. NA-G said, "I do not have any idea who shaves him. I have seen regular razors in his room. I give him razors as he requests, the plastic ones." During interview on 12/21/16, at 2:37 p.m. nurse manager (NM)-A said, "He scratches himself sometimes. We have an electric razor if he wants it. He sometimes uses a regular razor." NM-A verified the care plan lacked specific interventions to prevent bleeding with ADL's. During interview on 12/22/16, at 10:37 a.m. RN-E said, "for residents who are on blood thinners the staff need to be aware of bleeding risk, use electric razors not the hand razors to shave a resident, and notify the nurse if there are any problems. This should be on the care plan and assignment sheet." During interview on 12/22/16, at 2:32 p.m. the DON said lately the staff have been just using the disposable razors. We have not had any issues with residents bleeding. I know that we are trying to initiate electric razors for everyone but they	F 280		

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F 280	Continued From page 31 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 policy did not address updates to the care plan.	F 280		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		2/10/17

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Continued From page 32

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed’s dimensions are appropriate for the resident’s size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to implement interventions to reduce the risk of falls for 1 of 3 residents (R78) reviewed for falls. This resulted in actual harm for R78 who sustained a fracture resulting from a fall. In addition, the facility failed to provide adequate supervision for 1 of 1 resident (R104) reviewed for elopements and the facility failed to supervise 1 of 1 resident (R66) for safety related to use of a disposable razor.

Findings include:

R78 was observed on 12/20/16, at 2:20 p.m. R78 was lying in bed while a holiday party was in progress on the unit.

During an interview on 12/20/16, at 3:11 p.m., registered nurse (RN)-D stated R78 was on bed rest following a fracture of her right hip.

R78's significant change Minimum Data Set (MDS) 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. A previous MDS dated 10/4/16, indicated R78 had been independent with ambulation and required only one staff assistance for all other activities of daily living. R78's care

F 323

F323 Supervision and Interventions for Residents

Interventions have been developed and care planned to reduce the risk of falls for resident 78. Interventions for adequate supervision were developed and care planned to reduce the risk of elopement for resident 104. Resident 66 was reassessed for appropriate Interventions regarding adequate supervision for safe shaving. Resident 66’s care plan has been updated.

Residents throughout the facility were reviewed and care plans updated as needed for proper interventions/supervision regarding falls, elopement, and shaving.

Nursing staff will be trained on the Supervision/Intervention program as explained below by February 10th, 2017.

The facility has developed a new Resident Supervision/Intervention program that identifies residents that are at risk for falls, elopement, and safe shaving. The Resident Supervision/Intervention program will utilize the Resident

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F 323	Continued From page 33 plan dated 12/7/16, indicated a potential for falls due to cognitive deficit and identified a right hip fracture had been sustained on 11/15/16, as a result of a fall. The care plan directed staff to anticipate her needs, offer diversion, reminders to slow down and ensure proper foot wear (currently on hold due to bed rest.) A Area Assessment (CAA) dated 11/28/16, identified a risk for falls based on an actual fall on 11/15/16, and indicated R78 was at moderate risk for falls. A review of R78's Progress Notes and corresponding Incident Post Fall Scene Investigation Tools were reviewed from 2/5/16 to 11/15/16, and identified the following falls: - On 2/15/16, Progress Note indicated R78 was observed on the east hallway floor lying flat on her stomach. The correlating incident report indicated R78 was helped to bed and monitored by night shift. The interdisciplinary team (IDT) review indicated a new intervention of offering R78 tasks such as folding washcloth or cleaning to re-direct had been implemented. - On 2/22/16, Progress Note indicated R78 was walking very fast in hallway, missed her step and fell onto left side. The corresponding incident report indicated R78 was redirected and put in close observation. The IDT review of the fall indicated staff were to remind R78 to slow down when walking too fast, and to redirect as able. - On 3/1/16, Progress Note indicated R78 slid to the floor and landed on her bottom. The corresponding incident report indicated R78 was helped to a chair and educated on proper sitting position. The IDT review intervention initiated as a result included to encourage her to sit back in the chair. - On 3/20/16, Progress Note indicated R78 was found sitting on the floor facing the elevator. The	F 323	Supervision Checklist tool to identify residents that are or may be at risk so appropriate interventions can be implemented. New admissions will be screened and assessed when necessary for risks related to falls, elopement, and safe shaving, utilizing the Resident Supervision Checklist tool. If the resident has been identified with a fall, elopement or safe shaving risk, appropriate interventions/supervision will be implemented and reflected in the care plan. The Resident Supervision/Intervention Checklist tool will be initiated in the event of resident change of condition and or an applicable incident that relates to falls, elopements, or safe shaving. The tool used for this program is designed to identify residents at risk for falls, elopements, or safe shaving supervision needs, then, interventions for supervision are identified, followed by implementation of the supervision intervention. Using this tool, nursing can be assured of identification of residents in these (3) areas, interventions for supervision being developed, and implemented. The Director of Nursing or designee will audit the Resident Supervision/Intervention Checklist weekly 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 is February 10th, 2017	

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F 323	Continued From page 34 corresponding incident report indicated she was immediately put on a one to one and pain medication was administered. An IDT review of the fall was not completed. - On 4/8/16, progress note indicated R78 was found on the floor at 9:00 a.m. by the nurse's station lying on her left side and again an hour later was found sitting on the floor. The corresponding incident report indicated she was immediately brought closer to the nursing station. An IDT review of the incident was not completed. - On 4/22/16, a note labeled IDT Note indicated R78 had multiple falls related to pacing/fast walking. The recommended intervention included for staff to continue to re-direct prn (as needed). - On 5/13/16, Progress Note indicated R78 was found sitting on the floor in her room. The immediate intervention implemented was to advise R78 to use her call light. An IDT review of the fall was not completed. - On 7/8/16, a note labeled IDT note, indicated R78 had experienced two falls without injury related to rapid pace of wandering. There was no evidence the IDT had evaluated or assessed causative factors of the falls. - On 7/16/16, progress note indicated R78 was found on the floor in the dining room at 7:50 p.m. The corresponding incident report indicated an immediate intervention of offering her a snack. The IDT review portion of the incident form was not completed. - On 10/28/16, Progress Note indicated R78 fell following a loss of balance. No incident report was completed for the fall, nor was an IDT review documented. - On 11/15/16, Progress Note indicated R78 was found lying on floor near the elevator on her right side. She was complaining of hip pain and unable to bear weight.	F 323		

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- On 11/16/16, Progress Note indicated x-ray results had been called in to the physician and orders received to keep R78 at the care center for non-operative fracture care. The corresponding Incident Report form indicated no IDT review was completed.

During an interview on 12/21/16, at 2:05 p.m. nursing assistant (NA)-B stated R78 had a history of falls but she was not sure how many. She stated R78 used to walk very fast on the unit. NA-B further stated she was not aware of any fall prevention interventions other than to watch R78.

During an interview on 12/21/16, at 2:19 p.m. registered nurse (RN)-D stated when a resident has a fall, the nurse on duty fills out a risk management report. She stated the nurse will put an immediate intervention in place. RN-D stated the IDT reviews falls quarterly when completing an MDS but does not do a review following each fall.

During an interview on 12/21/16, at 2:37 p.m., the director of nursing (DON) stated when R78 fell, "It wasn't a surprise." The DON said R78 walks very fast and does not understand when staff tell her to slow down. The DON further stated falls were reviewed by a fall committee and stated the fall committee was "trying" to meet every two months. She stated the committee looks at the incident reports and tries to determine causative factors of the falls. The DON stated if she has concerns about a particular resident she will meet with the nurse manager after a fall, and stated prior to R78's fall with fracture, she (the DON) had no concerns about R78. The DON stated, "since I have been here (she started in January of 2016) I don't think she's had any other falls." The

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DON did not express an awareness of R78's nine falls since February of 2016. During a subsequent interview at 3:12 p.m., the DON verified there was no review of R78's fall history in the falls meeting minutes and stated "we were going to look at her this week."

During an interview on 12/22/16, at 1:30 p.m., the medical director (MD) stated he was aware of R78's fall history. The MD stated, with all the changes in the facility, the falls program needs to be re-invigorated. He stated the person who used to review falls was no longer at the facility and the fall program went away when she left.

An undated facility policy titled Assessing Falls and Their Causes was reviewed. The policy included: "Falls are a leading cause of morbidity and mortality among the elderly in nursing homes." The policy directed staff to begin to try to identify possible or likely causes of the fall. The policy further indicated documentation should include appropriate interventions taken to prevent future falls.

While R78 sustained multiple falls in the facility. There was no evidence the facility reviewed the falls since March of 2016. There was no evidence of interventions to prevent future falls or to reduce injury. Further, the facility initiated interventions in February and March that included reminders, however, R78 was severely cognitively impaired and the DON indicated she was unable to understand the directions.

R104's care plan dated 7/31/16, indicated R104 had limited physical mobility, needed reminders to use his walker, and may need a wheelchair when going out of the building. R104's MDS dated

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F 323	Continued From page 37 9/29/16, noted R104 had severe cognitive impairment and was admitted to the facility with a diagnoses of hepatic failure, cirrhosis of the liver with ascites and received hospice services. The care plan also included a date of 9/30/16, which indicated R104 was a smoker who required supervision with smoking in the outside designated area. R104's Physician Orders dated 10/8/16, included "OK for WanderGuard." Review of R104's Progress Notes included the following entries: On 11/8/16, at 5:54 p.m. family member (F)-B "had called 1st floor/Tcu mgr [transitional care unit/manager -RN-B] to report that R104 had gone shopping by cab yesterday and was staff aware. This writer asked R104 for the details and he stated the following 'Talked to 1st floor male honcho. Talked about rides available. Cab was ok. Went to Cub [grocery store] for some fruit and stuff. Why is she sticking her nose in? Why is she calling people.' Gave him names of men working on 1st floor and then he said 'The one who's [sic] name is on a plaque in the front.'" On 11/19/16, at 6:13 p.m. "Writer noticed at 1800 res [resident - R104] is not in his room. South nurse told writer that a family member came to visit and went with res [R104] on first floor. Writer checked on 1st floor, the smoking area and front of the building res [R104] was not there. On 12/16/16, at 2:04 p.m. "Resident was reported to be walking on the road this morning by the staff along vera cruz ave n [sic] about 350 meters from the facility. Writer went to get him back to the facility but he refused and insisted that he was going to cub he was redirected several time back but still he refused and kept on walking with the walker towards 36th. Staff called the facility who in turn called 911. After about 10 minutes, the police arrived who	F 323		

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F 323	Continued From page 38 then talked to him and he accepted to comeback. Vital signs were completed see vital section he denied having pain no SOB [shortness of breath] noted at the time morning medication administered and a 15 minutes check was initiated. All parties were notified hospice nurse gave new orders for see orders. He is currently out with [family]. Staff will cont. [continue] to monitor the resident." A care conference note dated 11/17/16, indicated R104 and family received re-clarification R104 required supervision out of the building. R104's medical record and facility documentation lacked evidence of any accident/incident reports regarding R104 missing from the facility on 12/16/16, R104 missing on 11/19/16 or R104's leave on 11/7/16. The medical record also lacked evidence of a comprehensive assessment of R104's risk for potential elopements. RN-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 licesned practical nurse (LPN)-C was the nurse working and searched the building after R104 was not in his room. RN-A indicated someone outside the building alerted staff that R104 was walking 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	F 323		

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F 323	Continued From page 39 building. When R104 was back in the building, the facility began every 15 minute checks and updated family, hospice, the NP and the DON. RN-A indicated the DON did the reporting to the SA and believed the incident was reported. When asked about the 11/8/16, Progress Note which indicated R104 left the facility in a cab, RN-A stated the incident did not occur. RN-A stated staff knew he wanted to call a cab and intervened before anything occurred. RN-A was not familiar with R104 missing from the 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 goes out every day and smokes." The DON did not know if R104 required supervision for smoking. The DON stated R104 was dressed appropriately for the weather on 12/16/16, and R104 was not confused. The DON confirmed R104 was not on facility grounds when he was found by staff on 12/16/16, and she did not consider the incident an elopement. The DON went on to say R104 has been trying to go out and smoke and she did not think R104 had a WanderGuard, but they had tried on in the past but staff keep a really close eye on him. The DON confirmed an elopement assessment or wandering assessment had not been completed for R104 and stated there was a difference between going out and going for a walk. The DON further confirmed R104 was not on the facility WanderGuard list and stated "he shouldn't	F 323		

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be, he goes out all the time." The DON further indicated R104 had the right to wander and confirmed again the incident was not reported because she did not view the incident as an elopement as he was found immediately by staff. The DON defined an elopement a "someone who has a WanderGuard but is gone, and cannot be found."

On 12/21/16, at 3:21 p.m. LPN-C was interviewed. LPN-C stated he was the nurse working on 12/16/16, and during morning report a night shift staff member who had left for the morning, returned to the facility and stated R104 was outside on the street. LPN-C confirmed no staff was aware R104 had left the building. LPN-C then went outside the facility to bring R104 back in. LPN-C stated it was freezing outside however R104 was dressed in a coat and had shoes on and was approximately 300 meters from the building. LPN-C stated he was unable to persuade R104 into the building and called RN-A to call police. LPN-C stated police arrived and persuaded R104 back into the building and police gave both R104 and LPN-C a ride back to the facility. LPN-C stated he assessed R104 when they returned to the facility and updated Hospice and F-B. LPN-C stated they then implemented every 15 minute checks. LPN-C was unaware of any other time R104 had left the building unsupervised. LPN-C stated he was unaware at how long R104 had been outside.

The director of social 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, leave from the facility. DSS stated she was aware of the incident and stated there was discussion of reporting the incident later in the day however, it

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F 323	Continued From page 41 was not reported because there was no harm to the resident and he was returned to the facility safely and appropriately. DSS stated she was on vacation during the week of 11/8/16, and did not know if R104 actually left the facility. DSS was not familiar with any other time R104 had been missing or left the facility without supervision. R104's F-B was interviewed on 12/21/16, at 12:43 p.m. F-B stated she was informed of R104 being outside on 12/16/16, and stated she was told staff observed R104 was gone from the facility and was found walking up the path outside of the facility. F-B stated R104 had a Wanderguard but it does not alwasy work when he has a coat on and was not sure if the wandergaurd had sounded. F-B stated R104 had left the facility one 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. 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 office and asked her 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 DON about what was told to her about R104 from F-B. RN-B stated she did not hear anything further regarding the situation from the DON or RN-A. RN-B was not aware of R104 ever leaving the facility unsupervised. RN-B stated she was aware of the 12/16/16, incident however, was not working at the time the incident occurred.	F 323		

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F 323	Continued From page 42 The administrator was interviewed on 12/21/16, at 1:04 p.m. The administrator stated he was notified on 12/16/16, R104 was outside and to his understanding staff had let him out front and he was walking down the side walk and a nurse followed him outside. The administrator confirmed the incident was not reported and stated the DON was aware of the incident and she had told him she had taken care of the situation. The administrator confirmed he was aware of what an elopement was and if that was what had been told to him it would have been reported. The administrator was interviewed regarding the 11/8/16, Progress Note and stated he did not tell the R104 that he could call a cab to leave the facility. The administrator was unaware if R104 left the facility. The administrator was not familiar with the 11/18/16, Progress Note or 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." During observation on 12/21/16, at 7:27 a.m. R66 was observed coming out of his room. There was fresh blood on the right side of chin and jaw. R66 said, "It is just from shaving and wiped at the blood. It will go away soon. I just cut myself shaving." Surveyor notified unknown nursing assistant of R66's bleeding. At 8:13 a.m. R66 observed in dining room, blood had been washed off R66's face. There was a 1 centimeter (cm) to 1.5 cm longitudinal cut on right side of the jaw.	F 323		

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R66's quarterly Minimum Data Set (MDS) dated 10/5/16, indicated R66 had moderate cognitively impaired and required assistance with personal hygiene. R66's MDS indicated R66's had diagnoses of dementia, hemiplegia and atrial fibrillation (irregular heart beat) on chronic Coumadin (blood thinner).

The ADLs Function/Rehabilitation Potential CAA dated 7/8/16, indicated R66 required, "Assist with dressing grooming and personal hygiene with set up and supervision to ensure tasks have been completed." Staff were to continue with current care plan and monitor for decline in self-care.

The ADL care plan revised 7/15/15, indicated R66 had altered status in ADLs related to alteration in decision making and thought process. The ADL care plan instructed staff, R66 was independent with shaving. The cardiac care plan revised 10/7/16, indicated R66 was on Coumadin and at risk for bruising and bleeding and instructed nursing assistants to observe and report blood in urine or pad tarry stools, bruises skin discolorations prolong bleeding from nose, gums or lab draw sites. The nurses were instructed to report to medical doctor or nurse practitioner and family bruises and symptoms of bleeding. The care plan did not address how to minimize bleeding risks while shaving, effect of hemiplegia on R66's safety to shave self with a disposable razor, or other interventions for staff to take to prevent bleeding.

Review of Progress Notes from 11/1/16, to 12/22/16, indicated
- On 11/12/16, R66 was noted to be bleeding from right thumb. Staff cleaned area applied triple

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F 323	Continued From page 44 antibiotic cream and a Band-Aid. The note indicated R66 stated," to have injured self from trying to shave. Will continue to be monitored." - On 12/5/16, R66 was noted to have scratches on head with a small amount of bleeding. Note indicated staff cleaned up the area and warned R66 not to use razor on his own. Per progress note, "[R66] stated it was a result of him shaving himself. Writer [sic] took all razors from his drawers as well. Will continue to be monitored." - On 12/19/16, progress note indicated, "Resident noted to have blood to nose when walking to the dining room for lunch. Resident's nasal was cleaned and two spots noted like from a scratch. Resident stated did not know how it happened. Will continue to monitor." - On 12/21/16, progress note indicated, "Resident noted to have blood to his cheek this morning. Scratches noted to the area. Resident stated no idea where it came from. Will continue to be monitored." The unlabeled Coumadin flow sheet indicated on 12/9/16, R66's INR was 1.9 and staff were to recheck INR on 12/23/16. The flow sheet also indicated R66 was on Coumadin 4 milligrams (mg) on Monday, Wednesday, Friday and Saturday. R66 was to receive Coumadin 3 mg. on Tuesday Thursday and Sunday. The 3rd Floor NA sheets dated 12/13/16, indicated R66 was independent with shaving. During interview on 12/21/16, at 2:19 p.m. registered nurse (RN)-A said, "Monday I noticed blood on his nose. I took him back to his room and washed it off and it was two small scrapes. I asked him, where did it come from? He said he did not know. I don't know where it came from but	F 323		

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he has a tendency to shave himself. I took all razors out that I found in his room. I have found razors in there in the past and that seems to be the cause. It would not surprise me to see that the nursing assistants are giving him more razors. I chart on the incident at the time but I do not do follow up on skin issues if they are small cuts from shaving."

During interview on 12/21/16, at 2:34 p.m. nursing assistant (NA)-G said, "I do not have any idea who shaves him. I have seen regular razors in his room. I give him razors as he requests, the plastic ones."

During interview on 12/21/16, at 2:37 p.m. nurse manager (NM)-A said, "He scratches himself sometimes. We have an electric razor if he wants it. He sometimes uses a regular razor." NM-A verified that care plan lacked specific interventions to prevent bleeding with ADLs.

During interview on 12/22/16, at 11:16 a.m. R66 said, "I ask the staff for a razor and they give it to me. Sometimes I cut myself but the bleeding will stop eventually."

During interview on 12/22/16, at 10:37 a.m. RN-E Staff development nurse said, "for residents who are on blood thinners the staff need to be aware of bleeding risk, use electric razors not the hand razors to shave a resident, and notify the nurse if there are any problems."

During interview on 12/22/16, at 2:32 p.m. the director of nursing (DON) said lately the staff have been just using the disposable razors. We have not had any issues with residents bleeding. I know that we are trying to initiate electric razors

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F 323	Continued From page 46 for everyone but they 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." Undated Shaving the Resident policy page 78 provided by facility instructed staff "The purpose of this procedure is to promote cleanliness and to provide skin care. 1. Review the resident's care plan to assess for any special needs of the resident." The policy did not indicate when to use an electric versus a safety razor. The complete policy requested but not received.	F 323		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 334		2/10/17

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F 334	Continued From page 47 (iv) The resident’s medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident’s representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident’s representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident’s representative has the opportunity to refuse immunization; and (iv) The resident’s medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident’s representative was provided education regarding the benefits and potential side effects of pneumococcal	F 334		

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F 334	Continued From page 48 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the current standards of immunization for pneumonia for 5 of 5 residents (R120, R29, R108, R94, R114) for residents over 65 years old, whose vaccination histories were reviewed. Findings include: R120's record indicated the resident had received a Pneumovax vaccination on 10/15/15, however it did not indicate which vaccine was administered, stated "Historical." R29's record indicated the resident had received a Pneumovax vaccination given on 7/15/16, however it did not indicate which vaccine was administered, stated "Historical." R108's record indicated the resident had received a Pneumovax vaccination given on 10/26/14, however it did not indicate which vaccine was administered, stated "Historical." R94's record indicated the resident had received a Pneumovax vaccination on 10/1/11, however id did not indicate which vaccine was administered, stated "Historical." R114's record indicated the resident had received a Pneumovax vaccination on 10/3/13, however it	F 334	F334 Resident Vaccinations/Immunizations Resident 120, 29, 108, 94, and 114 have had their records of vaccination/immunization reviewed and updated with actual names of vaccinations/immunizations as given. Resident 120, 29,108, 94, and 114 have been offered PCV13 or PPSV23 as per “CDC Standing Orders for Administering Pneumococcal Vaccines to adults 65 and older”. Residents have been reviewed to make sure that any historical vaccine have an appropriate name in their vaccination/immunization record. Additionally, residents have been reviewed to ensure that any aged aged 65 or older have been offered the appropriate vaccination per the CDC Standing Orders for Administering Pneumococcal Vaccines (PCV13 and PPSV23) to Adults. Nurses will be trained on all elements of the CDC Standing Orders for Administering Pneumococcal Vaccines by February 10th, 2017 and the new tracking program explained below. Staff Development or designee will utilize	

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did not indicate which vaccine was administered.

The infection control director, registered nurse (RN)-E was interviewed at 2:53 p.m. on 12/22/16. RN-E stated that she was not aware of documenting the specific Pneumovax vaccination and offering the PCV-13 to all residents in their facility greater or equal to 65 years of age or older.

The Center for Disease Control and Prevention dated 10/6/09, identified "Adults 65 years of age or older who have not previously received PCV13 [pneumococcal 13-valent Conjugate Vaccine] and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of pneumococcal 13-valent Conjugate Vaccine. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose."

Pneumovax Vaccine - Administration Policy provided by Pathways Health Service In., Infection Control Manual 2010.
"as a result of this welcome guidance, this facility has instituted as a Standing Order for Pneumovax Vaccine to assure that all eligible residents receive the vaccine. This is to assure that no opportunity is missed for disease prevention."
"General Procedure:
1. Primary care physicians will be notified by the facility Medical Director annually, via letter, that all new admissions will be screened and given the Pneumovax vaccine unless specifically ordered otherwise by Primary physician on admission orders.
a. This letter is sent to primary physician with current privileges to admit to this facility.

F 334

an Immunization Tracking Record specifically designed to identify resident aged 65 or older log to whom the pneumococcal vaccines identified in “CDC Standing Orders for Administering Pneumococcal Vaccines to adults 65 and older” should be offered. This tool will track the age of current residents and the age of residents at new admissions, and at re-admission to ensure residents are offered appropriate pneumococcal immunizations per the CDC Standing Orders for Administering Pneumococcal Vaccines at age 65 or older (reflecting residents who may have a birthday while on LOA, at hospital, or any other function found on re-admission, also).

The DON or her designee will audit the Vaccination and Immunization Tracking Record designed for residents 65 or older weekly x 4 and monthly thereafter to ensure compliance. The DON or her designee will report on the progress of this program monthly to the Quality Assurance Committee.

The correction date for completion is February 10th, 2017

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F 334	Continued From page 50 b. Nursing staff does not need to contact the primary physician for orders pertaining to administration of the vaccine for each resident. c. Nursing staff will contact the primary physician if they have questions or concerns that cannot be answered by resident or their medical decision maker about the criteria listed in the Standing Orders for Pneumovax Vaccine (e.g. disease or allergy history, history of receipt of the vaccine). 3. Every admission is screened for contraindications following the criteria contained within the standing orders and administered the vaccine, if indicated. 4. Licensed nursing staff performs the screening and vaccine administration. 5. A record of vaccination will be placed in the resident's medical record and in their vaccination record."	F 334		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		2/10/17

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(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 441	Continued From page 52 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure proper hand hygiene was performed to prevent the potential spread if infection for 3 of 5 residents (R48, R30, R25) whose cares were observed. Findings include: R48 During observation on 12/21/16, at 7:34 a.m. nursing assistant (NA)-G and NA-H washed their hands and put gloves on. NA-G asked R48, "Are you ready to get up for breakfast." NA-G washed R48's face and removed gown. NA-G washed R48's upper body avoiding gauze dressing on R48's upper abdomen. NA-G applied lotion to R48's face and upper body. NA-G put a red, light weight sweater on R48. NA-G removed gloves and applied new gloves without washing or sanitizing hands. NA-G loosened R48's incontinence product and wiped R48's peri area from back to front with a wet wash cloth. Wash cloth had brown substance on it after being used. NA-H rolled R48 to left side and NA-G wiped R48's bottom. Without changing gloves, NA-G placed a clean incontinence product on R48 and pulled down R48's sweater. NA-G rummaged in R48's from bed side table drawers to find socks for R48. NA-G washed hands and left room.	F 441	F441 Infection Control – Handwashing and Gloving Resident 48, 30, and 25 were reviewed by 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 if so, they have been resolved. Nursing will be retrained on the following; 1. Infection control principles for basic handwashing/gloving based on the I-CAR program. 2. Infection control principle for basic handwashing/gloving based on Association for Professionals in Infection Control and Epidemiology programs such as APIC - Minnesota. 3. 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 technique which will enable them to pass the return demonstrations will be taught	

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F 441	Continued From page 53 NA-H dressed R48's lower body with pants, socks and shoes. R48's quarterly Minimum Data Set (MDS) dated 10/12/16, indicated R48 had severe cognitive impairment and required assistance with all activities of daily living, except eating. R48's MDS indicated R48's diagnoses were aphasia [inability to communicate needs] and dementia. During interview on 12/21/16, at 2:34 p.m. NA-G verified not washing hands after changing gloves. NA-G said, "I must been nervous. I always wash from front to back. I should have done so today." R30 During observation on 12/21/16, at 10:28 a.m. NA-C explained to R30 what she was going to do to get her dressed. NA-C washed hands and put gloves on. NA-C washed R30's face, then washed arms, under arms and under breasts. NA-C put a shirt on R30, NA-C removed R30's incontinence product and then NA-C washed R30's abdomen, peri area from front to back and then R30's bottom. The wash cloth was stained brown. NA-C then washed R30's legs and feet and applied lotion without removing gloves or washing hands. NA-C put pants socks and shoes on R30. NA-C adjusted R30's head scarf and transferred R30 from bed to wheelchair. NA-C removed gloves and washed hands. R30's quarterly MDS dated 11/16/16, indicated R30 had severe cognitive impairment and required assistance with all activities of daily living, except eating. R30's MDS indicated R30's diagnosis was dementia. During interview on 12/21/16, at 2:10 p.m. NA-C	F 441	prior to the launch of the demonstration sessions. Infection control program: The facility is obtaining guidance in the development of a complete infection control program - including handwashing and gloving – from APIC Minnesota, infectious disease, epidemiology, prevention control division. Additional insight into infection control associated with handwashing and gloving will be obtained from MDOH – I-CAR program. Infection control practices: A new policy and procedure was developed for proper basic handwashing and gloving. Each nursing staff member will receive retraining and be required to provide returned demonstration on both basic handwashing and gloving. Nurses will be required to pass with a perfect score to graduate from this retraining. Retraining will be completed by February 10th, 2017. The standard required for passing the demonstration – and as taught – are the current acceptable standards for handwashing technique and gloving for basic resident care and clean technique (sterile technique is not being taught as part of this project). Staff Development or designee will conduct nursing basic handwashing and gloving spot audits weekly x 4 and monthly thereafter on each unit. Handwashing will include use of the “blue light” and gloving will include a demonstration of proper clean gloving technique for basic procedures and a written test on when gloving is appropriate and associated questions. Staff	

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	245289	A. BUILDING ______ B. WING ______	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

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F 441	Continued From page 54 said "I made a mistake" and verified using only one pair of gloves to get R30 ready for the day. During interview on 12/21/16, at 2:19 p.m. registered nurse (RN)-A said staff are to change their gloves and wash their hands after doing incontinence cares and before doing anything else. During interview on 12/22/16, at 10:37 a.m. RN-E Staff development nurse said, the nursing assistants are taught to wash hands or use sanitizer every time they remove their gloves, that they must change their gloves after washing the peri area and a resident's bottom. I teach them to wash a female resident from the front to the back of the perineum, then from front to back of each inner thigh, then to wash the resident's bottom. RN-E said, "They are told, "do not use the dirty soiled gloves to touch a brief or to put cream on a resident.'" During interview on 12/22/16, at 2:32 p.m. the director of nursing (DON) said she expected staff to wash their hands after using gloves, to change gloves after doing pericare and wash hands before doing anything else. DON said, "They [nursing staff] are to wash front to back with pericare. I started doing audits this morning." R25 was observed on 2/22/16, at 7:15 through 8:30 a.m. (NA)-C entered the room and placed a box of gloves on the foot of R25 ' s bed and then applied gloves. NA-C then removed the gloves to leave the room to gather more equipment i.e., padding and disposable washcloth. NA-C donned a new pair of gloves and pulled down R25 covers exposing the peri-area. R25 ' s front peri area was cleaned from front to back. Then R25 was	F 441	Development or designee will report on the progress of this program monthly to the Quality Assurance Committee. The correction date for completion is February 10th, 2017	

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F 441	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 a larger sling. Both staff assisted R25 into the sling and transferred R25 into the motorized chair, then removed the sling. RN-C removed gloves and left the room, NA-C continued with the same pair of	F 441		

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F 441	Continued From page 56	F 441		

gloves to comb R25 ' s hair, applied a blanket to the lap, and gave R25 the stuff animal as requested.

R25's quarterly MDS dated 10/19/16, indicated R25 had mild cognitive impairment and required extensive assistance with all activities of daily living, except eating.

During interview on 12/22/16, at 11:45a.m. RN-P indicated she expected staff to apply gloves when giving morning care, wash the face and chest area then remove their gloves and wash their hands and apply second pair of gloves to complete the care. "Our staff development director just completed a skills fair where we talked about gloving. "

During an interview on 12/22/16, at 11:48 a.m. NA-C said, "I change my gloves anytime I touch a dirty area, wash my hands and apply another pair of gloves if needed."

During an interview on 12/22/16, at 2:34 P.M, the director of staff development (DSD) was asked about glove changing during cares. DSD stated, "We just had a skills fair where we just talked about this and it is expected that staff change their gloves, wash or sanitized their hands after removing their gloves and before applying a second pair. The DON, who was also interviewed at the same time, was asked about hand washing and glove use. The DON stated she expected staff to wash their hands after using gloves, to change gloves after doing pericare and wash their hands before doing anything. "We just had a skills fair that addressed all these issues."

Undated Handwashing/hand hygiene policy

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F 441	Continued From page 57 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: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area from front to back. (1) Separate labia and wash area downward from front to back. (Note: if the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same wash cloth or water to clean the urethra or labia. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (Note: if the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.) (4) Gently dry perineum. c. Instruct or assist the resident to turn on her side with her top leg slightly bent if able. d. Rinse washcloth and apply soap or skin cleansing agent. e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the Labia. f. Rinse thoroughly using the same technique as described in "e " above. g. Dry area thoroughly. 11. Discard disposable items into designated container. Wash and dry your hands thoroughly."	F 441		

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

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PRINTED: 01/23/2017
FORM APPROVED
OMB NO. 0938-0391

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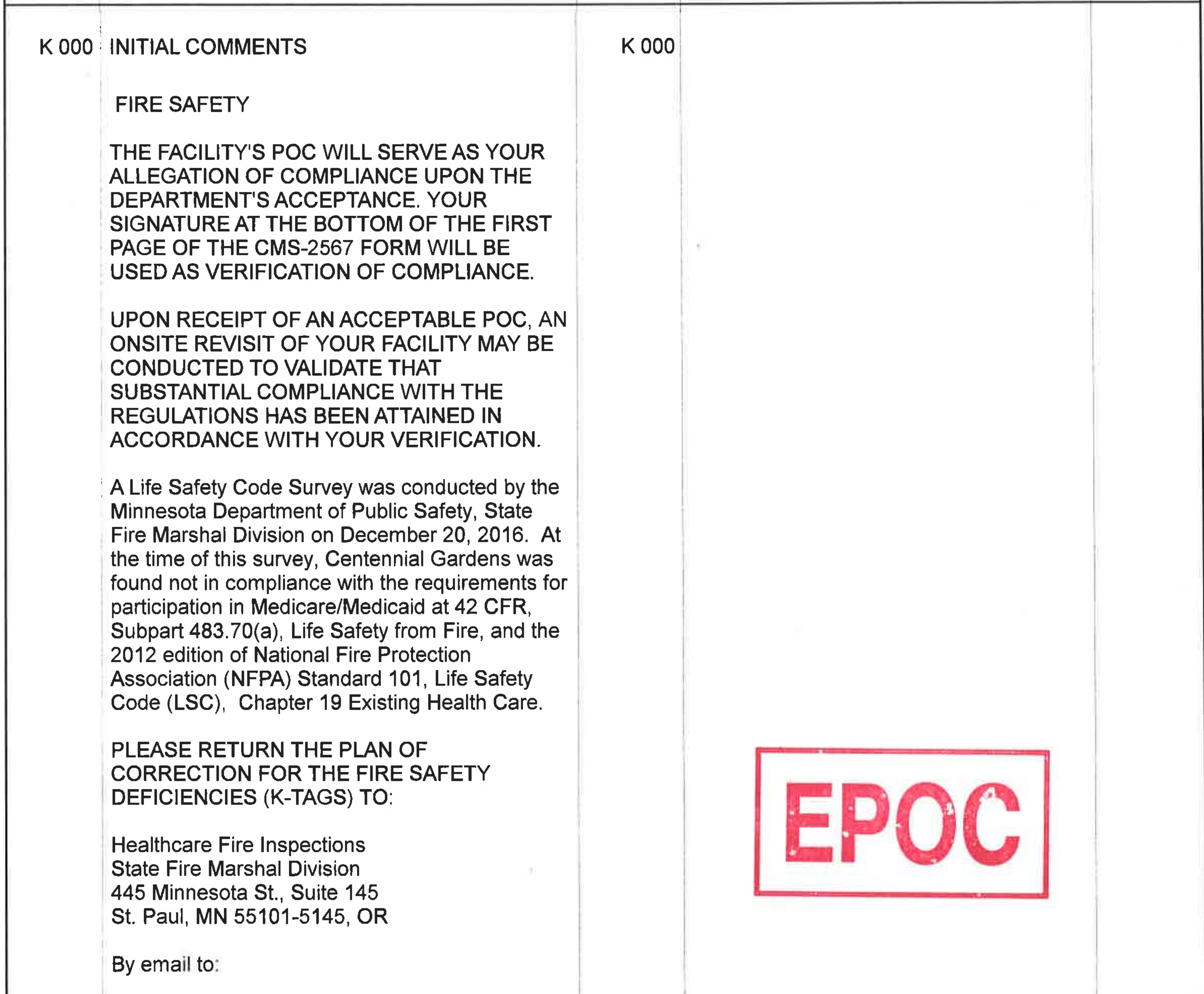

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 20, 2016. At the time of this survey, Centennial Gardens was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Centennial Gardens is a 3-story building that was constructed in 1971 and was determined to be of Type II (111) construction. It has a full basement and is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 130 beds and had a census of 98 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		2/10/17

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K 353	Continued From page 2 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ____ b) Who provided system test ____ c) Water system supply source ____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 98 residents. Findings include: 1. On a facility tour between the hours of 1130 and 1700 on December 20, 2016, observation revealed that the annual automatic sprinkler system inspection was conducted 21 months after the last annual inspection (02/19/2015-11/30/2016). 2. On a facility tour between the hours of 1130 and 1700 on December 20, 2016, observation revealed that the facility could not provide documentation for conducting quarterly automatic sprinkler system flow test for the second and third quarters of 2016.	K 353	K353 NFPA 101 Sprinkler System-Maintenance and Testing The facility has made the necessary corrections regarding maintaining and testing the automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101.9.7.5, 9.7.7, 9.7.8. An annual automatic sprinkler test was completed on 11/30/2016. The quarterly automatic sprinkler system and flow testing is scheduled for February 14th, 2017. Records of the system inspection and testing are maintained and stored in a secure location and are readily available. The facility reviewed and confirmed the contract schedule for quarterly and annual inspections with Viking Automatic Sprinkler Co, 301 York Ave, St. Paul, Mn55130 to ensure testing is completed in accordance with NFPA rules. The following inspections have been confirmed for 2017 and will be updated annually thereafter.	

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K 353	Continued From page 3 This deficient practice was verified by the director of maintenance at the time of inspection.	K 353	A) Quarterly Automatic Sprinkler System Inspection and Flow Test: February 14th, 2017 B) Quarterly Automatic Sprinkler System Inspection and Flow Test: May 2017 C) Quarterly Automatic Sprinkler System Inspection and Flow Test: August 2017 D) Annual Automatic Sprinkler System Inspection and Test: November 2017 To ensure that quarterly and annual automatic sprinkler system inspections and testing are completed within the timeframes set by the NFPA, the Maintenance Director and Administrator have developed a new tracking and notification system to ensure timely testing and inspections are completed. The tracking and notification system is as follows. The Maintenance Director has established a tracking calendar that list monthly required testing and inspections. This record is maintained and stored in a secure location and is readily available. This tracking calendar is reviewed monthly by both the Maintenance Director and Administrator. The Administrator has set up an automatic system that sends out alerts via email notifying both the Maintenance Director and Administrator of scheduled automatic sprinkler testing and inspections. The alerts are set to notify both the Maintenance Director and Administrator on the first day on the month the test and inspection is scheduled. A follow up alert will be automatically sent on the day of the scheduled test and inspection. All documents pertaining to the test and inspection will be obtained from Viking	

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K 353	Continued From page 4	K 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	
K 523 SS=D	NFPA 101 HVAC - Suspended Unit Heaters Suspended Unit Heaters Suspended unit heaters are permitted provided the following are met: * Not located in means of egress or in patient rooms. * Located high enough to be out of reach of people in the area. * Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not use probable space heating units in accordance with the 2012 edition of The Life Safety Code NFPA 101. 19.5.2.3(1). This deficient practice could affect the residents within the room. Findings include: On a facility tour between the hours of 1130 and 1700 on December 20, 2016, observation revealed that portable space heaters were being used in resident rooms 301 and 327. This deficient practice was verified by the director of maintenance at the time of inspection.	K 523	K523 NFPA 101 HVAC □ Suspended Unit Heaters The portable space heaters were immediately removed from room 301 and 327. All resident rooms were audited and no other space heaters were found. To ensure continued compliance with the 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 a space heater is found. Informational signs stating space heaters are not allowed in the facility have been posted at the reception desk, both elevators, and on each nursing unit. The training and signs	2/10/17

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K 523	Continued From page 5	K 523	direct staff to inform the Director of Maintenance or the Administrator and to remove the space heater immediately. A section has been added to our Centennial Gardens for Nursing and Rehabilitation Life Safety monthly audit form addressing space heaters. This documents will be maintained and stored in a secure location and will be readily available. The Administrator or designee will monitor and review the Life Safety audit monthly to ensure no space heaters are in the facility. The correction date for compliance is February 10th, 2017.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

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,

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: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: ______ B. WING ______	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REH	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has 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/inf	2 000		

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

Electronically Signed | 01/20/17

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2 000	Continued From page 1 obul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. An investigation of complaint # H5289051 was completed. The complaint was not substantiated.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise care planned interventions for 3 of 4 residents (R77, R78, R66) who had a change in care needs.	2 570	Corrected	2/10/17

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2 570	Continued From page 2	2 570		

Findings include:

R77's Minimum Data Set (MDS) dated 10/26/16, noted R77 to have both long term and short memory impairment. In addition, R77 required assist of one for all activities of daily living (ADLs) with the exception of eating and R77 did not ambulate. The comprehensive care plan dated 11/8/16, noted R77's diagnoses to include dementia with behavioral disturbance and muscle weakness. R77 had an injury to the arm that was not included on the care plan. The comprehensive care plan lacked interventions on how to care for the injured left arm.

R77 was observed on 12/19/16, at 2:00 p.m. in his room with the left elbow swollen the size of a baseball, and reddened. An x-ray was just completed of the arm. R77 was grimacing and stated, "I can't stand the pain." The injured left arm was not supported in the bed nor was it in a sling. 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."

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 lunchtime on 12/20/16, to treat a left arm fracture. LPN-A said, "No one could tell what happened to the arm, it started on Sunday" (12/18/16).
- At 3:20 p.m. NA-A was interviewed and stated R77 had complained of severe pain in the left arm on Sunday (12/18/16) afternoon shift, and remained on bedrest. NA-A stated the nurse told him to have R77 rest.

The NA Care Sheet dated 12/20/16, did not have

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2 570	Continued From page 3 any direction to keep on bedrest or to support the arm, and did not mention a fracture to the arm. The director of nursing (DON) was interviewed on 12/21/16, at 9:20 a.m. and stated care plans should be updated with changes to the resident's care needs. She verified R77's care plan had not been updated since R77 had complained of pain on 12/18/16. The x-ray on 12/19/16, had noted a complete fracture of the humerus (arm bone). Charais, Amy R78's MDS dated 10/4/16, indicated she was independent with ambulation and required only one staff assistance for all other ADLs. R78's significant change MDS 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. A Care Area Assessment (CAA) dated 11/28/16, identified a risk for falls based on an actual fall on 11/15/16, and indicated R78 was at moderate risk for falls. R78's care plan dated 12/7/16, indicated a potential for falls due to cognitive deficit and identified a right hip fracture sustained on 11/15/16, as a result of a fall. A review of Centennial Gardens for Nursing and Rehabilitation - SNF (Skilled Nursing facility) Progress Notes along with correlating Incident Post Fall Scene Investigation Tools indicated R78 sustained nine falls between 2/5/16 and 2/22/16. The most recent fall on 1/18/16, resulted in a fracture. R78's care plan dated 12/7/16, identified the following fall interventions: 1/23/15 - fall assessment per policy, 1/23/15 - anticipate and meet the resident's needs, 1/23/15 - the resident	2 570		

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2 570	Continued From page 4	2 570		

needs a safe environment, 1/29/16 - offer diversional activities, 1/29/16 - proper footwear (currently on hold) 4/20/16 - check and change and reposition the resident every two hours. The care plan did not include 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 had a history of falls but she was not sure how many. She stated she used to walk very fast on the unit. NA-B further stated she was not aware of any fall prevention interventions and stated she was told to watch R78.

During an interview on 12/21/16, at 2:19 p.m., registered nurse (RN)-D stated when a resident falls, the nurse on duty fills out a risk management report. She stated the nurse will put an immediate intervention in place.

During an interview on 12/21/16, at 2:37 p.m., the DON stated when R78 fell, "It wasn't a surprise." She stated she walked very fast and did not understand when staff told her to slow down. The DON stated falls were reviewed by a fall committee and stated the fall committee was "trying" to meet every two months. She stated the committee looks at the incident reports and tries to determine causes of falls. During a subsequent interview at 3:12 p.m., the DON stated there was no review of R78's fall history in the falls meeting minutes and stated "we were going to look at her this week."

Souther, Glenora
R66 was observed in hallway with an abrasion on the top of nose and one on the side of nose on

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2 570	Continued From page 5 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." During observation on 12/21/16, at 7:27 a.m. R66 was observed coming out of his room. There was fresh blood on the right side of chin and jaw. R66 said, "It is just from shaving and wiped at the blood. It will go away soon. I just cut myself shaving." Surveyor notified unknown nursing assistant of R66's bleeding. -8:13 a.m. R66 observed in dining room, blood had been washed off R66's face. There was a 1 centimeter (cm) to 1.5 cm longitudinal cut on right side of the jaw. R66's quarterly MDS dated 10/5/16, indicated R66 had moderate cognitively impaired and required assistance with personal hygiene. R66's MDS indicated R66's had diagnoses of dementia, hemiplegia and atrial fibrillation (irregular heart beat) on chronic Coumadin (blood thinner). The ADL (activities of daily living) Function/Rehabilitation Potential CAA dated 7/8/16, indicated R66 required, "Assist with dressing grooming and personal hygiene with set up and supervision to ensure tasks have been completed." Staff were to continue with current care plan and monitor for decline in self-care. The ADL care plan revised 7/15/15, indicated R66 had altered status in ADL's related to alteration in decision making and thought process. The ADL care plan instructed staff, R66 was independent with shaving. The cardiac care plan revised 10/7/16, indicated R66 was on Coumadin and at risk for bruising and bleeding and instructed nursing assistants to observe and report blood in urine or pad tarry stools, bruises skin	2 570		

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discolorations prolong bleeding from nose, gums or lab draw sites. The nurses were instructed to report to medical doctor or nurse practitioner and family bruises and symptoms of bleeding. The care plan did not address how to minimize bleeding risks while shaving, effect of hemiplegia on R66's safety to shave self with a disposable razor, or other interventions for staff to take to prevent bleeding.

The 3rd Floor NA sheets dated 12/13/16, indicated R66 was independent with shaving.

Review of Progress Notes from 11/1/16, to 12/22/16, indicated
- On 11/12/16, R66 was noted to be bleeding from right thumb. Staff cleaned area applied triple antibiotic cream and a band-aid. The note indicated R66 stated," to have injured self from trying to shave. Will continue to be monitored."
- On 12/5/16, R66 was noted to have scratches on head with a small amount of bleeding. Note indicated staff cleaned up the area and warned R66 not to use razor on his own. Per progress note, "[R66] stated it was a result of him shaving himself. Writer [sic] took all razors from his drawers as well. Will continue to be monitored."
- On 12/19/16, progress note indicated, "Resident noted to have blood to nose when walking to the dining room for lunch. Resident's nasal was cleaned and two spots noted like from a scratch. Resident stated did not know how it happened. Will continue to monitor."
- On 12/21/16, progress note indicated, "Resident noted to have blood to his cheek this morning. Scratches noted to the area. Resident stated no idea where it came from. Will continue to be monitored."

During interview on 12/21/16, at 2:19 p.m. RN-A

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2 570	Continued From page 7	2 570		

said, "I do not update the care plan the Nurse Managers do."

During interview on 12/21/16, at 2:34 p.m. NA-G said, "I do not have any idea who shaves him. I have seen regular razors in his room. I give him razors as he requests, the plastic ones."

During interview on 12/21/16, at 2:37 p.m. nurse manager (NM)-A said, "He scratches himself sometimes. We have an electric razor if he wants it. He sometimes uses a regular razor." NM-A verified the care plan lacked specific interventions to prevent bleeding with ADL's.

During interview on 12/22/16, at 10:37 a.m. RN-E said, "for residents who are on blood thinners the staff need to be aware of bleeding risk, use electric razors not the hand razors to shave a resident, and notify the nurse if there are any problems. This should be on the care plan and assignment sheet."

During interview on 12/22/16, at 2:32 p.m. the DON said lately the staff have been just using the disposable razors. We have not had any issues with residents bleeding. I know that we are trying to initiate electric razors for everyone but they 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 that 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 -

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2 570	Continued From page 8 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 policy did not address updates to the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to updating care plans. The DON or designee, could provide training for all nursing staff related to the timeliness of updating care plans. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced	2 830		2/10/17

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by:
Based on observation, interview, and document review, the facility failed to implement interventions to reduce the risk of falls for 1 of 3 residents (R78) reviewed for falls. This resulted in actual harm for R78 who sustained a fracture resulting from a fall. In addition, the facility failed to provide adequate supervision for 1 of 1 resident (R104) reviewed for elopements and the facility failed to supervise 1 of 1 resident (R66) for safety related to use of a disposable razor.

Corrected

Findings include:

R78 was observed on 12/20/16, at 2:20 p.m. R78 was lying in bed while a holiday party was in progress on the unit.

During an interview on 12/20/16, at 3:11 p.m., registered nurse (RN)-D stated R78 was on bed rest following a fracture of her right hip.

R78's significant change Minimum Data Set (MDS) 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. A previous MDS dated 10/4/16, indicated R78 had been independent with ambulation and required only one staff assistance for all other activities of daily living. R78's care plan dated 12/7/16, indicated a potential for falls due to cognitive deficit and identified a right hip fracture had been sustained on 11/15/16, as a result of a fall. The care plan directed staff to anticipate her needs, offer diversion, reminders to slow down and ensure proper foot wear (currently on hold due to bed rest.) A Area Assessment (CAA) dated 11/28/16, identified a risk for falls based on an actual fall on 11/15/16, and indicated

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2 830	Continued From page 10 R78 was at moderate risk for falls. A review of R78's Progress Notes and corresponding Incident Post Fall Scene Investigation Tools were reviewed from 2/5/16 to 11/15/16, and identified the following falls: - On 2/15/16, Progress Note indicated R78 was observed on the east hallway floor lying flat on her stomach. The correlating incident report indicated R78 was helped to bed and monitored by night shift. The interdisciplinary team (IDT) review indicated a new intervention of offering R78 tasks such as folding washcloth or cleaning to re-direct had been implemented. - On 2/22/16, Progress Note indicated R78 was walking very fast in hallway, missed her step and fell onto left side. The corresponding incident report indicated R78 was redirected and put in close observation. The IDT review of the fall indicated staff were to remind R78 to slow down when walking too fast, and to redirect as able. - On 3/1/16, Progress Note indicated R78 slid to the floor and landed on her bottom. The corresponding incident report indicated R78 was helped to a chair and educated on proper sitting position. The IDT review intervention initiated as a result included to encourage her to sit back in the chair. - On 3/20/16, Progress Note indicated R78 was found sitting on the floor facing the elevator. The corresponding incident report indicated she was immediately put on a one to one and pain medication was administered. An IDT review of the fall was not completed. - On 4/8/16, progress note indicated R78 was found on the floor at 9:00 a.m. by the nurse's station lying on her left side and again an hour later was found sitting on the floor. The corresponding incident report indicated she was immediately brought closer to the nursing station.	2 830		

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2 830	Continued From page 11 An IDT review of the incident was not completed. - On 4/22/16, a note labeled IDT Note indicated R78 had multiple falls related to pacing/fast walking. The recommended intervention included for staff to continue to re-direct prn (as needed). - On 5/13/16, Progress Note indicated R78 was found sitting on the floor in her room. The immediate intervention implemented was to advise R78 to use her call light. An IDT review of the fall was not completed. - On 7/8/16, a note labeled IDT note, indicated R78 had experienced two falls without injury related to rapid pace of wandering. There was no evidence the IDT had evaluated or assessed causative factors of the falls. - On 7/16/16, progress note indicated R78 was found on the floor in the dining room at 7:50 p.m. The corresponding incident report indicated an immediate intervention of offering her a snack. The IDT review portion of the incident form was not completed. - On 10/28/16, Progress Note indicated R78 fell following a loss of balance. No incident report was completed for the fall, nor was an IDT review documented. - On 11/15/16, Progress Note indicated R78 was found lying on floor near the elevator on her right side. She was complaining of hip pain and unable to bear weight. - On 11/16/16, Progress Note indicated x-ray results had been called in to the physician and orders received to keep R78 at the care center for non-operative fracture care. The corresponding Incident Report form indicated no IDT review was completed. During an interview on 12/21/16, at 2:05 p.m. nursing assistant (NA)-B stated R78 had a history of falls but she was not sure how many. She stated R78 used to walk very fast on the unit.	2 830		

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2 830	Continued From page 12	2 830		

Continued From page 12

NA-B further stated she was not aware of any fall prevention interventions other than to watch R78.

During an interview on 12/21/16, at 2:19 p.m. registered nurse (RN)-D stated when a resident has a fall, the nurse on duty fills out a risk management report. She stated the nurse will put an immediate intervention in place. RN-D stated the IDT reviews falls quarterly when completing an MDS but does not do a review following each fall.

During an interview on 12/21/16, at 2:37 p.m., the director of nursing (DON) stated when R78 fell, "It wasn't a surprise." The DON said R78 walks very fast and does not understand when staff tell her to slow down. The DON further stated falls were reviewed by a fall committee and stated the fall committee was "trying" to meet every two months. She stated the committee looks at the incident reports and tries to determine causative factors of the falls. The DON stated if she has concerns about a particular resident she will meet with the nurse manager after a fall, and stated prior to R78's fall with fracture, she (the DON) had no concerns about R78. The DON stated, "since I have been here (she started in January of 2016) I don't think she's had any other falls." The DON did not express an awareness of R78's nine falls since February of 2016. During a subsequent interview at 3:12 p.m., the DON verified there was no review of R78's fall history in the falls meeting minutes and stated "we were going to look at her this week."

During an interview on 12/22/16, at 1:30 p.m., the medical director (MD) stated he was aware of R78's fall history. The MD stated, with all the changes in the facility, the falls program needs to be re-invigorated. He stated the person who used

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2 830	Continued From page 13 to review falls was no longer at the facility and the fall program went away when she left. An undated facility policy titled Assessing Falls and Their Causes was reviewed. The policy included: "Falls are a leading cause of morbidity and mortality among the elderly in nursing homes." The policy directed staff to begin to try to identify possible or likely causes of the fall. The policy further indicated documentation should include appropriate interventions taken to prevent future falls. While R78 sustained multiple falls in the facility. There was no evidence the facility reviewed the falls since March of 2016. There was no evidence of interventions to prevent future falls or to reduce injury. Further, the facility initiated interventions in February and March that included reminders, however, R78 was severely cognitively impaired and the DON indicated she was unable to understand the directions. R104's care plan dated 7/31/16, indicated R104 had limited physical mobility, needed reminders to use his walker, and may need a wheelchair when going out of the building. R104's MDS dated 9/29/16, noted R104 had severe cognitive impairment and was admitted to the facility with a diagnoses of hepatic failure, cirrhosis of the liver with ascites and received hospice services. The care plan also included a date of 9/30/16, which indicated R104 was a smoker who required supervision with smoking in the outside designated area. R104's Physician Orders dated 10/8/16, included "OK for WanderGuard." Review of R104's Progress Notes included the following entries: On 11/8/16, at 5:54 p.m. family member (F)-B "had called 1st floor/Tcu mgr	2 830		

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[transitional care unit/manager -RN-B] to report that R104 had gone shopping by cab yesterday and was staff aware. This writer asked R104 for the details and he stated the following 'Talked to 1st floor male honcho. Talked about rides available. Cab was ok. Went to Cub [grocery store] for some fruit and stuff. Why is she sticking her nose in? Why is she calling people.' Gave him names of men working on 1st floor and then he said 'The one who's [sic] name is on a plaque in the front.'" On 11/19/16, at 6:13 p.m. "Writer noticed at 1800 res [resident - R104] is not in his room. South nurse told writer that a family member came to visit and went with res [R104] on first floor. Writer checked on 1st floor, the smoking area and front of the building res [R104] was not there. On 12/16/16, at 2:04 p.m. "Resident was reported to be walking on the road this morning by the staff along vera cruz ave n [sic] about 350 meters from the facility. Writer went to get him back to the facility but he refused and insisted that he was going to cub he was redirected several time back but still he refused and kept on walking with the walker towards 36th. Staff called the facility who in turn called 911. After about 10 minutes, the police arrived who then talked to him and he accepted to comeback. Vital signs were completed see vital section he denied having pain no SOB [shortness of breath] noted at the time morning medication administered and a 15 minutes check was initiated. All parties were notified hospice nurse gave new orders for see orders. He is currently out with [family]. Staff will cont. [continue] to monitor the resident."

A care conference note dated 11/17/16, indicated R104 and family received re-clarification R104 required supervision out of the building. R104's medical record and facility documentation lacked

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2 830	Continued From page 15 evidence of any accident/incident reports regarding R104 missing from the facility on 12/16/16, R104 missing on 11/19/16 or R104's leave on 11/7/16. The medical record also lacked evidence of a comprehensive assessment of R104's risk for potential elopements. RN-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 licesned practical nurse (LPN)-C was the nurse working and searched the building after R104 was not in his room. RN-A indicated someone outside the building alerted staff that R104 was walking 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 minute checks and updated family, hospice, the NP and the DON. RN-A indicated the DON did the reporting to the SA and believed the incident was reported. When asked about the 11/8/16, Progress Note which indicated R104 left the facility in a cab, RN-A stated the incident did not occur. RN-A stated staff knew he wanted to call a cab and intervened before anything occurred. RN-A was not familiar with R104 missing from the 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	2 830		

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2 830	Continued From page 16 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 goes out every day and smokes." The DON did not know if R104 required supervision for smoking. The DON stated R104 was dressed appropriately for the weather on 12/16/16, and R104 was not confused. The DON confirmed R104 was not on facility grounds when he was found by staff on 12/16/16, and she did not consider the incident an elopement. The DON went on to say R104 has been trying to go out and smoke and she did not think R104 had a WanderGuard, but they had tried on in the past but staff keep a really close eye on him. The DON confirmed an elopement assessment or wandering assessment had not been completed for R104 and stated there was a difference between going out and going for a walk. The DON further confirmed R104 was not on the facility WanderGuard list and stated "he shouldn't be, he goes out all the time." The DON further indicated R104 had the right to wander and confirmed again the incident was not reported because she did not view the incident as an elopement as he was found immediately by staff. The DON defined an elopement a "someone who has a WanderGuard but is gone, and cannot be found." On 12/21/16, at 3:21 p.m. LPN-C was interviewed. LPN-C stated he was the nurse working on 12/16/16, and during morning report a night shift staff member who had left for the morning, returned to the facility and stated R104 was outside on the street. LPN-C confirmed no staff was aware R104 had left the building.	2 830		

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LPN-C then went outside the facility to bring R104 back in. LPN-C stated it was freezing outside however R104 was dressed in a coat and had shoes on and was approximately 300 meters from the building. LPN-C stated he was unable to persuade R104 into the building and called RN-A to call police. LPN-C stated police arrived and persuaded R104 back into the building and police gave both R104 and LPN-C a ride back to the facility. LPN-C stated he assessed R104 when they returned to the facility and updated Hospice and F-B. LPN-C stated they then implemented every 15 minute checks. LPN-C was unaware of any other time R104 had left the building unsupervised. LPN-C stated he was unaware at how long R104 had been outside.

The director of social 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, leave from the facility. DSS stated she was aware of the incident and 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 safely and appropriately. DSS stated she was on vacation during the week of 11/8/16, and did not know if R104 actually left the facility. DSS was not familiar with any other time R104 had been missing or left the facility without supervision.

R104's F-B was interviewed on 12/21/16, at 12:43 p.m. F-B stated she was informed of R104 being outside on 12/16/16, and stated she was told staff observed R104 was gone from the facility and was found walking up the path outside of the facility. F-B stated R104 had a Wanderguard but it does not alwasy work when he has a coat on and was not sure if the wandergaurd had sounded. F-B stated R104 had left the facility one

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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.

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 office and asked her 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 DON about what was told to her about R104 from F-B. RN-B stated she did not hear anything further regarding the situation from the DON or RN-A. RN-B was not aware of R104 ever leaving the facility unsupervised. RN-B stated she was aware of the 12/16/16, incident however, was not working at the time the incident occurred.

The administrator was interviewed on 12/21/16, at 1:04 p.m. The administrator stated he was notified on 12/16/16, R104 was outside and to his understanding staff had let him out front and he was walking down the side walk and a nurse followed him outside. The administrator confirmed the incident was not reported and stated the DON was aware of the incident and she had told him she had taken care of the situation. The administrator confirmed he was aware of what an elopement was and if that was what had been told to him it would have been reported. The administrator was interviewed regarding the 11/8/16, Progress Note and stated he did not tell the R104 that he could call a cab to leave the facility. The administrator was unaware if R104 left the facility. The administrator was not familiar with the 11/18/16, Progress Note or

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2 830	Continued From page 19 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." During observation on 12/21/16, at 7:27 a.m. R66 was observed coming out of his room. There was fresh blood on the right side of chin and jaw. R66 said, "It is just from shaving and wiped at the blood. It will go away soon. I just cut myself shaving." Surveyor notified unknown nursing assistant of R66's bleeding. At 8:13 a.m. R66 observed in dining room, blood had been washed off R66's face. There was a 1 centimeter (cm) to 1.5 cm longitudinal cut on right side of the jaw. R66's quarterly Minimum Data Set (MDS) dated 10/5/16, indicated R66 had moderate cognitively impaired and required assistance with personal hygiene. R66's MDS indicated R66's had diagnoses of dementia, hemiplegia and atrial fibrillation (irregular heart beat) on chronic Coumadin (blood thinner). The ADLs Function/Rehabilitation Potential CAA dated 7/8/16, indicated R66 required, "Assist with dressing grooming and personal hygiene with set up and supervision to ensure tasks have been completed." Staff were to continue with current care plan and monitor for decline in self-care. The ADL care plan revised 7/15/15, indicated R66 had altered status in ADLs related to alteration in decision making and thought process. The ADL care plan instructed staff, R66 was independent with shaving. The cardiac care plan revised 10/7/16, indicated R66 was on Coumadin and at	2 830		

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2 830	Continued From page 20 risk for bruising and bleeding and instructed nursing assistants to observe and report blood in urine or pad tarry stools, bruises skin discolorations prolong bleeding from nose, gums or lab draw sites. The nurses were instructed to report to medical doctor or nurse practitioner and family bruises and symptoms of bleeding. The care plan did not address how to minimize bleeding risks while shaving, effect of hemiplegia on R66's safety to shave self with a disposable razor, or other interventions for staff to take to prevent bleeding. Review of Progress Notes from 11/1/16, to 12/22/16, indicated - On 11/12/16, R66 was noted to be bleeding from right thumb. Staff cleaned area applied triple antibiotic cream and a Band-Aid. The note indicated R66 stated," to have injured self from trying to shave. Will continue to be monitored." - On 12/5/16, R66 was noted to have scratches on head with a small amount of bleeding. Note indicated staff cleaned up the area and warned R66 not to use razor on his own. Per progress note, "[R66] stated it was a result of him shaving himself. Writer [sic] took all razors from his drawers as well. Will continue to be monitored." - On 12/19/16, progress note indicated, "Resident noted to have blood to nose when walking to the dining room for lunch. Resident's nasal was cleaned and two spots noted like from a scratch. Resident stated did not know how it happened. Will continue to monitor." - On 12/21/16, progress note indicated, "Resident noted to have blood to his cheek this morning. Scratches noted to the area. Resident stated no idea where it came from. Will continue to be monitored." The unlabeled Coumadin flow sheet indicated on	2 830		

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12/9/16, R66's INR was 1.9 and staff were to recheck INR on 12/23/16. The flow sheet also indicated R66 was on Coumadin 4 milligrams (mg) on Monday, Wednesday, Friday and Saturday. R66 was to receive Coumadin 3 mg. on Tuesday Thursday and Sunday.

The 3rd Floor NA sheets dated 12/13/16, indicated R66 was independent with shaving.

During interview on 12/21/16, at 2:19 p.m. registered nurse (RN)-A said, "Monday I noticed blood on his nose. I took him back to his room and washed it off and it was two small scrapes. I asked him, where did it come from? He said he did not know. I don't know where it came from but he has a tendency to shave himself. I took all razors out that I found in his room. I have found razors in there in the past and that seems to be the cause. It would not surprise me to see that the nursing assistants are giving him more razors. I chart on the incident at the time but I do not do follow up on skin issues if they are small cuts from shaving."

During interview on 12/21/16, at 2:34 p.m. nursing assistant (NA)-G said, "I do not have any idea who shaves him. I have seen regular razors in his room. I give him razors as he requests, the plastic ones."

During interview on 12/21/16, at 2:37 p.m. nurse manager (NM)-A said, "He scratches himself sometimes. We have an electric razor if he wants it. He sometimes uses a regular razor." NM-A verified that care plan lacked specific interventions to prevent bleeding with ADLs.

During interview on 12/22/16, at 11:16 a.m. R66 said, "I ask the staff for a razor and they give it to

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2 830	Continued From page 22 me. Sometimes I cut myself but the bleeding will stop eventually." During interview on 12/22/16, at 10:37 a.m. RN-E Staff development nurse said, "for residents who are on blood thinners the staff need to be aware of bleeding risk, use electric razors not the hand razors to shave a resident, and notify the nurse if there are any problems." During interview on 12/22/16, at 2:32 p.m. the director of nursing (DON) said lately the staff have been just using the disposable razors. We have not had any issues with residents bleeding. I know that we are trying to initiate electric razors for everyone but they 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." Undated Shaving the Resident policy page 78 provided by facility instructed staff "The purpose of this procedure is to promote cleanliness and to provide skin care. 1. Review the resident's care plan to assess for any special needs of the resident." The policy did not indicate when to use an electric versus a safety razor. The complete policy requested but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of ensuring assessment is conducted and plans of care developed to ensure residents receive care and supervision in a safe manner. The DON or designee, could randomly audit to be sure the e proper nursing care is provided the	2 830		

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CENTENNIAL GARDENS FOR NURSING & REH	3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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 page 23 residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to ensure proper hand hygiene was performed to prevent the potential spread if infection for 3 of 5 residents (R48, R30, R25) whose cares were observed. In addition, the facility failed to develop and implement and maintain an infection prevention and control program related to the surveillance log investigation, and analysis of staff diseases/infections in order to prevent, recognized and control, to the extent possible, the onset and spread of infections within the facility. This practice had the potential to affect all residents who resided in the facility. Findings include: R48 During observation on 12/21/16, at 7:34 a.m. nursing assistant (NA)-G and NA-H washed their hands and put gloves on. NA-G asked R48, "Are you ready to get up for breakfast." NA-G washed R48's face and removed gown. NA-G washed	21375	Corrected	2/10/17

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21375	Continued From page 24 R48's upper body avoiding gauze dressing on R48's upper abdomen. NA-G applied lotion to R48's face and upper body. NA-G put a red, light weight sweater on R48. NA-G removed gloves and applied new gloves without washing or sanitizing hands. NA-G loosened R48's incontinence product and wiped R48's peri area from back to front with a wet wash cloth. Wash cloth had brown substance on it after being used. NA-H rolled R48 to left side and NA-G wiped R48's bottom. Without changing gloves, NA-G placed a clean incontinence product on R48 and pulled down R48's sweater. NA-G rummaged in R48's from bed side table drawers to find socks for R48. NA-G washed hands and left room. NA-H dressed R48's lower body with pants, socks and shoes. R48's quarterly Minimum Data Set (MDS) dated 10/12/16, indicated R48 had severe cognitive impairment and required assistance with all activities of daily living, except eating. R48's MDS indicated R48's diagnoses were aphasia [inability to communicate needs] and dementia. During interview on 12/21/16, at 2:34 p.m. NA-G verified not washing hands after changing gloves. NA-G said, "I must been nervous. I always wash from front to back. I should have done so today." R30 During observation on 12/21/16, at 10:28 a.m. NA-C explained to R30 what she was going to do to get her dressed. NA-C washed hands and put gloves on. NA-C washed R30's face, then washed arms, under arms and under breasts. NA-C put a shirt on R30, NA-C removed R30's incontinence product and then NA-C washed R30's abdomen, peri area from front to back and then R30's bottom. The wash cloth was stained	21375		

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brown. NA-C then washed R30's legs and feet and applied lotion without removing gloves or washing hands. NA-C put pants socks and shoes on R30. NA-C adjusted R30's head scarf and transferred R30 from bed to wheelchair. NA-C removed gloves and washed hands.

R30's quarterly MDS dated 11/16/16, indicated R30 had severe cognitive impairment and required assistance with all activities of daily living, except eating. R30's MDS indicated R30's diagnosis was dementia.

During interview on 12/21/16, at 2:10 p.m. NA-C said "I made a mistake" and verified using only one pair of gloves to get R30 ready for the day.

During interview on 12/21/16, at 2:19 p.m. registered nurse (RN)-A said staff are to change their gloves and wash their hands after doing incontinence cares and before doing anything else.

During interview on 12/22/16, at 10:37 a.m. RN-E Staff development nurse said, the nursing assistants are taught to wash hands or use sanitizer every time they remove their gloves, that they must change their gloves after washing the peri area and a resident's bottom. I teach them to wash a female resident from the front to the back of the perineum, then from front to back of each inner thigh, then to wash the resident's bottom. RN-E said, "They are told, "do not use the dirty soiled gloves to touch a brief or to put cream on a resident.'"

During interview on 12/22/16, at 2:32 p.m. the director of nursing (DON) said she expected staff to wash their hands after using gloves, to change gloves after doing pericare and wash hands

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21375	Continued From page 26 before doing anything else. DON said, "They [nursing staff] are to wash front to back with pericare. I started doing audits this morning." R25 was observed on 2/22/16, at 7:15 through 8:30 a.m. (NA)-C entered the room and placed a box of gloves on the foot of R25 ' s bed and then applied gloves. NA-C then removed the gloves to leave the room to gather more equipment i.e., padding and disposable washcloth. NA-C donned a new pair of gloves and pulled down R25 covers exposing the peri-area. R25 ' s front peri area was cleaned from front to back. Then R25 was 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	21375		

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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 a larger sling. Both staff assisted R25 into the sling and transferred R25 into the motorized chair, then removed the sling. RN-C removed gloves and left the room, NA-C continued with the same pair of gloves to comb R25 ' s hair, applied a blanket to the lap, and gave R25 the stuff animal as requested.

R25's quarterly Minimum Data Set (MDS) dated 10/19/16, indicated R25 had mild cognitive impairment and required extensive assistance with all activities of daily living, except eating.

During interview on 12/22/16, at 11:45a.m. RN-P indicated she expected staff to apply gloves when giving morning care, wash the face and chest area then remove their gloves and wash their hands and apply second pair of gloves to complete the care. "Our staff development director just completed a skills fair where we talked about gloving. "

During an interview on 12/22/16, at 11:48 a.m. NA-C said, " I change my gloves anytime I touch a dirty area, wash my hands and apply another pair of gloves if needed. "

During an interview on 12/22/16, at 2:34 P.M, the director of staff development (DSD) was asked about glove changing during cares. DSD stated,

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"We just had a skills fair where we just talked about this and it is expected that staff change their gloves, wash or sanitized their hands after removing their gloves and before applying a second pair. The DON, who was also interviewed at the same time, was asked about hand washing and glove use. The DON stated she expected staff to wash their hands after using gloves, to change gloves after doing pericare and wash their hands before doing anything. "We just had a skills fair that addressed all these issues."

Undated Handwashing/hand hygiene policy 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:
a. Wet washcloth and apply soap or skin cleansing agent.
b. Wash perineal area from front to back.
(1) Separate labia and wash area downward from front to back. (Note: if the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.)
(2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same wash cloth or water to clean the urethra or labia.
(3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (Note: if the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.)
(4) Gently dry perineum.
c. Instruct or assist the resident to turn on her

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21375	Continued From page 29 side with her top leg slightly bent if able. d. Rinse washcloth and apply soap or skin cleansing agent. e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the Labia. f. Rinse thoroughly using the same technique as described in "e " above. g. Dry area thoroughly. 11. Discard disposable items into designated container. Wash and dry your hands thoroughly." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop, review, and/or revise policies and procedures to ensure hand hygiene was implemented. The director of nursing or designee could educate all appropriate staff on the policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and	21426		2/10/17

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unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the nursing home.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) baseline screening and tuberculin skin test (TST) was completed for 4 of 5 residents (R120, R29, R94, R114) and 3 of 5 employees (E1, E4, E5) upon hire, according to the Centers for Disease Control and Prevention (CDC) guidelines.

Corrected

Findings include:

Employee TB symptom screening and TST administration:
E1 had a hire date of 7/27/16. The facility provided a TB screen dated 7/26/16. The Health Care Worker ' s (HCW's) history section was noted to be incomplete. The question, "Have you ever had the BCG vaccine?" and " Have you received a live-virus vaccine within the past 6 weeks?" were void of an answer. The question, " Have you ever had a positive reaction to a TB skin test or TB blood test? " was also answered "No. " Yet the TB screen noted a chest x-ray dated 7/2/15, was completed due to "History of + [positive] PPD."

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E4 had a hire date of 10/29/13. The facility failed to complete a TB symptom screening. The facility failed to complete a first and second step TST upon hire as required.

E5 had a hire date of 10/16/12. The facility failed to complete a TB symptom screening.
When interviewed on 12/22/16, at 2:34 p.m. with the nfection control nurse (RN)-E verified the above.

Resident TST:
R120 was admitted on 8/30/16, had a baseline TB screening completed on 8/30/16, first step TST was administered on 9/9/16. R120's medical record did not indicate the date when the results of the first step TST were completed. The second step TST was not administered as indicated on R120's medical record as the facility was waiting for previous Nursing Home to fax over the results of a previous TST, no call was returned as of 12/21/16.

R29 was admitted on 1/5/16, had a baseline TB screening completed on 1/5/16. The first step TST was administered on 1/15/16, and the second step TST was administered on 1/25/16. Both the first step and second step TST lacked evidence of the date, time and results of the reading in millimeters (mm) and as negative or positive.

R108 was admitted on 6/29/16. R108 had a baseline TB Screening completed on 6/29/16. The baseline screening indicated R108 did not have a previous positive TST. A chest x-ray was provided from 1/28/14, however, it indicated it was for hypotension and the chest xray did not indicate it was for TB. The x-ray stated, "Has mild scarring or chronic atelectasis in lung base. No

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evidence of acute changes." The x-ray form was electronically signed 2/21/14, placed in the nurses notes 6/30/15.

R94 was admitted on 3/22/16. R94 had a baseline TB Screening completed, date unknown. R94 had three TST recorded as being given: The first TST record as given on 3/23/16, without results of being read. The second TST was documented on 4/1/16, without documenting which arm it was administered. The results were documented on 4/3/16, however, did not indicate mm or if it was positive or negative results. The third TST documented on the April 2016 Medication Administration Record as being administered on 4/23/16, did not document which arm it was administered in as well as they did not document the results of the reading on 4/25/16, with induration, negative or positive.

R114 was admitted on 12/29/15. Had a baseline TB Screening completed on 6/13/16. First TST was given on 6/14/16, without documenting which arm it was administered in, they did not document the reading of the TST.

The above findings were verified by the RN-E on 12/22/16, at 2:34 p.m.

Risk assessment:
On 12/22/16, the RN-E confirmed the facility could not find a copy of the Facility TB Risk Assessment for 2016. The facility policies did not indicate TB education with employees regarding the facility TB infection control plan. The last TB Facility assessment was conducted on 7/31/14.

The facility policy Tuberculosis (TB) Prevention and Control dated 8/2013, indicated in accordance with state and federal law health care

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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. 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 staff responsible for 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.	21426		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social	21495		2/10/17

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21495	Continued From page 34 services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically necessary equipment for 1 of 1 resident (R78) reviewed who required a specialized wheel chair in order to get up and remain out of bed. Findings include: R78's significant change Minimum Data Set (MDS) 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 hip fracture. A review of R78's Centennial Gardens for Nursing and Rehabilitation Progress Notes dated 12/12/16 through 12/20/16, indicated the following: - 12/12/16 - Has new orders for Broda chair. - 12/13/16 - 12/19/16 - Broda chair, every shift for hip fracture, on order or not available. - 12/20/16 - Resident was in bed during holiday party on unit.	21495	Corrected	

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During continuous observation on 12/20/16, at 2:20 p.m., R78 was lying awake in her bed. In the common area of the adjoining unit, a resident holiday party was beginning. At 2:33 a.m. the party continued with live music, a visit from Santa and presents for each resident. R78 continued to lay awake in her bed at this time. At 2:47 p.m., R78 remained in bed. She was moving around in the bed. Music could be heard from the party down the hall. At 3:10 p.m., she continued to lay awake in her bed.

During an interview on 12/20/16, at 3:11 p.m., registered nurse (RN)-D stated R78 had been on bed rest and stated the therapy department was looking into a chair for her. She stated the chair that was ordered by the physician was no available in the facility so they had to either rent one or buy one.

During an interview on 12/20/16, at 3:17 p.m., physical therapist (PT)-A stated the nursing department was supposed to be ordering the Broda chair for R78. During the same interview the therapy director stated she recommended the chair for R78 last week, after the physician released her from bed rest.

During an interview on 12/20/16, at 7:44 a.m., the director of nursing (DON) stated she was ordering the Broda chair for R78 that day.

During an observation on 2/21/16, at 7:44 a.m., a Broda chair was in R78's room.

During an interview on 12/21/16, at 11:06 a.m., the DON stated she was trying to find a vendor that could provide the chair for R78 as a rental. She stated R78 would only need the chair for about a month and the facility did not want to

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CENTENNIAL GARDENS FOR NURSING & REH	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, 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
21495	Continued From page 36 spend two thousand dollars to buy one. She stated she ordered the chair the previous day. The DON stated the reason for the delay was they were waiting for a rental chair, which we got (8 days after the order was written by the physician). While the Broda chair was received in the facility less than twenty four hours after it was ordered, R78 remained in bed for eight days after she was released from bed rest. Furthermore, R78 was unable to attend the resident holiday party due to the facility ' s failure to timely provide physician ordered medical equipment. A facility policy regarding timeliness of following up on physician's orders was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure arrangements were made for residents that required physician ordered equipment were provided with the medically necessary euipment in a tiemly manner. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21495		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting	21995		2/10/17

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21995	Continued From page 37 requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to immediately notify the administrator, investigate and report allegations of mistreatment/elopement(s) to the State agency (SA) timely for 2 of 4 residents (R77, R104). Findings include: R77's Minimum Data Set (MDS) dated 10/26/16, noted R77 to have both long term and short memory impairment. In addition, R77 required assist of one for all activities of daily living (ADLs) with the exception of eating and R77 did not ambulate. The comprehensive care plan dated 11/8/16, noted R77's diagnoses to include dementia with behavioral disturbance and muscle weakness. R77's Progress Note dated 12/3/16, indicated R77 had a bruise to the face, a skin tear on the left forearm, a bruise on the left wrist, and left knee. An Incident Report dated 12/3/16, noted the resident had been propelling himself in the wheelchair and said he hit his arm on the doorway going into his room. The bath skin check dated 12/10/16, indicated R77 noted a dark bruise to the face and left wrist, and a skin tear to the left forearm, there was no note of injury to the left elbow or upper arm. A Progress Note dated 12/18/16, at 4:00 p.m. indicated R77 complained his left arm hurt, and could not move the arm on his own.	21995	Corrected	

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21995	Continued From page 38	21995		

R77 was observed on 12/19/16, at 2:00 p.m. in his room laying in his bed. The resident's left 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 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 started on Sunday" (12/18/16).

On 12/20/16, at 3:20 p.m. NA-A was interviewed

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21995	Continued From page 39	21995		

and stated R77 had complained of severe pain in the left arm on Sunday, and that he (NA-A) had reported to the nurse on 12/18/16, during the afternoon shift. NA-A said R77 remained on bed rest. NA-A stated R77 was up and about with no arm problems the week before.

The director of nursing (DON) was interviewed on 12/21/16, at 9:20 a.m. and stated no report had been made to her, the administrator or the SA of a serious injury of unknown origin until 12/20/16. The DON stated a report had been submitted to the SA and an investigation was initiated on 12/20/16, at about 4:00 p.m.. The DON stated the investigation was not complete but she attributed the injury to an incident on 12/3/16, when R77 bumped into the wall. She confirmed R77 had experienced a change in pain on 12/18/16, and that the appearance of the arm changed on 12/19/16, which was subsequently checked by the nurse practitioner (NP). She stated there was no known injury since 12/3/16. When asked whether the fracture was considered a new injury, she stated no.

On 12/21/16, at 10:30 a.m. the administrator was interviewed and stated he'd heard about the injury for R77 on 12/3/16, and was told the arm hurt more on Monday 12/19/16, and that the resident had been diagnosed with a fracture. He stated that nursing was looking into it, but confirmed a report to the SA had not been made until 12/20/16. He stated he assumed the injury was not new.

NP-D was interviewed on 12/21/16, at 12:07 p.m. and stated she saw R77 on 12/19/16. NP-D said R77 had an acute injury to the left arm and could not move the arm. She stated medically she cannot imagine that was from an injury on

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21995	Continued From page 40 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. The facility policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigate all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse. The policy directed staff to immediately report abuse or neglect to the supervisor and the administrator. The supervisor should immediately report to the state agency (SA) if there was a suspicion that abuse occurred. R104's care plan dated 7/31/16, indicated R104 had limited physical mobility, needed reminders to use his walker, and may need a wheelchair when going out of the building. R104's MDS dated 9/29/16, noted R104 had severe cognitive impairment and was admitted to the facility with a diagnoses of hepatic failure, cirrhosis of the liver with ascites and received hospice services. The care plan also included a date of 9/30/16, which indicated R104 was a smoker who required supervision with smoking in the outside designated area. R104's Physician Orders dated 10/8/16, included "OK for WanderGuard." Review of R104's Progress Notes included the following entries: On 11/8/16, at 5:54 p.m. family member (F)-B "had called 1st floor/TCU mgr [transitional care unit/manager -Registered Nurse (RN)-B] to report that R104 had gone shopping by cab yesterday and was staff aware. This writer asked R104 for the details and he stated the following 'Talked to 1st floor male honcho. Talked	21995		

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21995	Continued From page 41 about rides available. Cab was ok. Went to Cub [grocery store] for some fruit and stuff. Why is she sticking her nose in? Why is she calling people.' Gave him names of men working on 1st floor and then he said 'The one who's [sic] name is on a plaque in the front.'" On 11/19/16, at 6:13 p.m. "Writer noticed at 1800 res [resident - R104] is not in his room. South nurse told writer that a family member came to visit and went with res [R104] on first floor. Writer checked on 1st floor, the smoking area and front of the building res [R104] was not there. On 12/16/16, at 2:04 p.m. "Resident was reported to be walking on the road this morning by the staff along vera cruz ave n [sic] about 350 meters from the facility. Writer went to get him back to the facility but he refused and insisted that he was going to cub he was redirected several time back but still he refused and kept on walking with the walker towards 36th. Staff called the facility who in turn called 911. After about 10 minutes, the police arrived who then talked to him and he accepted to comeback. Vital signs were completed see vital section he denied having pain no SOB [shortness of breath] noted at the time morning medication administered and a 15 minutes check was initiated. All parties were notified hospice nurse gave new orders for see orders. He is currently out with [family]. Staff will cont. [continue] to monitor the resident." A care conference note dated 11/17/16, indicated R104 and family received re-clarification R104 required supervision out of the building. R104's medical record and facility documentation lacked evidence of any accident/incident reports regarding R104 missing from the facility on 12/16/16, R104 missing on 11/19/16 or R104's leave on 11/7/16.	21995		

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21995	Continued From page 42	21995		

RN-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 not in his room. RN-A indicated someone outside the building alerted staff that R104 was walking 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 minute checks and updated family, hospice, the NP and the DON. RN-A indicated the DON did the reporting to the SA and believed the incident was reported. When asked about the 11/8/16, Progress Note which indicated R104 left the facility in a cab, RN-A stated the incident did not occur. RN-A stated staff knew he wanted to call a cab and intervened before anything occurred. RN-A was not familiar with R104 missing from the 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 goes out every day and smokes." The DON did not know if R104 required supervision for

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21995	Continued From page 43 smoking. The DON stated R104 was dressed appropriately for the weather on 12/16/16, and R104 was not confused. The DON confirmed R104 was not on facility grounds when he was found by staff on 12/16/16, and she did not consider the incident an elopement. The DON went on to say R104 has been trying to go out and smoke and she did not think R104 had a WanderGuard, but they had tried on in the past but staff keep a really close eye on him. The DON confirmed an elopement assessment or wandering assessment had not been completed for R104 and stated there was a difference between going out and going for a walk. The DON further confirmed R104 was not on the facility WanderGuard list and stated "he shouldn't be, he goes out all the time." The DON further indicated R104 had the right to wander and confirmed again the incident was not reported because she did not view the incident as an elopement as he was found immediately by staff. The DON defined an elopement a "someone who has a WanderGuard but is gone, and cannot be found." On 12/21/16, at 3:21 p.m. LPN-C was interviewed. LPN-C stated he was the nurse working on 12/16/16, and during morning report a night shift staff member who had left for the morning, returned to the facility and stated R104 was outside on the street. LPN-C confirmed no staff was aware R104 had left the building. LPN-C then went outside the facility to bring R104 back in. LPN-C stated it was freezing outside however R104 was dressed in a coat and had shoes on and was approximately 300 meters from the building. LPN-C stated he was unable to persuade R104 into the building and called RN-A to call police. LPN-C stated police arrived and persuaded R104 back into the building and police	21995		

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21995	Continued From page 44	21995		

gave both R104 and LPN-C a ride back to the facility. LPN-C stated he assessed R104 when they returned to the facility and updated Hospice and F-B. LPN-C stated they then implemented every 15 minute checks. LPN-C was unaware of any other time R104 had left the building unsupervised. LPN-C stated he was unaware at how long R104 had been outside.

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 office and asked her 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 DON about what was told to her about R104 from F-B. RN-B stated she did not hear anything further regarding the situation from the DON or RN-A. RN-B was not aware of R104 ever leaving the facility unsupervised. RN-B stated she was aware of the 12/16/16, incident however, was not working at the time the incident occurred.

The director of social 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, leave from the facility. DSS stated she was aware of the incident and 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 safely and appropriately. DSS stated she was on vacation during the week of 11/8/16, and did not know if R104 actually left the facility. DSS was not familiar with any other time R104 had been missing or left the facility without supervision.

The administrator was interviewed on 12/21/16, at 1:04 p.m. The administrator stated he was notified on 12/16/16, R104 was outside and to his

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21995	Continued From page 45	21995		

understanding staff had let him out front and he was walking down the side walk and a nurse followed him outside. The administrator confirmed the incident was not reported and stated the DON was aware of the incident and she had told him she had taken care of the situation. The administrator confirmed he was aware of what an elopement was and if that was what had been told to him it would have been reported. The administrator was interviewed regarding the 11/8/16, Progress Note and stated he did not tell the R104 that he could call a cab to leave the facility. The administrator was unaware if R104 left the facility. The administrator was not familiar with the 11/18/16, Progress Note or incident.

An undated elopement policy included "staff shall investigate and report all cases of missing residents." The policy further indicated when a departing individual returns to the facility the DON or Charge Nurse shall:
"a. Examine the resident for injuries;
b. Notify the Attending Physician;
c. Notify the resident's legal representative of the incident;
d. Complete and file Report of Incident/Accident; and
e. Document the event in the resident's medical record."

SUGGESTED METHOD FOR CORRECTION:
The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee(s) could provide training for all appropriate staff on these policies and

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21995	Continued From page 46 procedures. The administrator, DON, social services or designee(s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies	22000		2/10/17

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and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to operationalize their abuse prevention policy for 2 of 4 residents (R77, R104) reviewed for abuse.

Corrected

Findings include:

The facility policy for Abuse Reporting and Investigation dated 11/28/16, indicated the facility will thoroughly investigated all reports of suspected or alleged abuse, neglect, and financial exploitation. Injuries of unknown origin will be investigated to rule out potential abuse.

The policy directs staff to immediately report abuse or neglect to the supervisor and the administrator. The supervisor should immediately

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	00255	A. BUILDING: _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REH	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

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22000	Continued From page 48 report to the state agency (SA) if there was a suspicion that abuse occurred. R77's Minimum Data Set (MDS) dated 10/26/16, noted R77 to have both long term and short memory impairment. In addition, R77 required assist of one for all activities of daily living (ADLs) with the exception of eating and R77 did not ambulate. The comprehensive care plan dated 11/8/16, noted R77's diagnoses to include dementia with behavioral disturbance and muscle weakness. R77's Progress Note dated 12/3/16, indicated R77 had a bruise to the face, a skin tear on the left forearm, a bruise on the left wrist, and left knee. An Incident Report dated 12/3/16, noted the resident had been propelling himself in the wheelchair and said he hit his arm on the doorway going into his room. The bath skin check dated 12/10/16, indicated R77 noted a dark bruise to the face and left wrist, and a skin tear to the left forearm, there was no note of injury to the left elbow or upper arm. A Progress Note dated 12/18/16, at 4:00 p.m. indicated R77 complained his left arm hurt, and could not move the arm on his own. R77 was observed on 12/19/16, at 2:00 p.m. in his room laying in his bed. The resident's left 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."	22000		

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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 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 started on Sunday" (12/18/16).

On 12/20/16, at 3:20 p.m. NA-A was interviewed and stated R77 had complained of severe pain in the left arm on Sunday, and that he (NA-A) had reported to the nurse on 12/18/16, during the afternoon shift. NA-A said R77 remained on bed rest. NA-A stated R77 was up and about with no arm problems the week before.

The director of nursing (DON) was interviewed on 12/21/16, at 9:20 a.m. and stated no report had been made to her, the administrator or the SA of a serious injury of unknown origin until 12/20/16. The DON stated a report had been submitted to

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the SA and an investigation was initiated on 12/20/16, at about 4:00 p.m.. The DON stated the investigation was not complete but she attributed the injury to an incident on 12/3/16, when R77 bumped into the wall. She confirmed R77 had experienced a change in pain on 12/18/16, and that the appearance of the arm changed on 12/19/16, which was subsequently checked by the nurse practitioner (NP). She stated there was no known injury since 12/3/16. When asked whether the fracture was considered a new injury, she stated no.

On 12/21/16, at 10:30 a.m. the administrator was interviewed and stated he'd heard about the injury for R77 on 12/3/16, and was told the arm hurt more on Monday 12/19/16, and that the resident had been diagnosed with a fracture. He stated that nursing was looking into it, but confirmed a report to the SA had not been made until 12/20/16. He stated he assumed the injury was not new.

NP-D was interviewed on 12/21/16, at 12:07 p.m. and stated she saw R77 on 12/19/16. NP-D said R77 had an acute injury to the left arm and could not move the arm. She stated medically she cannot imagine that was from an injury on 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.

An undated elopement policy included "staff shall investigate and report all cases of missing residents." The policy further indicated when a departing individual returns to the facility the DON or Charge Nurse shall:
"a. Examine the resident for injuries;
b. Notify the Attending Physician;

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c. Notify the resident's legal representative of the incident;
d. Complete and file Report of Incident/Accident; and
e. Document the event in the resident's medical record."

R104's care plan dated 7/31/16, indicated R104 had limited physical mobility, needed reminders to use his walker, and may need a wheelchair when going out of the building. R104's MDS dated 9/29/16, noted R104 had severe cognitive impairment and was admitted to the facility with a diagnoses of hepatic failure, cirrhosis of the liver with ascites and received hospice services. The care plan also included a date of 9/30/16, which indicated R104 was a smoker who required supervision with smoking in the outside designated area. The care plan did not include the use of R104's WanderGuard or the elopements from the facility. R104's Physician Orders dated 10/8/16, included "OK for WanderGuard."

Review of R104's Progress Notes included the following entries: On 11/8/16, at 5:54 p.m. A family member (F)-B "had called 1st floor/Tcu mgr [transitional care unit/manager -Registered Nurse (RN)-B] to report that R104 had gone shopping by cab yesterday and was staff aware. This writer asked R104 for the details and he stated the following ' Talked to 1st floor male honcho. Talked about rides available. Cab was ok. Went to Cub for some fruit and stuff. Why is she sticking her nose in? Why is she calling people. ' Gave him names of men working on 1st floor and then he said ' The one who's [sic] name is on a plaque in the front. ' " On 11/19/16, at 6:13 p.m. -"Writer noticed at 1800 res [resident - R104] is not in his room. South nurse told writer that a

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family member came to visit and went with res [R104] on first floor. Writer checked on 1st floor, the smoking area and front of the building res [R104] was not there. On 12/16/16, at 2:04 p.m. "Resident was reported to be walking on the road this morning by the staff along vera cruz ave n [sic] about 350 meters from the facility. Writer went to get him back to the facility but he refused and insisted that he was going to cub he was redirected several time back but still he refused and kept on walking with the walker towards 36th. Staff called the facility who in turn called 911. After about 10 minutes, the police arrived who then talked to him and he accepted to comeback. Vital signs were completed see vital section he denied having pain no SOB [shortness of breath] noted at the time morning medication administered and a 15 minutes check was initiated. All parties were notified hospice nurse gave new orders for see orders. He is currently out with [family]. Staff will cont. [continue] to monitor the resident."

A care conference note dated 11/17/16, indicated R104 and family received re-clarification R104 required supervision out of the building. R104's medical record and facility documentation lacked evidence of any accident/incident reports regarding R104 missing from the facility on 12/16/16, R104 missing on 11/19/16 or R104's leave on 11/7/16.

RN-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

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22000	Continued From page 53 during morning rounds around 6:30 a.m. RN-A stated licensed practical nurse (LPN)-C was the nurse working and searched the building after R104 was not in his room. RN-A indicated someone outside the building alerted staff R104 was walking 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 minute checks and updated family, hospice, the NP and the DON. RN-A indicated the DON did the reporting to the SA and believed the incident was reported. When asked about the 11/8/16, Progress Note which indicated R104 left the facility in a cab, RN-A stated the incident did not occur. RN-A stated staff knew he wanted to call a cab and intervened before anything occurred. RN-A was not familiar with R104 missing from the 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 goes out every day and smokes." The DON did not know if R104 required supervision for smoking. The DON stated R104 was dressed appropriately for the weather on 12/16/16, and R104 was not confused. The DON confirmed R104 was not on facility grounds when he was found by staff on 12/16/16, and she did not consider the incident an elopement. The DON went on to say R104 has been trying to go out and smoke and she did not think R104 had a	22000		

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22000	Continued From page 54 WanderGuard, but they had tried on in the past but staff keep a really close eye on him. The DON confirmed an elopement assessment or wandering assessment had not been completed for R104 and stated there was a difference between going out and going for a walk. The DON further confirmed R104 was not on the facility WanderGuard list and stated "he shouldn't be, he goes out all the time." The DON further indicated R104 had the right to wander and confirmed again the incident was not reported because she did not view the incident as an elopement as he was found immediately by staff. The DON defined an elopement a "someone who has a WanderGuard but is gone, and cannot be found." On 12/21/16, at 3:21 p.m. LPN-C was interviewed. LPN-C stated he was the nurse working on 12/16/16, and during morning report a night shift staff member who had left for the morning, returned to the facility and stated R104 was outside on the street. LPN-C confirmed no staff was aware R104 had left the building. LPN-C then went outside the facility to bring R104 back in. LPN-C stated it was freezing outside however R104 was dressed in a coat and had shoes on and was approximately 300 meters from the building. LPN-C stated he was unable to persuade R104 into the building and called RN-A to call police. LPN-C stated police arrived and persuaded R104 back into the building and police gave both R104 and LPN-C a ride back to the facility. LPN-C stated he assessed R104 when they returned to the facility and updated Hospice and F-B. LPN-C stated they then implemented every 15 minute checks. LPN-C was unaware of any other time R104 had left the building unsupervised. LPN-C stated he was unaware at how long R104 had been outside.	22000		

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22000	Continued From page 55 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 office and asked her 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 DON about what was told to her about R104 from F-B. RN-B stated she did not hear anything further regarding the situation from the DON or RN-A. RN-B was not aware of R104 ever leaving the facility unsupervised. RN-B stated she was aware of the 12/16/16, incident however, was not working at the time the incident occurred. The director of social 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, leave from the facility. DSS stated she was aware of the incident and 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 safely and appropriately. DSS stated she was on vacation during the week of 11/8/16, and did not know if R104 actually left the facility. DSS was not familiar with any other time R104 had been missing or left the facility without supervision. The administrator was interviewed on 12/21/16, at 1:04 p.m. The administrator stated he was notified on 12/16/16, R104 was outside and to his understanding staff had let him out front and he was walking down the side walk and a nurse followed him outside. The administrator confirmed the incident was not reported and stated the DON was aware of the incident and she had told him she had taken care of the situation. The administrator confirmed he was aware of what an elopement was and if that was	22000		

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what had been told to him it would have been reported. The administrator was interviewed regarding the 11/8/16, Progress Note and stated he did not tell the R104 that he could call a cab to leave the facility. The administrator was unaware if R104 left the facility. The administrator was not familiar with the 11/18/16, Progress Note or incident.

SUGGESTED METHOD OF CORRECTION:
The administrator could in-service all staff on the need to follow the facility policy in regards to immediately reporting suspected abuse to the designated state agency/common entry point.

TIME PERIOD FOR CORRECTION: Twenty-One (21) days.