DEPARTMENT OF HEALTH A	ND HUMAN	SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: 6QVR		
	PART I	- TO BE COMP	PLETED BY T	'HE STA'	TE SURVEY AGENCY	Facility ID: 00260		
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245387	Э.	3. NAME AND AI (L3) ST OLAF R		LITY		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID NO.		(L4) 2912 FREM	ONT AVENUE	NORTH		1. Initial 2. Recentineation 3. Termination 4. CHOW		
(L2) 492242500		(L5) MINNEAPO	DLIS, MN		(L6) 55411	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 12/11/20	13 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS					
From (a):		X A. In Complia			And/Or Approved Waivers Of Th	e Following Requirements:		
To (b):			Requirements		2. Technical Personnel	6. Scope of Services Limit		
10 (b).		Compliar	nce Based On:		3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	80 (L18)	1.	Acceptable POC		4. 7-Day RN (Rural SNF			
13.Total Certified Beds	80 (L17)	B. Not in Co	mpliance with Prog	ram	5. Life Safety Code	9. Beds/Room		
15. Total Centiled Beds	80 (E17)		ents and/or Applied		* Code: A*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
80								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	S (IF APPI IC ABI	F SHOW LTC CANC	FULATION DATE).				
		L SHOW LIC CARE	LELATION DATE).				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:		
Sandra Christle, HFE N	IE II		02/04/2014	(L19)	Shellae Dietrich, Program Specialist 02/07/2014			
PAI	RT II - TO BE	E COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST			
19. DETERMINATION OF ELIGIBILITY		20. CON	MPLIANCE WITH	CIVIL	21. 1. Statement of Finan	ncial Solvency (HCFA-2572)		
			GHTS ACT:			l Interest Disclosure Stmt (HCFA-1513)		
 X 1. Facility is Eligible to Partic 2. Facility is not Eligible 	ripate				5. Bour of the Above	·		
2. Pacinity is not Engine	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	24. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Е	VOLUNTARY 00	INVOLUNTARY		
12/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement		
· · · ·	7. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(1.27)			(L44)			00-Active		
(L27)	B. Rescind Sus	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
			OF ADDROUTE		-			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	of approval D	AIE				
	(L32)	11/19/2013		(L33)	DETERMINATION APPR	OVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 6QVR PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00260

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN - 24-5387

An extended NOTC survey was completed on August 19, 2013 and deficiencies were found, the most serious at a scope and severity level of J. Conditions in the facility constituted IJ (F323) and SQC (F226 & F323).

As a result, we imposed State Monitoring effective September 16, 2013. In addition, we recommended the following remedy to the CMS RO for imposition:

Civil Money Penalties effective August 19, 2013; CMS imposed the following:

- Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013
- Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC

On November 8, 2013 we conducted a health PCR and on November 21, 2013, Public Safety conducted a LSC PCR. All LSC deficiencies were corrected. But Health had three deficiencies uncorrected. The most serious health deficiency was at a S/S level of E. As a result of the most recent revisit, State monitoring will remain in effect. In addition, we recommended the following remedies to the CMS RO for imposition and CMS concurred:

- Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013, remain in effect

- Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013, remain in effect

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013, remain in effect

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC

A second Health PCR was completed on December 10, 2013. All of the deficiencies were found corrected and the facility was in substantial compliance effective December 10, 2013. As a result of the second PCR we recommended the following remedies to the CMS RO and CMS concurred:

- Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013, will remain in effect

- Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013, will remain in effect

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013, be discontinued December 10, 2013.

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC.

See attached CMS-2567B forms from this revisit.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5387

February 7, 2014

Mr. David Uselman, Administrator St. Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

Dear Mr. Uselman:

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 December 10, 2013 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

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



Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

Mr. David Uselman, Administrator St Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

RE: Project Number S5387022

Dear Mr. Uselman:

On September 12, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 16, 2013. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013. (42 CFR 488.417 (b))

On November 21, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty of \$4,200.00 per instance for the instance of noncompliance at F323 (S/S: J) identified in the CMS-2567 survey ending August 19, 2013
- Federal Civil Money Penalty of \$1,500.00 per instance for the instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 survey ending August 19, 2013

Also, the CMS Region V Office notified you in their letter of November 21, 2013, 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 August 19, 2013.

This was based on the deficiencies cited by this Department for an extended survey completed on August 19, 2013 and not obtaining substantial compliance at the Post Certification Revisit (PCR) completed on November 8, 2013. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required

On November 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 21, 2013, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on August 19, 2013.

St Olaf Residence February 3, 2014 Page 2

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2013. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on August 19, 2013. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, this Department recommended and CMS concurred with our recommendations and authorized us to notify you of the actions related to the imposed remedies:

• Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of \$4,200.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of \$1,500.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013 will remain in effect. (42 CFR 488.417 (b))

Furthermore, 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 August 19, 2013.

On December 10, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 25, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 8, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 10, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of November 21, 2013:

• Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of \$4,200.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of \$1,500.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013 be discontinued, effective December 10, 2013. (42 CFR 488.417 (b))

St Olaf Residence February 3, 2014 Page 3

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.

As we notified you in our letter of September 12, 2013 and CMS notified you in their letter of November 21, 2013 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 August 19, 2013.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5387r3_13.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/10/2013
Nam	e of Facility	· ·	Street Address, City, State, Zip Code	
S	OLAF RESIDENCE		2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411	TH

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
	Correctio	on		Correction			Correction
ID Prefix	F0280 Complet 12/10/20		F0318	Completed 12/10/2013	ID Prefix	F0431	Completed 12/10/2013
	483.20(d)(3), 483.10(k)(2)		483.25(e)(2)			483.60(b), (d), (e)	
LSC		LSC			LSC		
	Correctio	on		Correction			Correction
	Complet			Completed			Completed
ID Prefix		ID Prefix		-			
Reg. #		Reg. #			Reg. #		
	Correctio	on		Correction			Correction
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Reg. #		Reg. #			Reg. #		
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Reg. #		Reg. #			Reg. #		
	Correctio	on		Correction			Correction
	Complet			Completed			Completed
				-			
Reg. # LSC		Reg. #			Reg. #		
Reviewed E	By Reviewed By	Date:	Signature of Su	veyor:		Dat	te:
State Agen	cy MM /SC	2/3/20	14				12/10/13
Reviewed E	By Reviewed By	Date:	Signature of Sur	veyor:		Dat	te:
CMS RO							
Followup t	Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?				
8/19/2013			Uncorrected Defic	ciencies (CM	S-2567) Sent to	the Facility? YE	ES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00260	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/10/2013
Name of Facility		Street Address, City, State, Zip Code	
ST OLAF RESIDENCE		2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411	ТН

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix	Correction Completed 20570 12/10/2013	ID Prefix	Correc Compl 20895 12/10/2	eted	21620	Correction Completed 12/10/2013
	MN Rule 4658.0405 Subp.	Reg. # LSC	MN Rule 4658.0525 Subp. :		MN Rule 4658.1345	
Reg. #	Correction Completed	Reg. #	Correc Compl	eted ID Prefix Reg. #		
ID Prefix Reg. #	Correction Completed	ID Prefix Reg. #	Correc Compl	eted ID Prefix		
ID Prefix Reg. # LSC	Correction Completed	Reg. #	Correc Compl	eted ID Prefix Reg. #		
ID Prefix Reg. # LSC	Correction Completed	Reg. #	Correc Compl	eted ID Prefix Reg. #		Correction Completed
Reviewed E State Agent Reviewed E	MM/SC	Date: 2/3/2014 Date:	Signature of Surveyor: 4 Signature of Surveyor:		Date: 12 Date:	2/10/13
	o Survey Completed on: 8/19/2013 M: REVISIT REPORT (5/99)		Check for any Uncorrected Uncorrected Deficiencies Page 1 of 1			NO

MEDICAREAMEDICAD CERTIFICATION AND TRANSMITTAL D::: 0078 1. MEDICAREAMEDICAD PROVIDER NO. (L1) 3. NAME AND ADDRESS OF PACILITY (L3) STOLAR RESIDENCE (L3) 2912 FREMOMON AVERAUE NORTH (L3) 2012 (L12) 2012 (L12) 2012 (L12) 2012 (L13) 2012 (1. MEDICAREAMEDICAL PROVUMER NU. 1. NAME AND ADDRESS OF PLATE STATE SURVEY AGENCY 4. TYPE DATE 2.371.71 VENDOR OR MERCIALD NO. 1.9 STOLAP RESUBENCE 1.9 STOLA	BE COMPLETED BY THE STATE SURVEY AGENCY Dating DD 203 MIE AND ADDRESS OF FACILITY TOLAR RESIDENCE 4. TYEE OF ACTION: 7.(1.8) 912 FREMONT AVENUE NORTH (1.6) 55411 UNNEAPOLIS, MN (1.6) 55411 OVIDENCY AVENUE NORTH (1.6) 55411 UNNEAPOLIS, MN (1.6) 55411 OVIDENCY 10 NP Pail & BINA 10 KKBB OVIDENCY 10 NP INTRODUCTION 10 KKBB INTRODUCTION 11 KCBP INTRODUCTION 12 KKBB INTRODUCTION 12 KKBB INTRODUCTION 10 KKBB INTOTION 12 KKBB INTOTION 13 KKBB INTOTION 13 KKBB INTOTION 13 KKBB INTOTION 13 KKB	DEPARTMENT OF HEALTH AND						EDICARE & MEDICAID SERVICES		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 6QVR PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00260

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN - 24-5387

An extended NOTC survey was completed on August 19, 2013 and deficiencies were found, the most serious at a scope and severity level of J. Conditions in the facility constituted IJ (F323) and SQC (F226 & F323).

As a result, we imposed State Monitoring effective September 16, 2013. In addition, we recommended the following remedy to the CMS RO for imposition:

Civil Money Penalties effective August 19, 2013; CMS imposed the following:

- Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013
- Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC

On November 8, 2013 we conducted a health PCR and on November 21, 2013, Public Safety conducted a LSC PCR. All LSC deficiencies were corrected. But Health had three deficiencies uncorrected. The most serious health deficiency was at a S/S level of E. As a result of the most recent revisit, State monitoring will remain in effect. In addition, we recommended the following remedies to the CMS RO for imposition and CMS concurred:

- Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013, remain in effect

- Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013, remain in effect

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013, remain in effect

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC.

See attached CMS-2567 and CMS-2567B from these revisits.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7009 1680 0002 2928 2130

November 1, 2013

Mr. David Uselman, Administrator St. Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

RE: Project Number S5387022, H5387075 and H5387058

Dear Mr. Uselman:

On September 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on August 19, 2013 that included an investigation of complaint number H5387057 and H5387058. Conditions in the facility constituted both substandard quality of care and an immediate jeopardy to resident health or safety. This survey found the most serious deficiencies to be isolated deficiencies that constituted immediate Jeopardy (Level J), whereby corrections were required.

However, compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the August 19, 2013 extended survey have not yet been verified. The most serious health LSC deficiencies in your facility at the time of the standard extended survey were found to isolated deficiencies that constituted immediate Jeopardy (Level J), 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 November 19, 2013. (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 November 19, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 19, 2013. 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

St Olaf Residence November 1, 2013 Page 2

subject to a an extended survey. Therefore, St Olaf Residence is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 19, 2013. This prohibition is not subject to appeal. 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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the August 19, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Oliver Potts, Chief 330 Independence Avenue, SE Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 February 19, 2014 (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.

St Olaf Residence November 1, 2013 Page 3

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

St Olaf Residence November 1, 2013 Page 4

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

538770dayNotice.rtf

		AND HUMAN SERVICES			FORM	11/27/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245387	B. WING		F 11/0	8/2013
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
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{F 000} {F 280} SS=D	Minnesota Departm through November During the course was investigated (k substantiated. 483.20(d)(3), 483.7 PARTICIPATE PLA The resident has th incompetent or oth incapacitated under participate in plann changes in care an A comprehensive as interdisciplinary te physician, a regist for the resident, an disciplines as dete and, to the extent the resident, the re legal representativ and revised by a t each assessment	revisit was conducted by the nent of Health on November 4 8, 2013. of the survey an H complaint 4 5387061) and was not 10(k)(2) RIGHT TO ANNING CARE-REVISE CP he right, unless adjudged herwise found to be er the laws of the State, to hing care and treatment or nd treatment. care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility nd other appropriate staff in ermined by the resident's needs, practicable, the participation of esident's family or the resident's ve; and periodically reviewed eam of qualified persons after)<	 F 280 Corrective Action: A) The care plan of reside was updated to reflect that correct splinting requirem and the potential for contractures related to CV were present. Therapy eval for baseline measurement upper and lower extremit. The care sheet was review and revised to reflect the resident's current needs r to splinting. Restorative r will pick up ROM to all extremities upon complet therapy. Corrective Action as it ap to Other Residents: A) All residents have the potential to be affected by same deficient practice. B) The care plans of all residents with contracturer risk were reviewed and revised to reflect their current ne including measures to proworsening or increased to C) Nursing staff was edu on the importance of foll care sheets and care plan relationship to splinting approximation. 	t the lents /A aluated s to ies. ved elated nursing ion of oplies y the es or at evised eds event ione. icated owing s in	
	Based on observ review the facility	ation, interview and document failed to revise a plan of care fo event further decline for 1 of 3	r			
		IDER/SUPPLIER REPRESENTATIVE'S SIG		TITLE <u>Executive Director</u> ion may be excused from correcting provid	12	(X6) DATE

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

		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: FORM A OMB NO.	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			RUCTION	(X3) DATE	SURVEY PLETED
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{F 280}	residents (R18) rev (ROM). Findings include: R18 left hand splint splint went missing R18 was observed dressed and sitting R18 was noted to h previous stroke. R flaccid and her han wrist. The nursing a left lower extrem she gets exercises room. When interv had a splint device R18 said she did n left hand splint as i R18 thought it may belongings that we R18 said that she f worse, contracting noted mild pain in The medical order To wear right hand morning. The med of survey) were to hand splint-not nee The current care p reviewed and inclu contractures to ha side. Goal was to o Interventions were Care plan also inc	t was not implemented as the on 11/6/13, at 9:05 a.m. to be in a wheelchair in the room. have left sided paralysis from a 18's left arm was noted to be of was curved inward at the assistant (NA)-A was applying ity leg brace. R18 explained for her legs twice daily in her iewed R18 was asked if she for her left upper extremity. ot know what happened to the t went missing a long time ago. thought her left wrist was in towards her body. She the left wrist mostly at night. s dated August 2013 included: splint on at bedtime, off in ical orders dated 11/6/13 (day discontinue orders for right eded. blan dated 9/13/13, was uded potential for increased nd related to CVA (stroke) left decrease risk of contractures. to apply splint as ordered. luded need for total assist with is of one with all other grooming	{F 2	3. 4. 5.	RECEIVE DEC - 9 2013 COMPLIANCE MONITORING LICENSE AND CERTIFIC ensuring appropriate order place and/or available. D) All residents will be reviewed for any changes care at care conferences including increased need f ADL's and use of assistive devices. Date of Completion: 11/2: Reoccurrence will be Preve by: A) Random audits will be completed weekly x 4 and monthly X3 with results b presented to the QA comm for follow up discussion/planning. The Correction will be Monitored by: Director of Nursing or des	in for e 5/2013 vented I then being nittee signee	t Page 2 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	11/27/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	LETED
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{F 280}	contracture. The restorative car Dec. 2013 listed por contractures to har Intervention listed w current medication November 2013 inco on at bedtime, off in The October 2013 record contained in completed the appl hand splint. The div confirmed that was the resident did nor The first floor restor motion program bo 2013. R18 had ord exercises to both lo NA-A was interview and explained he h R18. When asked assistant assignment surveyor that there sheet to apply a rig The first floor resid was interviewed or said, "I am fairly not this."	n did not have any fied for the left hand to prevent e plan dated Sept. through otential for increase ad related to stroke, left side. was splint as ordered. The administration record dated cluded: wear right hand splint, n morning. treatment administration nitials of staff as having lication of and removal of a left rector of nursing (DON) inaccurate documentation as t have a hand splint. orative ambulation and range of bok was reviewed for October ers for and received daily ower legs. wed on 11/6/13, at 9:10 a.m. had not seen a hand splint for if to see the current nursing ent sheet, NA-A showed the e was direction on the task ght hand splint for R18. lent care coordinator (RN)-A h 11/6/13, at 9:22 a.m. and ew here; I will have to look into	{F 2	80}			
	a.m. and stated R	rviewed on 11/6/13, at 10:20 18 has never had a left hand id say that R18 previously had			pility ID: 00260		t Page 3 of 11

Facility ID: 00260

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	11/27/2013 APPROVED 0938-0391
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{F 280}	a right hand splint if ability to smoke. The splint would be need resident had left side confirmed there way right hand splint and The DON added the from hospital she he DON said, "I am cub been missing." The have had that imple The DON obtained Therapy to evaluate the internal audit for somehow the left he for it was missed. On 11/6/13 at 11:2 degrees of flexion recommended a real left wrist and finge asked R18, "Woul replied, "Yes." The wrist to full range would benefit from recommended a he exercises. The Co department will ev contracture. The Co previous measure extremity in the real The facility policy for Program, dated as indicated that it was promote each resis functional potentia	age 3 but it interfered with R18's be DON was asked why a eded on R18's right hand if the ded hemiparesis and the DON as no indication for use of a and that was most likely an error. that after R18's latest return had no left hand splint. The urious to know how long it's e DON also stated she should emented a year and a half ago. I orders for Occupational the R18's left wrist contracture. that R18 was included in or range of motion but hand contracture and treatment 5 a.m. the COTA measured 35 to the left wrist and estorative program to prevent r contractures. The COTA d you wear a splint?'' R18 COTA was able to get the left with stretching and stated R18 a restorative program and and splint and range of motion DTA said the therapy aluate and treat the left wrist COTA stated that there were no ments of the left upper cords at the facility. titled, Restorative Nursing a revised October 2013, as the facilities policy to dent's ability to attain maximum al. Restorative nursing includes, o skill practice in walking,	{F 2	80}			

Facility ID: 00260

If continuation sheet Page 4 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES					FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			TE SURVEY		
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ST OLA	RESIDENCE					IS, MN 55411		
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{F 280} {F 318}	dressing, grooming transferring, amput communication, pa range of motion (Pl mobility. 483.25(e)(2) INCRI	, eating, swallowing, ation care, splint care, ssive range of motion/active ROM/AROM), and bed EASE/PREVENT DECREASE	{F 28					
SS=D	IN RANGE OF MO Based on the comp resident, the facility with a limited range appropriate treatme range of motion an decrease in range This REQUIREME by: Based on observa review the facility fi was implemented to of 3 residents (R18 (ROM). Findings include: R18 left hand splin splint went missing R18 was observed dressed and sitting R18 was noted to previous stroke. R flaccid and her har wrist. The nursing a left lower extrem	TION prehensive assessment of a <i>y</i> must ensure that a resident e of motion receives ent and services to increase d/or to prevent further of motion. NT is not met as evidenced tion, interview and document ailed to ensure a splint device to prevent further decline for 1 3) reviewed for range of motion				Corrective Action: A) Resident #18 have reassessed for splin She was assessed for program to preven LLE contractures a reflects current new Corrective Action to others: A) All residents in splints/braces, RO ambulation have th be affected by thes practices. B) The Restorative Policy was review Nursing Staff mem	as been nting needs. for a ROM t ULE and and care plan eds. as is applies need of M, and he potential to se deficient e Nursing ed and	

Facility ID: 00260

If continuation sheet Page 5 of 11

PRINTED: 11/27/2013

		AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM MB NO.	11/27/2013 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED R
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
{F 318}	room. When intervie had a splint device R18 said she did no left hand splint as it R18 thought it may belongings that wer R18 said that she the worse, contracting noted mild pain in the The medical orders To wear right hand morning. The medic of survey) were to on hand splint-not need The current care planed of survey) were to on hand splint-not need The current care planed contractures to har side. Goal was to of Interventions were Care plan also inclu- bathing and assist tasks. The restorative car Dec. 2013 listed po contractures to har Intervention listed of current medication November 2013 in on at bedtime, off i The October 2013 record contained in completed the app hand splint. The din confirmed that was	ewed R18 was asked if she for her left upper extremity. of know what happened to the went missing a long time ago. have been in a box of nt in storage some time ago. hought her left wrist was in towards her body. She he left wrist mostly at night. a dated August 2013 included: splint on at bedtime, off in cal orders dated 11/6/13 (day discontinue orders for right ded. an dated 9/13/13, was ded potential for increased hd related to CVA (stroke) left lecrease risk of contractures. to apply splint as ordered. uded need for total assist with of one with all other grooming e plan dated Sept. through bential for increase hd related to stroke, left side. was splint as ordered. The administration record dated cluded: wear right hand splint,	{F 3	18}	 educated on the need to complete the programs as ordered and document routi 3. Date of Completion: 11/25. 4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and the monthly X3 with results be presented to the QA comm for follow up discussion/planning. 5. Corrections will be monitor by: Director of Nursing or Destination 	/13 ed then bing ittee	

Facility ID: 00260

		AND HUMAN SERVICES				FORM	11/27/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED R
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ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 318}	Continued From pa	age 6	(F 3	818}			
	motion program bo	rative ambulation and range of ok was reviewed for October ers for and received daily ower legs.					
	and explained he h R18. When asked assistant assignme surveyor that there	ved on 11/6/13, at 9:10 a.m. nad not seen a hand splint for if to see the current nursing ent sheet, NA-A showed the e was direction on the task ght hand splint for R18.					
	was interviewed or	lent care coordinator (RN)-A n 11/6/13, at 9:22 a.m. and ew here; I will have to look into					
	interviewed on 11/	oational therapist (COTA) was 6/13, at 9:30 a.m. looked into ed that the surveyor would DON.					
	a.m. and stated R splint. The DON di a right hand splint ability to smoke. T splint would be ner resident had left si confirmed there w right hand splint at The DON added th from hospital she DON said, "I am c been missing." Th have had that imp	erviewed on 11/6/13, at 10:20 18 has never had a left hand id say that R18 previously had but it interfered with R18's he DON was asked why a eded on R18's right hand if the ided hemiparesis and the DON as no indication for use of a nd that was most likely an error. hat after R18's latest return had no left hand splint. The urious to know how long it's e DON also stated she should lemented a year and a half ago.					

Facility ID: 00260

If continuation sheet Page 7 of 11

	SURVĖY	
AND PLAN OF CORRECTION IDENTITION NONDER A. BUILDING	(X3) DATE SURVEY COMPLETED	
	R 11/08/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH		
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 318} Continued From page 7 {F 318} The DON also stated that R18 was included in the internal audit for range of motion but somehow the left hand contracture and treatment for it was missed. {F 318} On 11/6/13 at 11/25 a.m. the COTA measured 35 degrees of flexion to the left wrist and recommended a restorative program to prevent left wrist and finger contractures. The COTA asked R18, "Would you was a splint?" R18 replied, "Yes." The COTA was able to get the left wrist to full range with stretching and stated R18 would benefit from a restorative program and recommended a hand splint and range of motion exercises. The COTA stated that there were no previous measurements of the left upper extremity in the records at the facility. The facility policy titled, Restorative Nursing Program, dated as revised October 2013, indicated that th was the facilities policy to promote each resident's ability to attain maximum functional potential. Restorative nursing includes, but was not limited to skill practice in walking, dressing, grooming, eating, swallowing, transferring, amputation care, splint Care, communication, passive range of motion/active range of motion (PROM/AROM), and bed mobility. {F 431} KE 431 483.60(b), (d), (e) DRUG RECORDS, SEE LABEL/STORE DRUGS & BIOLOGICALS {F 431} The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an {F 431}		

Facility ID: 00260

If continuation sheet Page 8 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	Сом	E SURVEY PLETED
		245387	B. WING				08/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE				INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 431}	records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and perm have access to the The facility must p permanently affixe controlled drugs lis Comprehensive D Control Act of 1970 abuse, except whe package drug dist quantity stored is n be readily detected This REQUIREME by: Based on observa- review, the facility	tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the sory and cautionary he expiration date when a State and Federal laws, the all drugs and biologicals in nts under proper temperature hit only authorized personnel to e keys. rovide separately locked, and compartments for storage of sted in Schedule II of the rug Abuse Prevention and 6 and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose car d. ENT is not met as evidenced ation, interview and document failed to ensure medications	{F 4	31}	 F431 1. Corrective Action: A) The insulin pens have been discarded. All new pens are labeled. New pharmacy started on 12/1/13 and standard practice to also label all pens with a sticker to remind staff to label once taken out of the box. B) The tuberculin vial was discarded. The fridges are monitored nightly for compliance. 2. Corrective actions as it applies to other residents: A) All future residents and future staff members have the 		
	with shortened us after opening pote residents (R123, R received insulin fo	e dates were properly dated entially affecting 5 of 13 R124, R37, R57, R72) who or diabetes. In addition an (used to test for tuberculosis)			``````````````````````````````````````		

Facility ID: 00260

If continuation sheet Page 9 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LTIPLE	CONSTRUCTION	(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:				COMF	PLETED
						F	
		245387	B. WING		11/0	8/2013	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 431}	vial was not remove storage area, poter residents and new Findings include: The facility's medic observed on the thi a.m. in the presence nurse (LPN)-A. A L for R123, but was u opened, and had a 10/26/13. A Lantus pen and a Novolog pen were in use for to when they were pharmacy delivery Tubersol vial in the 9/27/13, the LPN-A week ago". When i Lantus and Novolo days" and they sho opened. The second floor m on 11/4/13, at 9:37 the licensed practic insulin pen was in delivery date of 7/2 unlabeled with the treat diabetes) insu pharmacy delivery date 9/3/13, had ex from the medicatio Lantus insulin pen pharmacy delivery undated when ope insulin pens used f	ed from the medication tially affecting newly admitted	{F 4	131}	 potential to be affected by the same deficient practice. B) Nursing staff was educated on the need to date all meds when opened and to discard after 30 days. Completion date: 11/25/13 Recurrence will be prevented by: A) Random audits will be conducted weekly x4 then monthly x3 with findings presented to the QA committee for follow up/discussion. Completion will be monitored by: Director of Nursing or Designee 		

Facility ID: 00260

PRINTED: 11/27/2013

		AND HUMAN SERVICES				FORM	11/27/2013 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245387	B. WING			F 11/C	< 8/2013
NAME OF	PROVIDER OR SUPPLIER	-			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAI	RESIDENCE				912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 431}	needed to be dated the expiration date, days after opening. R57's Humulin exp Humulin was disco removed from the r During interview or director of nursing trained and were ei- the insulin pens wh The DON also expl on October 4th abo medication labeling DON also stated th change pharmacy. The consultant pha 11/5/13, at 10:30 a interview. The manufacturer's Lantus package ins insulin had to be di Novolog package i open vials and ope be kept at room ter The undated Medic policy indicated the or pen was good for	d when first used to determine since they were good for 28 The LPN-B also verified ired, and explained the ntinued, however was not medication cart. a 11/5/13, at 9:43 a.m. the (DON) stated the staff were expected to write the date on the they were initially used. alained, staff received training but regarding proper g, medication storage. The te facility was in process to armacist (CP) was called on .m., and was not available for s recommendation in the sert indicated in-use/opened scarded after 28 days. The nsert for storage indicated and Novolog flex pen were to mperature "for up to 28 days." cations to Date When Opened e Novolog, and Lantus cartridge or "28 days" after its first use, artridge or pen was good for	{F 4	31}			

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00260	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/8/2013
Name	of Facility		Street Address, City, State, Zip Code	
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item		(Y5)	Date	(Y4) Ite	em	(Y5) D	ate
		Correction				Correction				Correction
ID Prefix	20255	Completed 10/03/2013		fix 2	20265	Completed 10/03/2013		D Prefix	20225	Completed 10/03/2013
		10/03/2013				10/03/2013				10/03/2013
Reg. # LSC	MN Rule 4658.0070	_	Reg	.# <u>M</u> SC	N Rule 4658.0085			Reg. # LSC	MN Rule 4658.0130	-
		_		<u> </u>			+	190		
		Correction				Correction				Correction
		Completed				Completed				Completed
ID Prefix	20560	10/03/2013	ID Pre	fix _2	20565	10/03/2013		D Prefix	20625	10/03/2013
•	MN Rule 4658.0405 Subp.	2	Reg	. # MI	N Rule 4658.0405 Subp. 3	3		Reg. #	MN Rule 4658.0450 Subp.	1 A-I
LSC		-	L	SC				LSC		
		Correction				Correction				Correction
ID Prefix	20830	Completed 10/03/2013	ID Pre	fix _2	20900	Completed 10/03/2013	1	D Prefix	20910	Completed 10/03/2013
Reg. #	MN Rule 4658.0520 Subp.	1	Reg	.# MI	N Rule 4658.0525 Subp. 3	3		Reg. #	MN Rule 4658.0525 Subp.	5 A.I
LSC		-	L	SC				LSC		-
		Correction				Correction				Correction
ID Prefix	20915	Completed 10/03/2013	ID Pre	fix 2	20920	Completed 10/03/2013	I	D Prefix	20940	Completed 10/03/2013
	MN Rule 4658.0525 Subp.			_	N Rule 4658.0525 Subp. (MN Rule 4658.0525 Subp.	-
LSC			-	SC	N Kule 4050.0525 Subp.			LSC	Min Rule 4058.0525 Subp.	-
							+			
		Correction				Correction				Correction
		Completed				Completed				Completed
ID Prefix	20965	_10/03/2013	ID Pre	fix _2	21290	10/03/2013		D Prefix	21325	10/03/2013
0	MN Rule 4658.0600 Subp.	2			N Rule 4658.0710 Subp. 3	3 A		0	MN Rule 4658.0725 Subp.	1
LSC		_	L:	SC			<u> </u>	LSC		
Reviewed By	/ Reviewed	Ву	Date:		Signature of Surve	yor:	1		Date:	
State Agency	y MM/	GD	11/26/	2013	30)182			11/08	/2013
Reviewed By			Date:		Signature of Surve	yor:			Date:	
CMS RO										
		E/00)			Dama 4 of 0				Event ID: COV/D12	

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00260	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/8/2013
Name	of Facility		Street Address, City, State, Zip Code	
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5) [)ate
ID Prefix	21475	Correction Completed 10/03/2013	ID Prefi	21525	Correction Completed 10/03/2013	ID Prefix	21530	Correction Completed 10/03/2013
	MN Rule 4658.1005 Subp.	_		MN Rule 4658.1305 A.B.C	-		MN Rule 4658.1310 A.B.C	- - -
	21535 MN Rule4658.1315 Subp.1	Correction Completed 10/03/2013 AB(21545 MN Rule 4658.1320 A.B.C	Correction Completed 10/03/2013	ID Prefix Reg. # LSC	21565 MN Rule 4658.1325 Subp.	Correction Completed 10/03/2013
	21665 MN Rule 4658.1400	Correction Completed 10/03/2013		21685 MN Rule 4658.1415 Subp.	Correction Completed 10/03/2013 2		_21695 MN Rule 4658.1415 Subp.	Correction Completed 10/03/2013 4
	21805 MN St. Statute 144.651 Su	Correction Completed 10/03/2013 bd. £		21980 MN St. Statute 626.557 Su	Correction Completed 10/03/2013 bd. 3	ID Prefix Reg. # LSC	22000 MN St. Statute 626.557 St	Correction Completed 10/03/2013
	22060 MN Rule 4658.4005	Correction Completed 10/03/2013						
Reviewed B	·	-	Date:	Signature of Surve	-		Date:	0/2012
State Agence Reviewed B CMS RO			11/26/20 Date:	013 3(Signature of Surve			11/0	8/2013
	Survey Completed on: 8/19/2013		 	-		Deficiencies. Was (CMS-2567) Sent	-	NO
STATE FOR	M: REVISIT REPORT (5	5/99)		Page 2 of 2			Event ID: 6QVR12	

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/8/2013			
Name of Facility			Street Address, City, State, Zip Code				
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH				
			MINNEAPOLIS, MN 55411				

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

(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem	(Y5) I	Date
ID	Prefix	F0157		Correction Completed 10/03/2013		ID Prefix	F0176		Correction Completed 10/03/2013		ID Prefix	F0225		Correction Completed 10/03/2013
	Reg. # LSC	483.10(b)(11)		-		Reg. # LSC	483.10(n)		-		Reg. # LSC	483.13(c)(1)(ii)-(iii), (c)(2)	- (4)
		F0226 483.13(c)		Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0241 483.15(a)		Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0250 483.15(g)(1)		Correction Completed 10/03/2013
	Prefix Reg. # LSC	F0252 483.15(h)(1)		Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0279 483.20(d), 483.20(k)(1)	Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 10/03/2013
	Prefix Reg. # LSC	F0309 483.25		Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0311 483.25(a)(2)		Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 10/03/2013
		F0314 483.25(c)		Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 10/03/2013		ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 10/03/2013
Revie	wed By	,	Reviewed I	-		ite:	Signature	of Surve	-				Date:	/2012
	Agency wed By RO		MM/ Reviewed I			1/26/20 nte:	13 Signature			182			11/08 Date:	/2013

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/8/2013			
Name of Facility		Street Address, City, State, Zip Code	·				
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH				
		MINNEAPOLIS. MN 55411					

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

(Y4)	Item		(Y5)	Date	(Y4)	Item			(Y5)	Date	(Y4	ltem	1	(Y5)	Date
				Correction						Correction					Correction
				Completed						Completed					Completed
IC) Prefix	F0325		10/03/2013		ID Prefix	F032	27		10/03/2013		ID Prefix	F0329		10/03/2013
	•	483.25(i)				Reg. #	483.2	5(j)					483.25(I)		
	LSC					LSC						LSC			_
				Correction						Correction					Correction
IC) Prefix	F0387		Completed 10/03/2013		ID Prefix	F04 ⁻	11		Completed 10/03/2013		ID Prefix	F0425		Completed 10/03/2013
	Reg. #	483.40(c)(1)-(2	`			Reg. #	483 5	5(a)				Reg #	483.60(a),(b)		_
	LSC	-03.40(0)(1)-(2	/			LSC	403.5	5(a)				LSC			_
															_
				Correction						Correction					Correction
				Completed						Completed					Completed
IC	Prefix	F0428		10/03/2013		ID Prefix	F040	65		10/03/2013		ID Prefix	F0492		10/03/2013
	-	483.60(c)				Reg. #	483.7	0(h)					483.75(b)		
	LSC					LSC						LSC			_
				Correction						Correction					Correction
IL) Prefix	F0497		Completed 10/03/2013		ID Prefix	F05'	14		Completed 10/03/2013		ID Prefix	F0520		Completed 10/03/2013
				10/00/2010						10,00,2010					
	Reg. # LSC	483.75(e)(8)				Reg. # LSC	483.7	5(1)(1)				Reg. # LSC	483.75(o)(1)		_
	200				<u> </u>	200						200			_
Revie	wed By	,	Reviewed E	Βv	Dat	e:		Signature of	fSurve	vor:	1			Date:	
	Agency		MM/G	-	11/	26/201	3		0182						8/2013
Reviewed By Reviewed By			Dat	te: Signature of Surveyor:				Date:							
CMS RO															
Followup to Survey Completed on:						Check for any Uncorrected Deficiencies. Was a Summary of						+			
8/19/2013				Uncorrected Deficiencies (CMS-2567) Sent to the Facility?						YES	NO				

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245387	(Y2) Multiple Construction A. Building B. Wing 01 - MAII	N BUILDING 01	(Y3) Date of Revisit 11/21/2013		
Name of Facility		Street Address, City, State, Zip Code			
ST OLAF RESIDENCE		2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			

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

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date (Y4) Item	(Y5)	Date
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		08/23/2013	ID Pref	x	10/08/2013	ID Prefix _		
Reg. #	NFPA 101	_	Reg.	# NFPA 101		Reg. #		
LSC	K0027	-	LS	C K0029				
		Correction			Correction			Correction
ID Prefix		Completed	ID Pref	x	Completed	ID Prefix		Completed
Reg. #		_	Reg.	#	-	Den #		
LSC		-	LS			-		
		-						
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Pref	x	-	ID Prefix		
Reg. #		_	Reg.		_	Reg. #		
LSC		-	LS			LSC _		
		Correction			Correction			Correction
ID Prefix		Completed	ID Pref	x	Completed	ID Prefix		Completed
Reg. #		-	Reg.		-			
LSC		-	-	# C	-	LSC		
		-						
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Pref	x	-	ID Prefix _		
Reg. #		_	Reg.		-	Reg. #		
LSC		-	LS	C				
Reviewed By	/ Reviewed	Ву	Date:	Signature of Surve	eyor:		Date:	
State Agenc	MM/	PS	11/26/20	28120	0		11/2	1/2013
Reviewed By	/ Reviewed	Ву	Date:	Signature of Surve			Date:	
CMS RO								
Followup to	Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of				
	8/13/2013			the Facility? YES	NO			



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2304 1219

November 27, 2013

Mr. David Uselman, Administrator St Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

RE: Project Number S5387022 and H5387061

Dear Mr. Uselman:

On September 12, 2013, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 16, 2013. (42 CFR 488.422)

On November 1, 2013, this Department recommended and the Centers for Medicare and Medicaid Services (CMS) concurred and informed you in their letter of November 21, 2013 that the following enforcement remedies were being imposed:

- Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of \$4,200.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of \$1,500.00. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of November 21, 2013, 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 August 19, 2013.

This was based on the deficiencies cited by this Department for an extended survey completed on August 19, 2013 that included an investigation of complaint number H5387075 and H5387058. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

St Olaf Residence November 27, 2013 Page 2

On November 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 21, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on August 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on November 8, 2013. The deficiencies not corrected are as follows:

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

• Per instance civil money penalty of \$4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of \$4,200.00 would remain in effect. (42 CFR 488.430 through 488.444)

• Per instance civil money penalty of \$1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of \$1,500.00 would remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013 would remain in effect. (42 CFR 488.417 (b))

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 September 12, 2013 and CMS notified you in their letter of November 21, 2013, 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 August 19, 2013.

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 Statement of Deficiencies (CMS-2567) and Post Certification Revisit Form, (CMS-2567B) from this visit.

St Olaf Residence November 27, 2013 Page 3

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 PO Box 64900 Saint Paul, Minnesota 55164-0900

Telephone: (651) 201-3792 Fax: (6521) 201-3790

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 third revisit.

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 February 19, 2014 (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.

St Olaf Residence November 27, 2013 Page 5

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

5387r1_13HlthOHFC.rtf

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	ID: 6QVR								
MEDICARE/MEDICAID PROVIDER (L1) 245387		3. NAME AND ADI (L3) ST OLAF RE	E SURVEY AGENCY	Facility ID: 00260 4. TYPE OF ACTION: 2 (L8)					
(L2) 492242500		(L4) 2912 FREMO (L5) MINNEAPO		ORTH	(L6) 55411	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OW (L9)	/NERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
	9/2013 (L34) (L10)	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II			14 CORF	FISCAL YEAR ENDING DATE: (L35)			
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC			15 ASC 16 HOSPICE	09/30				
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:						
From (a):		A. In Complian	ice With		And/Or Approved Waivers Of The Following Requirements:				
To (b):		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit			
12.Total Facility Beds		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	7. Medical Director 8. Patient Room Size 9. Beds/Room				
13.Total Certified Beds	80 (L17)	X B. Not in Compliance with Program Requirements and/or Applied Waivers:			* Code: B * (L12)				
14. LTC CERTIFIED BED BREAKDOW!	N				15. FACILITY MEETS				
18 SNF 18/19 SNF 80	19 SNF	ICF IID			1861 (e) (1) or 1861 (j) (1): (L15)				
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
See Attached Remarks	×		*						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL Date:				
Rebecca Wong, HFI	E NE II	11/12/2013 (L19)			Kate JohnsTon, Enforcement Specialist 11/19/2013 (L20)				
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	L OFFICE OR SINGLE STAT	TE AGENCY			
19. DETERMINATION OF ELIGIBILIT _X1. Facility is Eligible to Pace 2. Facility is not Eligible		20. COMPLIANCE WITH CIVIL RIGHTS ACT:			 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
						(20)			
22. ORIGINAL DATE	23. LTC AGREEMI		24. LTC AGREEM		26. TERMINATION ACTION: VOLUNTARY 00	(L30)			
OF PARTICIPATION 12/01/1986	BEGINNING	DATE ENDING DATE		E	VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety			
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination	nt 06-Fail to Meet Agreement			
25. LTC EXTENSION DATE:	27. ALTERNATIVI				04-Other Reason for Withdrawal	OTHER 07-Provider Status Change			
	of Admissions: (L44) pension Date:				00-Active				
(L27)									
			(L45)						
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)	_				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION O	OF APPROVAL DA	ГЕ					
	(L32)	11/19/2013		(L33)	DETERMINATION APPRO	VAL			

DEPARTMENT OF HEALTH AND HUMAN SERVICES		CENTERS FOR MEDICARE & MEDICAID SERVICES		
	MEDICARE/MEDICAID CERTIFICATION AND TRANS	MITTAL	ID: 6QVR	
	PART I - TO BE COMPLETED BY THE STATE SURVEY	AGENCY	Facility ID: 00260	
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS			

At the time of the extended survey completed August 19, 2013, two complaint investigations were completed, H5387057 and H5387057, and substantiated during this period. Deficiencies were issued as a result of substantiated findings at F323, also the facility was not in substantial compliance with the participation requirements. Conditions in the facility constituted both substandard quality of care (SQC) and immediate jeopardy (IJ) to resident health or safety. The facility would not be given an opportunity to correct before remedies are imposed. As a result, this department imposed state monitoring effective September 16th. In addition, we recommended to the CMS Region V Office that the following remedy be imposed:

- CIVIL MONEY PENALTY

Refer to the following forms: CMS 2567 for both Health and Life Safety Code, including the facility's plan of correction. Post certification revisit (PCR) to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5779

September 11, 2013

Mr. David Uselman, Administrator St. Olaf Residence 2912 Fremont Avenue North Minneapolis, Minnesota 55411

RE: Project Number S5387022, H5387057 and H5387058

Dear Mr. Uselman:

On August 19, 2013, an extended survey was completed at your facility by the Minnesota Department 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 August 19, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number H5387057 and H5387058.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 19, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number H5387057 and H5387058 that was found to be substantiated.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 16, 2013, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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 Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 16, 2013. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil Money Penalty (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Olaf Residence is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 19, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

> Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Oliver Potts, Chief 330 Independence Avenue, SE Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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

If substantial compliance with the regulations is not verified by November 19, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

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

Enclosure

cc: Licensing and Certification File

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second s	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		245387	B. WING		C 08/19/2013	
ME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CON	DE 1 00/19/2013	
TOLA	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
F 000	INITIAL COMMEN	TS	F 00	00		
	Minnesota Departr	rvey was conducted by the nent of Health on August 12 2013. The survey resulted in		F 157	OK W	
a f v c 2 2 7	an Immediate Jeop facility's failed resp which resulted in th	bardy (IJ) at F323 related to the onse to a resident's elopement he high potential for harm or n August 14, 2013, at 6:23	ł	#68 was n	cian of Resident otified of his refusals, some	
	p.m. The IJ was re 2:25 p.m.	moved on August 16, 2013, at	- Cor	medication discontinu	is were	
	THE FACILITY PLAN OF CORRECTION (WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT ACCEPTANCE. YOUR SIGNATURE AT TH BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.		John ,	that Ativar were not g #81 on said has been a timely. C) The physic	and Ambien iven to Resident d dates and since dministered vian of Resident	
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.	Certur .	swelling an resident's was update orders	otified of the ad bruising of the leg and the family ed with new	
	During the course of complaints were su	of the survey two of two H Ibstantiated. H5387057 was 15 and H5387058 was	C		ts have the be affected by	
F 157 SS=D	483.10(b)(11) NOT (INJURY/DECLINE	IFY OF CHANGES /ROOM, ETC)	F 15	7 B) The Chang Policy was	nt practice. e of Condition reviewed and aff were educated	
	consult with the res known, notify the re or an interested fan accident involving t	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in		on the poli C) Pharmacy		
ORATORY	DIRECTOR'S OR PROVID	PER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE	Executive Direct	(X6) DATE	

ollowing 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 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MB NO.	APPROVED 0938-0391 E SURVEY PLETED
		245387	B. WING	·		C 08/19/2013	
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	29 ⁴ MI	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life t clinical complication significantly (i.e., a existing form of treat consequences, or the treatment); or a dec the resident from th §483.12(a). The facility must als and, if known, the re or interested family change in room or r specified in §483.1 resident rights under regulations as spect this section. The facility must ree the address and ph legal representative This REQUIREMEN by: Based on interview facility failed to ensu- condition were repo- resident (R68) who 1 of 8 residents (R8 notified when a med the resident exhibited	nge 1 potential for requiring physician ificant change in the resident's r psychosocial status (i.e., a lith, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced v and document review, the ure significant changes in orted to the physician for 1 of 1 received dialysis services; for 81) whose physician was not dication was not available and ed increased symptoms; and R18) who developed cellulitis	F	157	 in place to receive medications in a tim manner. The facilit now receive two de runs daily and new within 2 hour time any issues are immereported to the DOP D) Nursing Staff was e on the need to contar pharmacy if medicar not received on the run. A direct access has been given in carbon the contents of the pharmacy response E) Nursing Staff was e on the contents of the Pyxxis machine and they are to use the I machine to obtain medications when the not available from pharmacy. 3. Date of Completion: 10/3/2 4. Reoccurrence will be Preve A) Random audits will completed weekly of then monthly X3 w results being present the QA committee follow up discussion/planning 	ty will elivery orders frame ediately N. educated act ations ar expected as numbe ase poor educated he d that Pyxxis they are 013 anted by: l be x 4 and ith nted to for	l ed r i

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUT	IPLE CONSTRUCTION		. 0938-0391	
	OF CORRECTION	IDENTIFICATION NUMBER:	perior of the second state states	NG	(X3) DATE SURVEY COMPLETED		
		245387	B. WING		10.000	C 08/19/2013	
NAME OF	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CO		10/2010	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 157	Continued From page 2 Findings include: R68 consistently did not receive two of his medication and his physician was not notified of the refusals. A significant change Minimum Data Set (MDS) was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68		F 1	57 5. The Correction will by: A) Director of N designee			
	did exhibit periods disorganized think or behavioral issue was cooperative w personal cares. H of one staff with b toilet use and personal	of being inattentive and ting. He had no mood concerns es. The MDS indicated R68 with staff efforts to provide him e needed extensive assistance ed mobility, transfers, dressing, sonal hygiene. He received yed a therapeutic diet as result		RECE SEP 2	6 2013		
	Kionex 15 grams/	rdered the resident receive 60 milliliter (ml) suspension hyperkalemia (elevated 7/13.		COMPLIANCE MONI LICENSE AND C			
	A review of the Medication Administration Records (MAR) for June 2013, July 2013, and August 2013, revealed the resident had not received the medication on all but two occasions. The documentation on the MAR document indicated the resident refused the medications. A review of the medical record revealed no documentation of the resident's physician being informed of the resident's refusal.						
ir F V	Viactiv chewable t osteoporosis on 6	dered the resident receive ablets orally on a daily basis for /12/13. A review of the MAR for 013, and August 2013, revealed					

Service Services	COLLEGE DOWN OF A SERVICE STRUCTURE				0	MB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	And a strength of the	TIPLE CONSTRUCTION	-		LETED
		245387	B. WING			C 08/1	; 9/2013
NAME OF	PROVIDER OR SUPPLIER	μ	·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	00/1	012010
ST OLAF	RESIDENCE			2912 FREMONT AVENUE N			
				MINNEAPOLIS, MN 554	11		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE		BE	(X5) COMPLETIO DATE
F 157	Continued From pa	age 3	F 1	57			
	all but two occasio MAR document ind medications. A rev revealed no docum	ot received the medication on ns. The documentation on the dicated the resident refused the iew of the medical record mentation of the resident's formed of the resident's refusal.					
1		R68 was completed on 8/16/13, e reported he had not refused nedications.					
	(LPN)-D was comp LPN-D reported the these medications physician had been refusal. She report	censed practical nurse oleted on 8/16/13, at 9:30 a.m. e resident consistently refused and was unsure if the n made aware of the resident's red they had been told just to dent's refusal on the back of			54 14		
		ne director of nurses (DON) 8/19/13, at 12:16 p.m. She s.					
	Physician Notificat the attending physic changes in residen The policy did not s	dent Change of Condition ion policy directed staff to notify ician or physician on call of it's condition or health status. specifically direct staff to notifiy sident's refusal to take					58
	resident did not rev from 8/2/13 throug	sician was not notfied when the veive anti-anxiety medication h 8/5/13, or the hypnotic n from 6/17/13 through 6/26/13 cian orders.					
	Nurse's notes date	d 6/17/13 through 8/5/13, at no					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A Strangers		Ģ	X3) DATE COMP	SURVEY LETED
		245387	B. WING _			C 08/1	9/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	00/1	5/2015
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETIO DATE
F 157	point was the physi not being available On 8/5/13, at 1:40 R81 was noted to h sweating, droopy, h no lunch, had bad the pharmacy had and writer wrote hat medication had bee on 8/5/13, did not s of R81's noted cha R81's quarterly MD had anxiety disorded depression and psy schizophrenia). The taking antipsychotic and hypnotic medic loss/dementia Care dated 10/8/12, indic diagnoses including disorder, anxiety, m psychosis. R81's psychotropic 10/19/12, identified to diagnoses of par disorder, anxiety di evidenced by receiv The care plan ident health maintenance maintained with cur interventions including	ician notified of medications and given as ordered for R81. p.m. a Nurse's Note indicated have "increased tremors, had ate very little at breakfast, breath." According to the note, been called regarding Ativan id spoken with someone that en sent out. The nursing note state the physician was notified	F 15	57			
	Center Psychiatry of	ennepin County Medical linic visit progress note dated inder assessment: "2.					

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(a) (b) (b) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	15/2015
ST OLA	FRESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Insomnia. Patient reby the tremor. I am adding Ambien 5 m anxiety. Currently A t.i.d. [three times a control anxiety." R81's Physician Or lorazepam (anti-an: be given three time prescription dated 6 (Ambien-sleep aid) mouth at bedtime. During review of M/8/5/13, R81 had mi from 6/17/13 throug doses of Ambien. On 8/15/13, at 10:2 nursing (O)-D verifihad not been admir were circled with not that "Ativan 1 mg not that "Ativan 1 mg not that "Ativan 1 mg not there was no script there was a prescript dated 6/17/13, that from appointment a same date. The undated Reside Physician Notification and the section of the state of the s	age 5 eports her sleep is disrupted going to go ahead and try ing at bedtime. 4. Severe attivan she is getting at least day], which she needs to ders dated 6/19/13, noted xiety) 1 milligram (mg) was to s daily and another 5/17/13, noted zolpidem 5 mg was to be given by AR dated 8/2/13 through ssed nine doses of Ativan and gh 6/26/13, had missed 10 1 a.m. consultant director of ed that the both medications histered on those days and otes behind MAR for Ativan ot available nurse notified." p.m. O-D approached t she had inquired from the medication was not filled as from the provider even though ption sheet in R81's chart resident had brought to facility and had been noted on the ent Change of Condition on policy directed "The or physician on call will be es in resident's condition or tween the hours of 8:00 am	F1	57			

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Alexandra and a second		E CONSTRUCTION	CON	TE SURVEY
		245387	B. WING				C / 19/2013
NAME OF	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	10/2010
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 157	and 10:00 p.m., sey physicians or physi all condition or hea the hours of 10:00 attending physician	ven (7) days a week, attending cian on call is to be notified of lth status change. 2. between p.m. and 8:00 am. the is or physician on call should hange in condition, health	F 1	57			
	inclusive-examples that has the potenti intervention in mental or psycho R18's family was no days after the the fa	only): Resulted in an injury ial for physician and significant change osocial status." ot notified of an injury for four acility had knowledge of an					
	to the staff by the re The Resident Admi indicated R18 had unspecified idiopati	on 5/11/13, but was reported esident on 5/12/13. ssion Record dated 8/5/02, diagnoses including, hic peripheral neuropathy, disease, and diabetes					
	somewhat swollen. had hit it on the me 5/11/13, which the we report of incident . If pillow. writer wrote continue to monitor -On 5/13/13, at 12:0 tender to touch and elevated on a pillow ten minutes and the and read 98.9 (no r	e evening shift, R18 eg pain. The leg was Resident reported that she dication cart the previous day writer had no knowledge or Resident leg was propped on WNL (within normal limit)			Χ.	÷	

Facility ID: 00260

If continuation sheet Page 7 of 298

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	12. X 1277 C 121PC		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING	i		2007 Sec. 115	C 19/2013
	PROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	change of condition -On 5/13/13, at 6:50 a small bruise had swelling in the left lis screamed out where claimed that medic. Saturday 5/11/13, b time of day. No furt nurse's notes about during document ref The Resident Incide revealed R18 had a outer lower extremit continued to complibeen noted "somew staff that she had h 5/11/13. R18's emer representative was per the incident rep During review of Ph between 5/13/13, th were given by both practitioner related included two x-ray's and left foot/ankle (all the orders receive emergency family of notified on treatment The annual MDS da BIMS (a Brief Interview was able to make a structured setting, of	at that time. 0 a.m. nurse's notes indicated been noted; very minimal ower extremity. The resident n leg was touched and resident ation cart bumped into her on but was not able to recall the her documentation in the t R18's family being notified	F	157			

Facility ID: 00260

If continuation sheet Page 8 of 298

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	이 이 이 이 있는 것이 같아.	PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		0/5005				С	
		245387	B. WING			08/19/2013	
AME OF I	PROVIDER OR SUPPLIER				ITY, STATE, ZIP CODE		
T OLAF	RESIDENCE			2912 FREMONT AV			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDE	R'S PLAN OF CORRECTION	(X5)	
PREFIX TAG						COMPLETI	
F 157	Continued From pa	age 8	F 15	7			
		and had resident had no	1 10				
		s in cognition since previous		-			
	0-04040-4000						
) a.m. an interview was I-A. RN-A stated if there was a					
		status, the nurses are to					
	update the nurse p	ractitioner or the attending					
		tely and or promptly if the					
		thing new and if resident was					
	provider. RN-A furt	cations as ordered by the ber stated that					
		ve always had to be notified of					
		nt and injury immediately staff					
cł id		out. Later, on 8/16/13, at 12:45 d with RN-A's statement.					
	On 8/19/13, at 11:1	0 a.m. an interview was N-C. LPN-C stated the					
		bosed to be updated					
		taff had noted R18's change of					
		bered calling early regarding					
		got to the floor for her shift.					
		rious shifts had not notified the ras a change of resident					
		completed the assessment.					
		"You never know what it is. I					
		m figure that out with my					
		is is what every nurse should to notified promptly."					
		on policy provided by facility					
	upon request.						
F 176 SS=D		NT SELF-ADMINISTER ED SAFE	F 17	6			
	An individual reside the interdisciplinary	ent may self-administer drugs if					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		245387	B. WING			08	/19/2013
NAME OF F	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CO		
ST OLAF	RESIDENCE			0.00000000000	REMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 176	practice is safe. This REQUIREMEN by: Based on observat review, the facility farsidents (R1) for sime medications (SAM). Findings include: During observation was observed comit two respiratory inhat trained medication and medication cart. TN the medication cart. The Resident Admited was admitted to the diagnosis to include The quarterly Minim 7/23/13, indicated F (misconceptions or contrary to reality). Status (BIMS) score was cognitively inta An alteration in thou 1/25/13, indicated F retardation which in included interventio	AT is not met as evidenced ion, interview, and document ailed to assess 1 of 2 elf-administration of on 8/16/13, at 7:46 a.m. R1 ng from her room and handing lers (ProAir and Spiriva) to the aide (TMA)-E at the IA-E returned the inhalers to ssion Record indicated R1 facility on 1/16/13, with e chronic airway obstruction. hum Data Set (MDS) dated R1 had and had delusions beliefs that are firmly held, A Brief Interview of Mental e of 15 which indicated she	F	176	 Completed. 2. Corrective Action a Other Residents: A) All residents A) All resident medication potential to this deficie. B) Self Admin Medication Assessmen completed residents ar residents ar residents we completed reviewed q C) Physician contained for future resident of future residents ar self. D) Care plans to reflect er ability to S E) Nursing Staton the Self. 	tion of Assessment as it applies to ts who receives have the be affected to nt practice. histration of (SAM) ts were for all current and all future for all current and all future for all current and all future will have the S upon admit a uarterly. orders will be or all current a lents who are propriate to will be updat ach resident's AM. aff was educa	e py t SAM nd and ted s atted on
p	patient. Staff to re-direct prn." A Physician's Progress note dated 6/5/13,						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Sec. Margaret and	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245387	B. WING			08/19/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1 00		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 176	her cares with her I psychiatric illness." The Nursing Assist received 8/15/13, ir "Non-compliant/res The June 2013 Me	dependent on nursing for all of imited mobility and sever ant Assignment Sheet ndicated R1 was istive to cares." dication Administration Record	F 17	 3. Date of Completion: 1 4. Reoccurrence will be H A) Random audits completed weathen monthly 2 results being p the QA commit 	Prevented by will be only x 4 and x 3 with resented to		
F 225 SS=E	every four hours as medication adminis requested. Review indicated R1 receiv 8:00 a.m. The Augu not include an order Review of R1's me an assessment for physician's order to When interviewed TMA-E stated she and then R1 return done. When interviewed director of nursing a SAM assessmen she would expect a	dical record lacked evidence of ability to SAM and lacked a o SAM. on 8/16/13, at 8:02 a.m. gave the inhalers for R1 to do s the inhalers when she was on 8/16/13, at 9:41 a.m. the (DON) stated R1 did not have t completed. The DON stated a SAM assessment be hysician's order be obtained for sAM. (c)(2) - (4) PORT		follow up discussion/plat 5. The Correction will be by: A) Director of Nu designee	Monitored		
	The facility must no	ot employ individuals who have f abusing, neglecting, or					

1

		AND HUMAN SERVICES			PRINTED: 09/11/ FORM APPRO OMB NO. 0938-0
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1201 120	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED
		245387	B. WING		C 08/19/201:
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 225	mistreating residen had a finding enter- registry concerning of residents or misa and report any know court of law agains indicate unfitness fi	ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or o the State nurse aide registry	F 22	 1. Corrective Action: A) Resident #41, 81, 87, 13, 18, 56 and their Incident Rep chart reviewed by Care plans were u accordingly. B) Resident #18 had 	23 had ort and/or an RN. pdated her
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established State survey and co The facility must haviolations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclu- certification agency incident, and if the appropriate correct This REQUIREMEN	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported		 incident from 5/13 the medication can foot reported to th Agency/CEP on 8 C) Resident #23 had incident related to allegation of staff reported to the Sta Agency/CEP on 8 D) Residents #55,85, 597, 598 and 599 longer residents of Olaf's facility. E) Resident #45 has wander guard dev is placed in the pr of his w/c. His ca reflects the use of wander guard. 2. Corrective Action as it ap Other Residents: A) All residents hav potential to be aff these deficient pr 	rt and her e State /12/13. his the abuse abuse ate /14/13. 89, 595, are no f St. a new rice and it oper area are plan the fected by

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Second and the second	LTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED C
		245387	B. WING	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	
F 225	unknown origin wer administrator and S to ensure allegatior investigated for 6 o neglect reviewed (F of abuse and negle facility failed to reportable events (re immediately reported to the State agency (SA), and failed	F 2	 B) The Wander Guard System policy has been revised to include how to check that the device and system are functioning. C) The Missing Resident policy was reviewed. D) The Abuse Prevention Plan has been revised to include
	inappropriate beha was found by facilit contact with anothe incident was not im administrator and S	have a history of sexually viors towards others and R41 y staff engaging in sexual er resident (R81) on 6/1/13, the mediately reported to the State agency and then out potential resident to	1	 immediate reporting language and reporting of elopements. E) A Resident to Resident Altercation policy has been added to abuse prevention policy. F) All facility staff has been educated on the revised policies.
	On 6/1/13, at 6:30 p.m. R41's Nurse's Notes indicated, "Resident [R41] was witnessed in his room engaging in a sexual act with another resident [R81], when door opened, this resident stated 'Get out, Respect our privacy'! [sic]" The note indicated the weekend supervisor, the social service designee (SSD) and nurse practitioner were notified via telephone or had a voice message left for them. On 6/2/13, at 1:00 p.m. a Nurse's Note indicated R41 had "no sexually inappropriate behavior" noted. A note at 5:00 p.m. indicated R41's conservator was called and updated on the 6/1/13 incident. Although the clinical record indicated R41 was monitored for sexual activity and behaviors after the incident on 6/1/13, the clinical record lacked			 Date of Completion: 10/3/13 Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. The Correction will be Monitored by: A) Director of Nursing or Designee

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second second second			(X3) DAT	E SURVEY	
		245387	B. WING		41	5 × 5 × 5 × 5	C 19/2013	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ST OLAF	RESIDENCE		2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE	
F 225	evidence the admir were notified imme the incident was inv sexual contact was residents. R81's quarterly Min 7/8/13, indicated R8 delusions, manic de disorder (other than indicated R81 Brief (BIMS a tool used t 10, indicating mode R81's Cognitive los 10/8/12, indicated R that included deme disorder, anxiety, m psychosis. The Resident Admi indicated R41's diag herpes, psychosis, alcohol addiction. T 5/31/13, indicated a impairment); identifi occurring 1-3 days days in the assess extensive assistant toileting, dressing, p identified R41's beh participation in activ risk for physical inju the privacy or activit disrupted care or liv indicated R41 rejec assessment period indicators. The CAA	age 13 histrator and State agency diately and lacked evidence vestigated to determine if the consensual between both himum Data Set (MDS) dated 81 had anxiety disorder, epression and psychotic in schizophrenia). MDS also Interview of Cognitive Status to determine cognition) was erate cognitive impairment. s/dementia CAA dated R81 had multiple diagnoses ntia (Lewy body), bipolar nood disorder and nonorganic ssion Record (undated) gnoses included genital history of cocaine, drug and he annual MDS dated a BIMS of 15 (no cognitive ied physical behaviors and verbal behaviors 4 to 6 ment period; he required the with bed mobility, dressing, personal hygiene. The MDS haviors interfered with vities, put others at significant try, significantly intruded on ty of others, significantly ving environment. The MDS ted care 1 to 3 days during the and he had no mood A for cognitive loss/dementia tified R41 had verbal behaviors directed at others,	F 2	25				

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000 (000000)		PLE CONSTRUCTION G	(X3) DAT CON	E SURVEY
		245387	B. WING	ı			C /19/2013
NAME OF	PROVIDER OR SUPPLIER			(STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
ST OL AF	RESIDENCE			1	2912 FREMONT AVENUE NORTH		
OT OLA	REDIDENCE				MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	rejected cares, had schizophrenia and I CAA identified R41 history of refusing of living (ADL) Function Incontinence/Press identified R41 used locomotion. The ps dated 6/14/13, iden diagnosis of parano and Ativan as need hallucinations which behaviors. The CAA 6/14/13, identified F others was impaired part/intent of a mess The care plan dated history of sexual/se behavioral symptom paranoid schizophr pornography in his masturbating in his advances towards of care plan directed t behavior endangers Intervene as necess R41 was seen by of plan identified to ref rooms. The care plan directed intervention abusive behaviors. was at risk for harm diagnosis of parano thoughts, delusions The care plan direct assessment and ab	a diagnosis of paranoid had a "guardian in place." The had delusional thinking and a cares. The activities of daily onal Status/Urinary ure ulcer CAA dated 6/14/13, an electric wheelchair for ychotropic medication CAA tified R41 used Abilify for the bid schizophrenia, and Haldol ed. R41 was identified to have n affected his mood and A for communication dated R41 ability to understand d and R41 may miss some sage.	F	225	5		

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	accession and a		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245387	B. WING			C 08/19/2013		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	RESIDENCE		2912 FREMONT AVENUE NORTH					
	0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.				MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	Continued From pa	ge 15	F 2	225	5			
	behaviors, resisted thought process.	cares, and had altered						
	identified, "Schizop remains. Acting out	ess note dated 7/16/13, hrenia - Severe paranoia sexual behaviors have been						
		ate comments [sic] & touch. epakote as it may be causing						
	R41 could be an "a "explosive persona out for psych [psycl a new psychiatrist i psychiatric appointr R41. SSD-A stated the Office of Health agency (OHFC, SA having "lunged" at a having lunged at ar residents, that R41 escalating behavior	6 a.m. SSD-A stated she felt ggressor" because of his lity." SSD-A stated R41 "goes niatric] services," and R41 had nvolved. SSD-A stated ments were scheduled for R41 had "multiple" reports to Facility Complaints, the State)." SSD-A described R41 has and struck out at SSD-A; nd struck out at other required crisis intervention for 's in the past. SSD-A sident's aren't safe" around					×	
		d R41 was not being to move freely throughout the			(4			
	(O)-G, registered no consultant were not note which indicate sexual encounter w stated she believed (the other resident v Information regardin The consultant RN	2 a.m. the director of nursing urse (RN)-A, and nurse iffied of the 6/1/13, nurses d R41 was found having a ith another resident. O-G she "may be" aware of whom was), but was unclear. ng the incident was requested. checked the "Fall Tracking" s not recorded there.						

Event ID: 6QVR11 Facility ID: 00260

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	TIPLE CONSTRUCTION	(COMF	SURVEY PLETED	
		245387	B. WING	VING 08/19/2013				
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 2912 FREMONT AVENUE NOF MINNEAPOLIS, MN 55411	ктн			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD E	1997 (1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 199	(X5) COMPLETION DATE	
F 225	- At 2:12 p.m. the s regarding R41's 6/7 was found by facilit sexual act with R81 O-G stated when s the residents reque alone in the room, f notified and SSD w stated both of the n were contacted; nu both were updated. R41 was alert and of "that choice" and st R81's BIMS was "1 indicated a lower so impairment]." Both mental illness, R81 consent." Both staff okay with the conta the question R81's stated the mental h familiar with R81 ha "through the comm R81 was identified activity." Both verific completed regardin R41's diagnosis of and unclear if he wa he completed his of observe his genitali ordering a HSV tes R81. The SSD-A st notified the administ the voicemail and w was unclear when t both confirmed no i after the administra no time was the Sta	urveyor, O-G and SSD-A met I/13 incident. O-G verified R41 y staff to be engaging in a I in R41's room. SSD-A and taff discovered R81 with R41, ested privacy, they were left the nurse supervisor was as called. O-G and SSD-A esidents' guardians and family rse practitioners (NP's) for Both O-G and SSD-A stated priented and able to make cated R81 had a mental illness, 5 [even though the last BIMS	F 2	25				

Event ID: 6QVR11

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Action action contract			(X3) DAT	E SURVEY
		245387	B. WING			C 08/19/2013	
NAME OF	PROVIDER OR SUPPLIER		· · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	19/2013
					912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE				MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 17	F 2	25			
1 220		consent, both felt the incident	F 2	.20			
		due to both residents being					
	On 8/20/13, at app	roximately 11:15 a.m. R81's					
	guardian (G)-A was verified she was av	s contacted via telephone and vare of the 6/1/13 incident on					
	incident and all par	R81's family was notified of the ties believe the contact was					
		proximately 3:00 p.m. the R41 was contacted via					
		firmed he was notified of the 6/2/13. G-B stated he believed					
	the contact was con	nsensual. Both G-A and G-B scuss the details of the					
		ssed they felt adequately					
	notified of the incid	ent. Both stated R41 and R81 of eliciting sexual contact.					
		nave vaginal bleeding of ich was not reported.					
	The quarterly MDS	dated 3/6/13, indicated R82 red cognitive skills for daily					
	decision making.	e's Notes dated 4/14/13,					
	revealed R82 had b	blood on the buttocks. The indicated "no cut areas noted					
	possible had vagina	al bleeding." There were no s regarding the possible					
	vaginal bleeding.	4/19/13, indicated the blood					
	observed on 4/14/1 run down R82's leg	3, was dark red, was noted to s and a urinalysis/urine culture					
		on 8/16/13, at 8:44 a.m. SSD					
2		aware of R82's potential d the occurrence was not					
	reported nor investi	gated. SSD indicated she al bleeding would be reported.					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 8 - 16 State			(X3) DATI COM	E SURVEY
		245387	B. WING	<u> </u>		C 08/19/2013	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
STOLAR	RESIDENCE		8	2	912 FREMONT AVENUE NORTH		
ST OLA	RESIDENCE			N	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	200.19	E.	005			
1 225		82 was not delusional, just	F 2	225			
	disorganized and c						
	The licensed practi	ical nurse (LPN)-I, who wrote					
		dated 4/14/13, was unavailable					
	for interview. Review of the facili	ity Abuse Prevention Plan For					
	Minnesota Skilled	Nursing Facilities dated 6/6/13,					
		al bleeding was included as a					
		of abuse. In addition, the Abuse or Minnesota Skilled Nursing					
		an injury is considered an					
		source and must be reported					
		f the injury was not observed ne source of the injury could					
		y the resident; and the injury is					
	suspicious because the injury.	e of the extent or location of					
đ	R1's allegations of sexual advances w	another resident making vere not reported.					
	The Resident Admi	ission Record indicated R1					
		e facility on 1/16/13, with					
		de brain injury, lupus,					
	obesity, schizophre	nbago, diabetes, morbid enia, and epilepsy.					
	The quarterly MDS	dated 7/23/13, indicated R1	ĺ				
		which indicated cognitively					
	A care plan dated 1	1/25/13, indicated R1 was at					
		self and others and would					
	remain free of harn	m or injury from self or others.					
		ress noted dated 3/13/13,					
		a poor historian in that she had uss but knew how she felt.					
	A Referral Form da	ated 6/13/13, from the					
		ed R1 was alert and oriented in					
	three spheres and	had no signs of psychosis.					

Event ID: 6QVR11 Facility ID: 00260 If continuation sheet Page 19 of 298

		AND HUMAN SERVICES			FORM): 09/11/2013 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Second Second	TIPLE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		245387	B. WING		2.5 S. (1997)	C / 19/2013
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP COD		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE
F 225	A Nurse's Notes da "moody" and report (NA) was making fu the NA later apolog NA a necklace. A Nurse's Notes da appeared upset and another resident ha sexual pleasure. Th she felt bad and ha that had happened wanted to talk to the about moving to an When interviewed of reported she had bu- residents at the fac stated she tells the won't leave her alor staff about the incid incident occurred la A social service pro- indicated R1 had m another resident. Th another resident has asked her for sexual indicated an investif accused resident has the time. When R1 stated she "made it A social service pro- indicated R1 had a against staff and ot sexual behavior. When interviewed of SSD-A indicated she 7/16/13, incident be had been out of the allegation. SSD sta	ted 6/29/13, indicated R1 was ted she felt a nursing assistant un of her. The note indicated ized to R1 and R1 gave the ated 7/1/13, noted R1 d was crying and stated ad offered her money for ne note indicated R1 stated d flash backs of bad things to her as a child and that she e social service designee other floor. on 8/13/13, at 12:59 p.m. R1 een propositioned by other ility for sexual activity. R1 other residents no and they ne. R1 reported she had told lents and the most recent ast month. ogress noted dated 7/16/13, iade a complaint against he note indicated R1 reported id come into her room and al activity. The note further gation was started and the ad been out of the building at was re-approached, she	F 2:	225		

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING			C 08/19/2013	
	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	incidents had not be to the State agency expected to report a R87 was noted to h the knuckles of the bruising to the right observation on 8/12 asked, R87 reporte During observation continued to have t and the right wrist a x 4 cm dark purple forearm.	ge 20 een investigated nor reported . SSD stated staff was allegations immediately. ave dark purple bruising on left hand and dark purple wrist area during an 2/13, at 5:42 p.m. When d she fell down the stairs. on 8/15/13, at 9:16 a.m. R87 he bruising to the left knuckles and another 7 centimeter (cm) was noted to R87's left 6 a.m. R87 was observed to	F 2	225			
	have a dark purple, inner forearm. The Resident Admit was admitted to the R87's diagnoses no progress noted date Alzheimer's disease anxiety disorder and The admission MDS R87 had both short problems and mode for daily decision m R87's care plan dat being at risk for har to a diagnosis of de not identify risk for h addition R87's care	thumb sized bruise on her left ssion Record indicated R87 facility on 12/5/12. oted on the nurse practitioner ed 7/16/13, included with paranoia and delusions, d hypertension. S dated 12/18/12, indicated and long term memory erately impaired cognitive skills					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	No. of the state o		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING	;			C 19/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
STOLAF	RESIDENCE				2912 FREMONT AVENUE NORTH		
					MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From pa "When resident beg try task later. Do no R87 was observed sitting and walking Behavior/Intervention August 2013, noted "abusive to others" two to three days of A Resident Incident a 4 cm x 5 cm bruiss The immediate inter monitor and redirect from the nurse pract indicated trial of ger and to monitor area to grab hands, just A Nurse's Notes dat bruises noted to bot The last Resident In 3/27/13. A Resident Incident a.m. indicated R87 2.5 cm bruise on the to monitor skin daily when residents hold hands. A Nurse's Notes dat bruises on both (uni A Nurse's Notes data bruises on both (uni A Nurse's Notes data	ge 21 gins to resist care, STOP and of force to do task." on all days of the survey to be with R82. R82's on Monthly Flow Record for I R82 was monitored for which was noted as occurring in day shift from 8/7-8/12/13. Report dated 3/27/13, noted se to R87's outer left hand. rventions were noted as it and requested geri-sleeves stitioner. RN assessment ri-sleeves was unsuccessful as and encourage resident not hold hands. ted 4/29/13, indicated more dy, blue and yellow in color. incident Report was dated Report dated 6/14/13, 7:00 was noted to have a 1.5 cm x e left wrist. Interventions noted y and monitor for and redirect ding arms/wrists to hold ted 7/6/13, noted multiple identified area) remained. ed 7/20/13, indicated R87 had lower arms. Review of the eports and the Nurse's ealed no documentation	F 2		DEFICIENCY)		
	A physician's order	dated 7/29/13, directed to					

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Facility ID: 00260

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STATEMENT OF DEFICIENCIES (XI) PROVIDERSUPPLIERCUA (XI) PROVIDERSUPPLIER (XII) PROVIDERSUPPLIER (XII) PROVIDERSUPPLIER (XIII) PROVIDERSUPPLIER (XII		a manufacture and a state of the second		(20) 1411 1	PERCENTER AND A PROPERTY AND A PERCENT	OMB NO	APPROVED
245387 B. WING 0819/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH 2912 FREMONT AVENUE NORTH Commentation PRETX REACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSCIDENTIFYING INFORMATION) PRETX TAG CONTINUE OR CORRECTIVE ACTION SHOULD BE CROSS REPERVENCE TO THE APPROPRIATE DEFICIENCY COMMENTION Commenti			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second			
NAME OF REVUGER OR SUPPLIER STREET ADDRESS. CITY STATE. 2P CODE ST OLAF RESIDENCE 231 FREMONT VAEVUE NORTH (Xi) ID PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES. (EACH OFFICIENCY MIST BE PRECEDE BY FULL TAG ID PRETIX (EACH OFFICIENCY ACTION NOT CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Confuture DEFICIENCY F 225 Continued From page 22 monitor skin every shift and document new areas in the nurse's Notes revealed no documentation of Druising from 7/29-8/19/13. F 225 On 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. F On 8/16/13, at 11:11 a.m. the nurse consultant stated bruises noted throughout the survey. Review of the Nurse's Notes dated 4/8/13. Review of the Nurse's Notes dated 4/8/13. revealed R87 was found to have multiple bruises during evening cares. The bruises included a 3.5 centimeter (Cm) x 5.5 cm to the test indicated staff was unaware of how the resident sustained the bruises. All Resident Incident Reports for R87 were required. All Resident Incident R875 bruises of unknown origin were investigated or reported as required. None N16/13, at 8:43 a.m. SSD-A indicated all bruises below the shoulder were to be reported for R87.			245387	B. WING		240704	- The second second
STOLAR RESIDENCE MINNEAPOLIS, MN 55411 (%1)D PREFIX TX0 SUMMARY STATEMENT OF DEFICIENCIES (EAD DEFICIENCY MOST BE PRECEDED BY FULL RESULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX RESULATORY OR USE CONTRACTION (EAD OF ORRECTIVE ACTION PROTOUD BE ORDESPRETE DEFICIENCY) ID PREFIX RESULATORY OR USE CONTRACTION (EAD OF ORRECTIVE ACTION PROTOUD BE ORDESPRETE DEFICIENCY) ID PREFIX RESULATORY OR USE CONTRACTION (EAD OF ORRECTIVE ACTION PROTOUD BE ORDESPRETE DEFICIENCY) ID PREFIX RESULATORY OR USE CONTRACTION (EAD OF ORRECTIVE ACTION (EAD OF ORRECTIVE ACTION PROTOUCD BE ORDESPRETE DEFICIENCY) ID PREFIX RESULATORY OR USE CONTRACTIVE DEFICIENCY IED OF ORRECTIVE ACTION (EAD OF ORRECTIVE ACTION PROFINATE DEFICIENCY) ID PREFIX RESULATORY OR USE CONTRACTIVE (EAD OF ORRECTIVE ACTION DEFICIENCY) ID PREFIX RESULATORY OR USE CONTRACTIVE (EAD OF ORRECTIVE ACTION DEFICIENCY) ID PREFIX RESULATORY OR USE CONTRACTIVE (EAD OF ORRECTIVE ACTION DEFICIENCY) ID PREFIX RESULATORY OR CONTRACTIVE (EAD OF ORRECTIVE (LPN)-D Stated DEFICIENCY) ID PREFIX RESULATORY OR CONTRACTIVE (LPN)-D Stated DEFICIENCY (LPN)-D Stated DEFICIENCY (LPN)-D Stated DEFICIENCY (LPN)-D Stated DEFICIENCY (LPN)-D Stated DEFICIENCY (LPN)-D Stated DEFICIENCY (LPN)-D STATE (LPN)-D ST	NAME OF I	PROVIDER OR SUPPLIER				1 00	15/2015
Přečik TAO (EACH ODRĚCHV OR LSC IDENTIFYING INFORMATION) Přečav TAO (EACH CORRÈCIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DEFICIENCY F 225 Continued From page 22 monitor skin every shift and document new areas in the nurses notes. F 225 Review of the Nurse's Notes revealed no documentation of bruising from 7/29-8/19/13. F 225 On 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. F On 8/16/13, at 11:11 a.m. the nurse consultant stated bruises were tracked on incident reports. On 8/19/13, at 2:09 p.m. O-G was again asked for documentation for R87's bruises noted throughout the survey. Review of the Nurse's Notes tated 4/8/13, revealed R87 was found to have multiple bruises during evening cares. The bruises included a 3.5 centimeter (cm) x 5.5 cm to her back, a 2.5 cm x 3.8 cm to hel left hand, and a 7 cm x 6.5 cm to the right hand. The Nurse's Notes indicated staff was unaware of how the resident sustained the bruises. All Resident Incident Reports for R87 were requested and one was not provided for 4/8/13. There was no indication that R87's bruises of unknown origin were investigated or reported as required. When interviewed on 8/16/13, at 8:43 a.m. SSD-A indicated all bruises below the shoulder were to be reported for R87.	ST OLAF	RESIDENCE					
 monitor skin every shift and document new areas in the nurses notes. Review of the Nurse's Notes revealed no documentation of bruising from 7/29-8/19/13. On 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. On 8/16/13, at 11:11 a.m. the nurse consultant stated bruises were tracked on incident reports. On 8/19/13, at 2:09 p.m. O-G was again asked for documentation regarding assessment and intervention for R87's bruises noted throughout the survey. Review of the Nurse's Notes dated 4/8/13, revealed R87 was found to have multiple bruises during evening cares. The bruises included a 3.5 centimeter (cm) x 5.5 cm to her back, a 2.5 cm x 3.8 cm to the left hand, and a 7 cm x 6.5 cm to the right hand. The Nurse's Notes indicated staff was unaware of how the resident sustained the bruises. All Resident Incident Reports for R87 were requested and one was not provided for 4/8/13. There was no indication that R87's bruises of unknown origin were investigated or reported as required. When interviewed on 8/16/13, at 8:43 a.m. SSD-A indicated all bruises below the shoulder were to be reported for R87. 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC	D BE	COMPLETION
be reported for R87.	F 225	monitor skin every in the nurses notes Review of the Nurs documentation of the On 8/14/13, at 9:19 (LPN)-D stated bru Nurse's Notes. On 8/16/13, at 11:1 stated bruises were On 8/19/13, at 2:09 for documentation intervention for R87 the survey. Review of the Nurs revealed R87 was during evening care centimeter (cm) x 5 3.8 cm to the left hat the right hand. The was unaware of ho bruises. All Resident Incider requested and one There was no indic unknown origin wer required.	shift and document new areas a. be's Notes revealed no pruising from 7/29-8/19/13. 9 a.m. licensed practical nurse ises were monitored in the 1 a.m. the nurse consultant e tracked on incident reports. 9 p.m. O-G was again asked regarding assessment and 7's bruises noted throughout be's Notes dated 4/8/13, found to have multiple bruises es. The bruises included a 3.5 5.5 cm to her back, a 2.5 cm x and, and a 7 cm x 6.5 cm to Nurse's Notes indicated staff w the resident sustained the nt Reports for R87 were was not provided for 4/8/13. ation that R87's bruises of re investigated or reported as on 8/16/13, at 8:43 a.m. SSD-A	F 22	5		
		be reported for R87	7.				

Event ID: 6QVR11

Facility ID: 00260

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STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED				
		245387	B. WING		0.8	C /19/2013		
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411					
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 225			F 225					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMPER		St. Kanasara		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
245387		B. WING	;		C 08/19/2013		
NAME OF	PROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
STOLA	RESIDENCE			1 3	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID	SUMMARY STA		ID	_	PROVIDER'S PLAN OF CORRECTI		(ME)
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX }	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	225			

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
245387			B. WING			C 08/19/2013			
	NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411					
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 225	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			225					

Facility ID: 00260

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245387			B. WING			C 08/19/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	CODE		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 225	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 2	225			

Facility ID: 00260

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PR CENTERS FOR MEDICARE & MEDICAID SERVICES ON								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245387		B. WING	۰ 		C 08/19/2013			
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	PERIDENCE			2	2912 FREMONT AVENUE NORTH			
STULA	RESIDENCE		MINNEAPOLIS, MN 55411					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 2	225				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- St. State and a second	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
		245387	B. WING _			C 19/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
ST OLAI	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE
F 225	recommendation we environment, but the misbehaving. Where always take him our leave him here. On 8/12/13, at 5:20 SSD, and RN nurse verified that R8 had and struck R78, the 8/24/13, and was the County and the Stat they also verified the perpetrator (R8) has attacked" other peo- out of the building" times, received inpar- medication changes into the facility. R599's Resident Act 8/20/12, noted R599 mental disorder, alt a right below the kne abnormality, and act The care plan dated required assistances transition from sitting transfers. R599 left the facility medications during according to the Re Neglect of Vulneration	as to remove others from the ey refuse since they are not n 9-1-1 was called, they do not t to HCMC; if he refuses they p.m. the administrator, DON, e were in the DON office and had an altercation, yelled at a buse was reported on ben reported to Hennepin te agency (SA), in addition e statement of R78 that the d "verbally and physically ple and had been "crisised (by calling 9-1-1) several atient psychiatric stays and s, and had been allowed back mission Record dated 9 had diagnoses of persistent ered mental status, diabetes, ee amputation, gait tive drug abuse. d 9/19/12, indicated R599 e of staff to stabilize during ig to ambulation or for f (elopement) without orders or the week of 11/23/12, port of Suspected Abuse or ole Adults form. R599 was unknown date and time)	F 25	225		

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		AND HUMAN SERVICES			FORM	D: 09/11/2013 MAPPROVED). 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED		
		245387	B. WING	B. WING 08/19/2				
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE		
F 225	On 1/3/13, the elop Hennepin County a discharge after 41 of the resident left the not reported to the	ement was reported to is "against medical advice days." It was unclear what day building. The elopement was SA for eight months. The rt the elopement after the	F 2	225				
	noted 598 to have of with ascites (enlarg the abdomen), a his	dmission record dated 7/24/12, diagnoses of liver cirrhosis led liver with fluid backup into story of heart bypass surgery, ilure (fluid backup into the feet etes.						
	risk of falls due to le transitions. R598 h	d 8/1/12, noted R598 had a oss of balance during ad verbally abusive behavioral d threatened and screamed at						
	on 1/3/13, accordin Suspected Abuse of form. R598 left in the stating "get me the	y (elopement), without orders g to the (un-timed) Report of or Neglect of Vulnerable Adult ne company of his daughter (profanity) out of here." R598 e facility. The facility did not nt to the SA.		5				
-	data base diagnose hypertension, learn	on 8/14/12, with admission es of chronic kidney disease, ing difficulty, homelessness, te and disruptive behavior.						
		9/13, indicated R85 was ad independent in all activities		-				

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A- WARE ARE 22		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING				C 19/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	ST OLAF RESIDENCE				912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 30	F 2	25			
	self-care deficit, so	ated 8/5/13, indicated a cially inappropriate behavior in illed and threw things), and medications.					
*	(elopement) during according to the (un Abuse or Neglect o unclear when the a (un-timed). It was u to Hennepin County was added to say the facility on 1/9/13, at was updated on 1/1 of a police report of	g without signing out the evening on 1/8/13, n-timed) Report of Suspected f Vulnerable Adult form. It was dministrator was notified unclear when it was reported y (un-timed) and a statement he resident returned to the t 7:00 p.m. Hennepin County 10/13. There was no indication f a missing person report being d not report the elopement to					
	have diagnoses wh fractures from a fall backup into the lun	dmission Record noted 597 to ich included multiple rib I, congestive heart failure (fluid gs), chronic obstructive (lung disease), diabetes, and					
	No assessments w	ere completed for R597.					
	An admission care R597 used a cane	plan dated 1/28/13, indicated to ambulate.					
	stay" (elopement) o (un-timed) Report o	y, "stating he did not want to on 1/30/13, according to the of Suspected Abuse or Neglect form. The facility did not nt to the SA.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A STANDARD		E CONSTRUCTION	CON	E SURVEY
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 31	F 2	225			
	impaired cognitive s decisions poor, cue required extensive a and transfers, exter dressing, personal A care plan for R89 provided. R89 left the facility (un-timed) Report of of Vulnerable Adult (elopement) after b for a leave of abser facility. That was re nursing (DON) on 2 report the elopement R55 left the facility f The MDS dated 4/2 cognition. R55 required	2/20/13, indicated moderately skills for daily decision making- s/supervision required. R89 assist of two with bed mobility hygiene and toilet use. was requested and not on 2/25/13, according to the of Suspected Abuse or Neglect form. R89 left with his family eing told there were no orders he, he did not return to the ported to the director of 2/25/13. The facility did not int to the SA.					
	required assist of o and toilet use, supe up for personal hyg Mental Status (BIM score of 15/15 - wh On 4/25/13, at 11:0 building but did not On 4/26/13, at 8:00	ne with bed mobility, dressing ervision with transfers, and set iene. The Brief Interview for S) 4/24/13, indicated a BIMS ich depicted intact cognition. 0 a.m. R55 signed out of the return (first elopement). a.m. a Report of Suspected f Vulnerable Adult form was					

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	PLE CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
NAME OF I	PROVIDER OR SUPPLIER	<u>t</u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE	2. 				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
F 225	4/26/13, at 8:33 a. was notified (un-tir resident not back i medical advice dis (undated and un-ti evening hours" (ur to the facility and H were notified of the not reported to the	m. the medical doctor (MD) med) and gave parameters if in 24 hours to do an against scharge. Police were notified med). On 4/26/13, "in the n-timed) the resident returned Hennepin County and Police e return. The elopement was a SA.	F 22	5		
	Suspected Abuse form, R55 left the did not return (sec County was notifie report to the police attached to the for the resident return	ing to the (un-timed) Report of or Neglect of Vulnerable Adult facility without supervision, and ond elopement). Hennepin d on 5/7/13, at 2:08 p.m. a e (undated and un-timed) was m. On 5/7/13, at 11:34 p.m. ed to the facility. The t reported to the SA.				
e,	5/31/13, R595 was which included bi-p	dmission Record dated noted to have diagnoses polar adjustment disorder o assessments were				
	not return to the fa the Report of Susp Vulnerable Adult fo 6/3/13, at 8:00 a.m notified on 6/3/13, the elopement) and	vere going for a walk and did cility (elopement), according to bected Abuse or Neglect of orm which was dated Monday a. Hennepin County was at 8:00 a.m. (three days after d the police were notified med). The elopement was not				
	Documentation for provided.	R595 was requested and not				

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.		CONSTRUCTION	CON	E SURVEY
		245387	B. WING				C / 19/2013
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAI	FRESIDENCE			- 65	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 33	F 2	225	5		
	identified for abuse report immediately SSD, Hennepin Co an allegation of abu the investigation wa results of the invest administrator, Henr the late reporting w state that she had of education on how to continued to work w since the staff wait further stated that se administration not to the SA, even thoug situations. The SSD improvement of the grievance log. The DON investigated of and the SSD invest resident to resident sexual abuse, corp investigated. When resident altercation the policy, the SSD policy you'll need to and DON. On 8/12/13, at 7:55 reported and non-re was made to the fa nursing O-G and St identified during sta surveyors. O-G staff available for review not surprised by the	a.m. the SSD (the person concerns) stated staff would to administrator, the DON, unty and the SA. If there was use, staff were removed until as completed, and then the tigation were reported to hepin County and SA. When as discussed, the SSD did created and provided oreport for the staff, but she with them on timely reporting for her to report. The SSD she had been directed by prior oreport the above cases to h she questioned the D had been working on a buse tracking log and the SSD further stated that the complaints against the staff tigated the others, such as altercations. All allegations of oral punishment, etc. would be a sked why the resident to s and elopement were not in stated that's a corporate o speak to the administrator p.m. a request for all of the eported Vulnerable Adult forms cility administrator, director of SD-A, as abuse had been age one survey by all four ted they would have the files in the morning, and she was a request. p.m. administrator and O-G					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/11/201 APPROVEI 0938-039
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		COM	E SURVEY IPLETED
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	00/	10/2010
07 OL 41	- BEAIDENAE			2912 FREMONT AVENUE NORT	ſН		
STOLA	F RESIDENCE			MINNEAPOLIS, MN 55411			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 225	were notified of IJ, supervision and lac Wanderguard for F abuse policy were between State and policy was explained paragraph titled sitt defines therapeutic allowable in the feo statement of conse- relationship whether giver relationship of was identified as st mistreatment was i language. In addition statement of reside elopements as pote facility policy conta contained signs an neglect, the facility abuse and neglect the policy or appen neglect and failed t even when it report The administrator st Ecumen corporate have corporate ma 8/16/13 at 8:43 a.m for abuse concerns immediately to adm SSD-A, Hennepin G allegation of abuse investigation was c Administrator, Hen results of the inves reporting of eloper did state that she h	age 34 explained F323 was due to ck of system with the R45. The particulars with the reviewed, and the difference Federal language in the abuse ed. The facility policy contains a uations that are not abuse and conduct, which was not deral language, and included a ensual sexual personal er it existed prior to the care or not. The word maltreatment tate language and the word identified as the federal on the policy lacked a ent to resident altercations or ential abuse or neglect. The ined an Appendix (B) that d symptoms of abuse and failed to operationalize the policy and report events that dix identified as abuse or to report to the state agency ted to Hennepin County. stated the policy was an policy and they would need to ke any changes to the policy. h., SSD-A the person identified a stated staff would report ninistrator, the O-G and County and the SA. If e staff were removed until the complete, then report to nepin County and the SA the tigation. When the late nents was discussed SSD-A nad created and provided to report for the staff, but she	F 2	225			

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		AND HUMAN SERVICES				FORM	D: 09/11/201 APPROVE D: 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00025252327				TE SURVEY MPLETED
		245387	B. WING)		08	C / 19/2013
NAME OF	PROVIDER OR SUPPLIER	k		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	continued to work of since they wait for that she had been not to report the ab (provided by the fa- to the SA, even the SSD-A had been we abuse tracking log, further stated that the investigated compli- investigated compli- investigated the oth resident altercation abuse, corporal pu- investigated. When resident altercation the policy, SSD-A spolicy you'll need to and O-G." -At 9:30 a.m. SSD involved with the el- brought up in the III meetings. SSD-A mood and behavior The Elopement Assidated as revised of policy was to assess potential risk factor identified, "All resid admission and ann resident determine will be assessed que the completion of the Assessment [Risk Review]." The polic appropriate interve- bottom of the form, "elopement preven	age 35 with them on timely reporting, her to report. SSD-A stated directed by prior administration pove elopement cases cility in the non-reportable file) bugh she questioned that. vorking on improvement of the and the grievance log. SSD-A the director of nursing aints against the staff and she hers, such as resident to is. All allegations of sexual nishment, etc. would be a sked why the resident to is and elopement were not in stated "that was a corporate of speak to the administrator -A stated to surveyor she was opements when they were DT [interdisciplinary team] verified she completed the r sections of the care plan. sessment policy and procedure in 5/15/13, identified the facility as each resident to identify is for elopement. The policy lents will be assessed on ually for elopement. That d to be 'at risk' for elopement uarterly." The policy directed he "Elopement Risk of Elopement Risk of Elopement Risk of Elopement Care plan." tion/management care plan." lirected, "8. If Wanderguard is	F	225			

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
ST OLAF RESIDENCE				2	912 FREMONT AVENUE NORTH		
				N	/INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	an intervention. Tes [sic] working proper 9. Implement signal test Wanderguard of tested and working. The Ecumen Incide dated August 2003, September 2011, re 1. An incident repor incident occurs. An actual or potential in Incidents include, b observed or unobse altercation between non-resident, elope without following fac trauma or physical, Incidents also includ source. An injury of when 1) the source by any person or the not be explained by is suspicious becau or the location of the injury is not located vulnerable to trauma one particular point injuries over time. 2. A separate incide involved in an incide 3. As soon as possi licensed employee of completes the first p Report (LPN, RN, s etc.). Incidents of su defined in Ecumen's reported to the direct	et Wanderguard to ensure it rly before putting on resident. ling device testing calendar, daily and sign daily that it is "" ent Reporting-Resident policy and last reviewed and revised evealed: t is completed whenever an incident is defined as an	F2	225			

Facility ID: 00260

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		AND HUMAN SERVICES					APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			.E CONSTRUCTION (.	COM	E SURVEY PLETED
		245387	B. WING			08/1	C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
	DEGIDENOE			2	912 FREMONT AVENUE NORTH		
STOLAP	RESIDENCE			N	INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	Sec. 6. 19	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From pr	27	-	005			
1 225	Continued From pa		F2	225			
	complete the "Post	our. Follow-Up. An RN must					
		on the Resident Incident					
	Report is recorded						
		d and timed. Signatures on the					
		ude full name and title.					
		family members and physician					
		ely fashion of the incident. sident's physician, and					
		ardian or interested family					
	member are notif	fied as soon as possible if					
	there is:						
		volving the resident which					
		has the potential for requiring					
	-A significant c	hange in the resident's					
		r psychosocial status (i.e. a					
		alth, mental, or psychosocial					
		threatening conditions or					
	clinical complicatio						
		r treatment significantly (i.e., a e an existing form of treatment					
		isequences, or to commence a					
	new form of treatm						
		ransfer or discharge the					
	resident from the fa						
		ort remains on the unit for 24					
		ompletion of the report which					
	incident report is ke	o the DON. The signed original ept in separate file as				0	
		ity (do not copy or place					
	incident form in the	resident's medical record).					
		sidents or suspected					
		ents, a Resident Incident					
		d IN ADDITION to following					
		ent" policy and procedure issing residents, suspected or					
	actual elopement o						
	must be reviewed f	or possible neglect pursuant to					

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATI COM	E SURVEY PLETED
		245387	B. WING	;	2		C 19/2013
	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		9
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL P			IX S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa the facility Abuse P		F 2	225	5		
		ty employee had bumped her ation cart on 5/11/12.					
	admitted to the faci diagnoses included (CVA) with left hem disease, unspecifie neuropathy, periphe unspecified, adjust disturbance of emo osteoarthrosis gene sites, blindness one sickle-cell disease	eralized involving multiple e eye not otherwise specified, unspecified, diabetes mellitus e II and unspecified drug			2		
	BIMS was 11 out of cognitive patterns. Care Area Assessmi identified R18 was decisions in a struct relay on her sisters complex medical de	dated 4/2/13, indicated R18's f-a possible 15 points for The Cognitive loss/dementia nent (CAA) dated 4/2/13, able to make appropriate stured setting, continued to and brothers to help make ecisions and had resident had ges in cognition since previous					
	risk for harm from s	ted 4/16/12, identified R18 at self or others with goal "will n or injury from self or					
		on 8/12/13, at 3:53 p.m. s of abuse by a facility					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	C. Commence		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
ST OLA	FRESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	employee. R18 indi her foot on the med a lot of pain and sh the hospital. R18 st asked a lot of quest nothing had been d around me to provid afraid of this staff e hair. I now have to comb my hair, when now she always con also added "I have her in trouble most especially with staff On 8/12/13, at 5:16 allegations to the fa nursing (O)-G, regis all at the time in O R18's complaint ha and was considered R18's care plan had making fools allega this case when she run over her toe. SS the incident had had investigation was st was sent out to the evaluation related in temp, and redness meeting the admini- this allegation to SA During review of the indicated: R18 had evening shift that st medication cart on was getting her into	cated that NA-H had bumped dication cart which resulted to e had been also admitted to ated "after the incident I was tions but as long as I knew one as the staff still comes de care, am very scared and ven to ask her to comb my wear my wig as am not able to n she comes into my room mes with another staff." R18 a big mouth and this would get of the time in the facility "" p.m. surveyor reported the ncility administrator, director of stered nurse (RN)-A, and SSD G office. SSD-A stated that d been received, investigated d not reportable to the SA and d been updated with focus for tions about staff which fell in made the allegation staff had SD-A further added to say that	F	225			

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						FORM): 09/11/2013 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	CON	TE SURVEY
		245387	B. WING	÷		C 08/19/2013	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STOLAF	RESIDENCE				2912 FREMONT AVENUE NORTH		
					MINNEAPOLIS, MN 55411		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 40	F	225	5		
					-		
	some edema and c	continued complaint of pain to					
							4
							2.5
	pronounced degene	erative changes within the				FORM OMB NO (X3) DAT COM 2007 ZIP CODE TH F CORRECTION CTION SHOULD BE O THE APPROPRIATE	
	AN OF CORRECTION IDENTIFICATION NUMBER: 245387 OF PROVIDER OR SUPPLIER LAF RESIDENCE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						
	witnessed the resid	ent getting her foot bumped					
	SES FOR MEDICARE & MEDICAID SERVICE OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER 245387 ROVIDER OR SUPPLIER RESIDENCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Continued From page 40 The resident nor any other staff reported this the nurse at the time the resident says her f was bumped. On 5/13/13, AM shift an order received from the MD to complete an x-ray or some edema and continued complaint of pa the left foot. The x-ray was taken on 5/13/13 the tibia/fibular (Leg bones) which was nega for a fracture but indicated there are rather pronounced degenerative changes within th knee. Staff interviews were conducted for th staff that had been in the area when the res says her foot was bumped reported they har witnessed the resident getting her foot bump on 5/11/13, nor did the resident report this to staff at that time. On 5/13/13, R18 was interviewed and continued to complain of pa the left foot. The left foot was inspected no bruising was noted but the ankle area was s swollen. Several orders were given by the provider in relation to addressing the pain bu eventually on 5/18/13, at 0025 the resident v sent to the emergency room (ER) due to left ankle pain, edema (swelling) and with a low temperature. R18 was admitted to the hospi cellulitis of the left lower extremity, Gout and chronic kidney disease. On the investigation was determined there was no abuse or negl found. The investigation was signed by administrator, SSD-A, consultant director of nursing (O)-D and interim director of nursing On 8/16/13, at 12:51 p.m. interviewed O-D s "resident reported the incident on the 13th Monday and started the investigation for th						
	interviewed and cor	ntinued to complain of pain to					
	provider in relation	to addressing the pain but					
		일부는 물건 가지 않는 것은 것을 알았는 것을 물건 것을 많은 것을 잘 못했다. 같은 것을 것을 것 같아요. 가지 않는 것 같아요. ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ?					2
							1
	temperature. R18 w	vas admitted to the hospital for					
	found. The investigation	ation was signed by				FORM OMB NO. (X3) DAT COM (X3) DAT COM 2004 TCOM TION SHOULD BE THE APPROPRIATE	
		menin director of hursing.					
	allegation." O-D als	o stated the issue was not					

Facility ID: 00260

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		AND HUMAN SERVICES				FORM): 09/11/2013 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	B. Same		E CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		245387	B. WING				C / 19/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	10/2010
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECT		(95)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 41	F 2	225	5		
	was brought to the decided it was not r of the night when it never said anything changed her story. she believed it was NA-H involved in th off the schedule due later given verbal co Although the facility the SA about NA-H never addressed in on 8/12/13, R18's re afraid of the caregiv able to ask for assis caregiver continued R23 alleged a facilit during cares. The resident admiss admitted to the facil diagnoses obtained 6/24/13, included C hemiplegia, diabete hypertension, and s The MDS dated 6/2 was 10 out of a pos patterns. The vulner identified R23 was a others related to CV	did report R18's allegation to bumping her foot, the facility the report submitted to the SA eport of being scared and ver to the point of not being stance with cares as the I to provide cares to R18. ty staff had been aggressive sion record indicated R23 was lity on 10/27/08. R23's from the quarterly MDS dated VA with right sided s type II, depression,					
	other"	or injury from self or on 08/12/2013 4:38 p.m. R23					

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		AND HUMAN SERVICES					FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 80 - 836		PLE CONSTRUCTION G		СОМ	E SURVEY PLETED
4		245387	B. WING	÷			~~~	C 19/2013
NAME OF F	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZI	P CODE	00/	10/2010
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD	BE	(X5) COMPLETION DATE
F 225	stated "This aide I of and left me in the to Pulls me and never right side and she at toilet. I told the head On 8/12/13, at 5:16 allegations to the fa RN-A, and SSD-A at the end of the meet SSD-A to report this immediately. During review of int was noted that the never statement indicating Resident was able to stated "approximate hard with me transfe this because I am be country, she is rude I am not her father. had not worked with interviewing NA-H se issue with resident. frequently took care morning person. Th unsigned note indic incident happened r using an EZ-stand (staff assisting with t use extra momentu gained strength. Th was validated, staff was present and no On 8/16/13 at 12:25 stated all complaints immediately to the S	don't know her name came pilet. She is also aggressive. really cares. I cannot use my always leaves me alone on the d nurse." p.m. surveyor reported the cility administrator, O-G, all at the time in O-G office. At ing the administrator asked a allegation to the SA ernal facility investigation it resident had made a g aid was rough handling him. to identify NA-H, R18 also ely a month ago she was too erring me off the toilet, she did lack, we are from the same e, I have daughters of my own, "Resident also stated NA-H in him since the incident. Upon the stated she never had any Resident also stated NA-H of him and that he was not a e follow up undated and ated that during the time the resident was transitioning from machine used to transfer) to ransfers and staff needed to m with belt to pivot as resident e note indicated no abuse was met with and education disciplines on file.		225				
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6QVR1	1	Fa	acility ID: 00260	continuation	sheet Da	12 of 201

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	CON	TE SURVEY MPLETED
		245387	B. WING				C / 19/2013
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
STOLA	RESIDENCE				2912 FREMONT AVENUE NORTH		
31 OLAI	RESIDENCE				MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	employee is supposed schedule pending in R23's allegation of 8/14/13 after international by nursing departmes ubmitted investigation of directly received. Set to report more than from the previous a she was educating immediately and not on 08/16/13, at 9:3 stated resident compared to report it to and decided if they. On 8/16/13, at 1:11 she went immediately upon restaff who report it to and decided if they. On 8/16/13, at 1:11 she went immediately upon restaff who report it to and decided if they. On 8/16/13, at 1:11 she went immediately upon restaff who report it to and decided if they. On 8/16/13, at 1:11 she went immediately upon restaff who report it to and decided if they. On 8/16/13, at 1:11 she went immediately upon restaff who report it to state after she had reported to facility the nursing assistant "Pa", he was okay wanted the aide to restate after she had been abuse issue going on." Su issue " was specifie SSD-A around at th was treated different and verified facility culture and that all to state after she had been abuse issue going on." Su issue " was specifie SSD-A around at th was treated different and verified facility culture and that all to state after she had been abuse issue going on." Su issue " was specifie SSD-A around at th was treated different and verified facility culture and that all to state after she had been abuse issue going on." Su issue " was specifies SSD-A around at th was treated different and verified facility culture and that all to state after she had been abuse issue going on." Su issue " was specifies SSD-A around at th was treated different and verified facility provide the to state after she had been abuse issue going on." Su issue " was specifies SSD-A around at th was treated different and verified facility provide the to state after she had been abuse issue going on." Su issue " was specifies SSD-A around at th was treated different and verifies facility provide the to state after she had been abuse issue going on the to state after she had been abuse issue goingo	During the investigation the sed to be removed from the nivestigation. SSD-A verified abuse was reported on al investigation was completed tent. SSD-A stated that she tions when she was told to do implaints that she had not SD-A further stated she what's she is being allowed to report idministrator directions and staff on reporting to the SA of waiting for her. 0 a.m. interviewed RN-A implaints were investigated eporting all allegations to the ormanagement to follow up needed to be called to the SA. p.m. interviewed O-G stated ely to resident after surveyor ility about issue and started	F	225			

Facility ID: 00260

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		AND HUMAN SERVICES			FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATI COM	E SURVEY PLETED
		245387	B. WING			C 19/2013
NAME OF I	PROVIDER OR SUPPLIER	*		STREET ADDRESS, CITY, STATE, ZIP CODE		
STOLAD	RESIDENCE			2912 FREMONT AVENUE NORTH		
STOLA	RESIDENCE			MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa same.	ige 44	F 22	5		
F 226 SS=F	Ecumen's Abuse Pr Skilled Nursing faci "Immediately* cond investigation and de Incident Form(s) and Records. " The pol alleged violations a were to be reported the facility was to a determine what cha policies and proced occurrences. The fact the same nursing a residents that she a accordingly. Addition language and not fact 483.13(c) DEVELO ABUSE/NEGLECT. The facility must dee policies and proced mistreatment, negle and misappropriation This REQUIREMEN by: Based on observat review, the facility fac included resident to elopements and im reporting timely to t 2 residents (R41, R altercations, 7 of 7	becumenting findings on the ad Resident(s) Medical licy lacked directions that all and all substantiated incidents to the State Agency and that nalyze the occurrences to anges are needed, if any to lures to prevent further acility failed to investigate why assisted and analyze the cause onally the policy used state ederal terms. PP/IMPLMENT , ETC POLICIES	F 220	5		

Facility ID: 00260

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second second		(X3) DATE	0938-0391 SURVEY PLETED
		245387	B. WING _		08/	C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		13/2013
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETION DATE
	residents (R56, R8 origin. This had the residents residing in Findings include: Review of facility po Prevention Plan for Facilities dated 06// direction for residen for elopement. In a "This facility has an suspected maltreat who has reason to is being or has bee knowledge that a vi a physical injury wh explained, shall imm information to the o	7) with bruises of unknown potential to affect all 66 in the facility. Dicy titled, "Ecumen's Abuse Minnesota Skilled Nursing 06/13, lacked evidence of int to resident altercations and didition, the policy directed internal reporting system for ment. A mandated reporter believe that a vulnerable adult in maltreated, or who has ulnerable adult has sustained ich is not reasonably mediately report the irector of nursing (DON). If the	F 22	F 226 1. Corrective Action: A) Resident #41, 8 87, 13, 18, 56 a their Incident R chart reviewed Care plans were accordingly. B) Resident #18 ha incident from 5 the medication foot reported to Agency/CEP or C) Resident #23 ha incident related allegation of sta reported to the	 a, 8, 82, 1, and 23 had by an RN. e updated ad her /13 related to cart and her the State a 8/12/13. ad his to the aff abuse State 	
	DON is absent, it shall be reported to the DON's designee and if no designee then the facility nursing supervisor. The facility professional who receives the report of suspected maltreatment is then responsible for immediately reporting the maltreatment to the facility Administrator or the Administrator's designee, the Minnesota Department of Health and the common entry point (CEP) as decided in this section." On 8/12/13, at 7:55 p.m. a request for all of the reported and non-reported Vulnerable Adult forms was made to the facility administrator, DON and social service designee (SSD), as abuse had been identified during the stage one survey by all four surveyors. The DON stated they would have the files available for review in the morning, and she was not surprised by the request.			Agency/CEP or D) Residents #55, 597, 598 and 59 longer residents Olaf's facility. E) Resident #45 ha wander guard d is placed in the of his w/c. His reflects the use wander guard. 2. Corrective Action a to Other Residents: A) All residents ha potential to be a these deficient p	 85, 89, 595, 99 are no 99 are no	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Maria Conservation	TIPLE CONSTRUCT			SURVEY
			A. BUILD	NG			
		245387	B. WING	and the second second			9/2013
NAME OF I	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT MINNEAPOLIS	AVENUE NORTH S, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	abuse policy were r and DON. The polic resident to resident potential abuse or r The facility policy or contained signs and neglect. The facility abuse and neglect policy or appendix if and failed to report elopement to the S. The administrator s Ecumen corporate have corporate mai R41 was identified sexually inappropria were found by facili encounter on 6/1/1 immediately reporte was not thoroughly potential resident to On 6/1/13, at 6:30 indicated, "Residen room engaging in a resident [R81], whe stated 'Get out, Re note indicated the v service designee (S were notified via te message left for the On 6/2/13, at 1:00 R41 had "no sexua noted. A note at 5:0	eviewed with the administrator cy lacked a statement of altercations or elopements as neglect and reportable events. ontained an Appendix (B) that d symptoms of abuse and failed to operationalize the policy, report events that the identified as abuse or neglect incidents of abuse or A. stated the policy was an policy and they would need to ke any changes to the policy. by the facility as having ate behaviors, R41 and R81 ity staff during a sexual 3; the incident was not ed to the administrator, ed to the State agency and investigated to rule out or resident mistreatment. p.m. R41's Nurse's Notes at [R41] was witnessed in his a sexual act with another en door opened, this resident spect our privacy'! [sic]" The weekend supervisor, the social SSD) and nurse practitioner lephone, or had a voice	F 2		 B) The Wander Guard policy has been revisinclude how to check the device and syster functioning. C) The Missing Reside policy was reviewed D) The Abuse Prevention has been revised to immediate reporting language and report elopements. E) A Resident to Reside Altercation policy hadded to abuse prevention added to abuse prevention. F) Staff and Resident of were educated that residents must sign sign back in when the leave the facility. G) All facility staff has educated on the rever Wander Guard politation of the Missing Reside and resident sign of at reception desk. Date of Completion: 10 Reoccurrence will be Prevention Herever added to a server added to a server and resident sign of at reception desk. 	ised to ok that em are ent d. ion Plan include g ting of dent has been vention Council all out and hey s been ised cy, the Plan, the policy, nt Policy ut book	7

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

		AND HUMAN SERVICES			FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A STATE OF A STATE OF	TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED C
		245387	B. WING			19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 226	Although the clinical monitored for sexual the incident on 6/1/ evidence the admin were notified immed the incident was inv	age 47 al record indicated R41 was al activity and behaviors after 13, the clinical record lacked histrator and State Agency (SA) diately and lacked evidence vestigated to determine if the consensual between both	F 2	B) Random aud completed w then monthly	veekly x 4 and y X3 with presented to mittee for lanning.	
	(DON), registered r RN nurse consultar Notes on 6/1/13, wh having a sexual end The DON stated sh aware of whom (the unclear. Information requested. The RN "Fall Tracking" log a recorded there. On 8/19/13, at 2:12 SSD met regarding DON verified R41 v engaging in a sexua The SSD and DON R81 with R41, the r they were left alone supervisor was noti The DON and SSD guardians and fami practitioners (NPs) the DON and SSD oriented and able to stated R81 had a m "15 [even though th score and moderate	2 a.m. the director of nursing nurse manager (RN)-A, and nt were notified of the Nurse's hich indicated R41 was found counter with another resident. he believed she "may be" e other resident was), but was n regarding the incident was nurse consultant checked the and stated the incident was not p.m. the surveyor, DON and R41's 6/1/13 incident. The was found by facility staff to be al act with R81 in R41's room. stated when staff discovered residents requested privacy, e in the room, the nurse ified and the SSD was called. stated both of the residents' ily were contacted; nurse for both were updated. Both stated R41 was alert and o make "that choice" and hental illness, R81's BIMS was he last BIMS indicated a lower e impairment]." Both stated a mental illness, R81 was able		3. The Correction V Monitored by: B) Director of N Designee		

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		AND HUMAN SERVICES				FORM	D: 09/11/2013 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. W	NG	<u></u>	08	C /19/2013
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CC		
STOLAS	RESIDENCE			2	2912 FREMONT AVENUE NORTH		
STULAP	RESIDENCE			1	WINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PR	id Efix 'Ag	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	guardian was okay guardian referred th health worker. The worker was more fa with R81 "through th DON stated R81 was history of sexual act report was complete DON stated R41's of was "latent" and it w having problems as and staff did not ob stated the facility was for genital herpes) th called and notified th she received the vot incident, but was un DON and SSD both was completed after notified and verified contacted. Although investigated to deter felt the incident was residents being "co R8's Resident Adm indicated R8 had di disorder with depre muscle spasm, infa hemiplegia (loss or the body), contractor control), and narcis anti-social traits. The resident had a physical abuse that the facility by a call Hennepin County M	sent." Both staff stated R44 with the contact and R81's the question to R81's ment SSD stated the mental he amiliar with R81 having wo the commitment process." as identified to have a "lon ctivity." Both verified no incl ted regarding the incident. diagnosis of genital herpes was unclear if he was actu is he completed his own ca oserve his genitalia. The Di as ordering a HSV test (a for R81. The SSD stated so the administrator as soon bicemail and was aware of inclear when that was. The in confirmed no investigation of the administrator was d at no time was the SA h the incident was not ermine resident consent, b is not reportable due to both	1's sal alth orked gident The sally ures ON test she as the on oth th 08, s, le of cle with nd from the isis	F 226			
FORM CMS-2		and/or behavioral program		Fa	acility ID: 00260 If cor	ntinuation sheet	Page 49 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. C.		E CONSTRUCTION	COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			1.000	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE				INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	for R8 to prevent re abuse to staff and p R8's care plan initia vulnerable adult at inappropriate behar related to nursing h staff, verbally abus cares, disruptive be swearing and yellin arguing with staff a very impulsive and residents, verbally cares, received and and anti-anxiety me plan indicated R8 h perseverate on me glasses, etc. Interv choices, remind hir appropriate or acce and re-enforce his Remove him to his needed, set limits w he was verbally ag remind him to spea crisis (intervention more space betwee and fellowship hall, listen to concerns, efforts to be a gent outcomes. Discuss throughout his life; positively impacted away). Kill with kind following as neede puzzles. Inform re Complete vulnerab continue to post ab	ated 9/29/08, indicated risk for harm to self or others, vior and altered mood state nome placement, anger with ive/name calling, refusing ehaviors in common areas, g in dining room, physically nd others. R8 was noted to be easily angered by other abusive and resistive with ii-psychotic, anti-depressant, edication as needed. The care	F2	226			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	198 - Concerner			(X3) DATE COM	E SURVEY PLETED
		245387	B. WING			08/1	; 19/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	annually trained on plan included repor County but lacked of The significant char dated 6/7/13, revea Status (BIMS) scor moderate cognitive evidence of delirium that comes and goo assistance and two bed mobility and tra of one person for d toileting, and locom independent in loco indicated R8 had ve towards others one behaviors one to th period. The Care A triggered behaviora	ge 50 abuse reporting. The care ting abuse to Hennepin direction to report to the SA. nge Minimum Data Set (MDS) led a Brief Interview for Mental e of 11/15, which indicated impairment and included n - psychomotor retardation es. R8 required extensive person physical assist with ansfers, extensive assistance ressing, personal hygiene, notion off the unit, and was perbal behaviors directed to three days and physical ree days in the look back rea Assessment (CAAs) al symptoms, which was not AAs narrative summary.	F 2	226			
	8/27/12, going forw noted: - On 8/27/12, during television (TV) in the struck R78 on the h (cm) by 1.5 cm bru watching a TV prog came into the dinin TV, I told him I was and would change started yelling at m room, but he hit me to his room and at nurse that R8 had a SA on 8/28/12 (one	s for R8 were reviewed from ard and the following was g an altercation over the third floor dining room, R8 nand leaving a 3.0 centimeter ise. R78 stated he "was gram at 7:00 p.m. and [R8] g room and wanted to watch already watching a program it at commercial time, he [R8] e so I tried to go back to my on my hand!." R78 returned 10:30 p.m. reported to the floor struck him. The report to the a day late), indicated a 2N) responded to yelling in the					

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		AND HUMAN SERVICES				PRINT FOI OMB N	RM	APPR	OVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) I	DATE Comi	E SURVI	EY
		245387	B. WING	·) 1/80) 19/201	13
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE		COMPL	(5) LETION ATE
F 226	dining room and sa prevent R8 from ch report was submitted stated "I got so may report indicated R8 aggressive behavior residents at the num house psychologist psychiatrist in the of care plan, they are themselves, move to safety and call 9 unit if R8 was non r also spoken with th regarding alternative that would better su will make a referral more appropriate e - On 9/9/12, (un-tim R599 attempted to something off the fl R599 to move out of move fast enough, R599 in the arm and the way. The incide 9/10/12 (one day la submitted 9/13/12, interventions were aggressive behavior Residents were imm was asked to lower incidents at the fac place for R8, staff v send R8 to HCMC unmanageable." Th requesting Hennep to assess to see if group home setting	w a nursing assistant (NA) arging R78. The investigative ed 8/30/12, and noted R8 d that I just hit him!." The had a history of physically or towards staff and other rsing home. R8 had both in on an as needed basis and a community. Staff followed the to protect residents and other residents away from R8 11 to send R8 to HCMC crisis re-directable. The SSD had he primary doctor (MD) re placement in the community uit R8's behaviors. The SSD for relocation services for a		226	5				

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245387	B. WING	;		and the second sec	C 19/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH		
					MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 52	F 2	226	6		
	management.						
	"R8 did not agree w dining room that the changed and verba resident on 3rd floo dining room. The in	report at 8:00 p.m. revealed with other residents in the e TV channel should be ally threatened R76, another or that was present in the incident was reported to the SA					
	on 1/1/13 (one day	late).					
	interview with surve being slandered by abused her. R8 wa watching a movie,	p.m. R8 requested an eyor, and stated his name was a resident that said he had s sitting at a dining room table with his puzzle books and mail mbudsman name and phone ed to R8.					-
	have a verbal outbut slandering him, and forward repeatedly peer, staff intervent the resident who co R8 was again at a	p.m. R8 was observed to urst at the peer he said was d became agitated, leaning in his wheelchair, towards the ed and attempted to redirect ontinued his verbal outburst. third floor dining room table with his puzzle book nearby.					
	have a verbal outbut third floor, during th	p.m. R8 was observed to urst in the dining room on the ne dinner meal. The staff was R8 and the DON had to R8.					
	not aware of the ph not the appropriate had been attemptin 30 day discharge.	a.m. the SSD stated she was sysician comment that this was setting for R8, and stated she of to get ammunition to get a The SSD stated she had foral management plan for R8					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245387	B. WING	·			C 19/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 226	and was told to move the dining room, but go, because they and The SSD stated that refused to watch the was not aware that address physical ag 911 to remove R8 ff further stated that we restricted him to his into the facility and because the plan (we book) had not been further stated R8's was ill in May and J attempted to find of refused and stated family wants him he conferences, but sat this behavior." The recommendation we environment, but the misbehaving. When always take him out leave him here. On 8/12/13, at 5:200 SSD, and RN nurse verified that R8 had and struck R78, the 8/24/13, and was the County and the Stat they also verified that	ve the other residents out of t the other residents refuse to re not doing anything wrong. at R8 is very territorial and had e TV in his room. The SSD R8's care plan did not ggression other than the call to rom the facility. The SSD when R8 acts out and she had s room, she will come back find R8 in the dining room, written in the communication o followed by staff. The SSD behaviors dissipated when he lune 2013 and the facility had ther placement for him, but he he wanted to be here and the ere and participate in care ay "how can he get away with	F	226			
FORM CMS-25	attacked" other peo out of the building" times, received inpa	ople and had been "crisised (by calling 9-1-1) several atient psychiatric stays and s, and had been allowed back	1	F	- Facility ID: 00260 If continua	tion sheet P	age 54 of 298

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	中的一种38分的123		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245387	B. WING				C 19/2013
	RESIDENCE			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 54	F	226	5		
	8/20/12, noted R59 mental disorder, alt	dmission Record dated 9 had diagnoses of persistent tered mental status, diabetes, nee amputation, gait ctive drug abuse.					
j.	required assistance	d 9/19/12, indicated R599 e of staff to stabilize during ng to ambulation or for					
	medications during according to the Re Neglect of Vulnerat	y (elopement) without orders or the week of 11/23/12, eport of Suspected Abuse or ble Adults form. R599 was unknown date and time) edications.					
	Hennepin County a discharge after 41 of the resident left the not reported to the	ement was reported to is "against medical advice days." It was unclear what day building. The elopement was SA for eight months. The rt the elopement after the d.					
	noted 598 to have of with ascites (enlarg the abdomen), a his	dmission record dated 7/24/12, diagnoses of liver cirrhosis led liver with fluid backup into story of heart bypass surgery, ilure (fluid backup into the feet etes.					
	risk of falls due to lo transitions. R598 ha	d 8/1/12, noted R598 had a oss of balance during ad verbally abusive behavioral d threatened and screamed at					

Event ID: 6QVR11

Facility ID: 00260

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	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		TE SURVE	
	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED	
		245387	B. WING		08	C 8/ 19/201	3
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC			
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLI DAT	
F 226		age 55	F 226				
	others.						
	on 1/3/13, accordin Suspected Abuse	y (elopement), without orders ng to the (un-timed) Report of or Neglect of Vulnerable Adult					
		he company of his daughter e (profanity) out of here." R598					
	did not return to the	e facility. The facility did not					
	report the elopeme	ent to the SA.					
	Doc						
	data base diagnos hypertension, learr	on 8/14/12, with admission es of chronic kidney disease, ning difficulty, homelessness, ate and disruptive behavior.					
		19/13, indicated R85 was nd independent in all activities		×			
	self-care deficit, so	ated 8/5/13, indicated a ocially inappropriate behavior in elled and threw things), and medications.					
	(elopement) during according to the (u Abuse or Neglect of unclear when the a (un-timed). It was to Hennepin Count was added to say to facility on 1/9/13, a was updated on 1/ of a police report of	g without signing out g the evening on 1/8/13, in-timed) Report of Suspected of Vulnerable Adult form. It was administrator was notified unclear when it was reported ty (un-timed) and a statement the resident returned to the t 7:00 p.m. Hennepin County 10/13. There was no indication f a missing person report being d not report the elopement to					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		ATE SURVEY
		245387	B. WING		08	C B/ 19/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 226	have diagnoses wh fractures from a fall backup into the lung pulmonary disease depression. No assessments w An admission care R597 used a cane R597 left the facility stay" (elopement) of (un-timed) Report of of Vulnerable Adult report the elopement R89's MDS dated 2 impaired cognitive a decisions poor, cue required extensive and transfers, exter	dmission Record noted 597 to ich included multiple rib I, congestive heart failure (fluid gs), chronic obstructive (lung disease), diabetes, and ere completed for R597. plan dated 1/28/13, indicated to ambulate. v, "stating he did not want to on 1/30/13, according to the of Suspected Abuse or Neglect form. The facility did not	F 220			
	A care plan for R89 provided.	was requested and not				
	(un-timed) Report of of Vulnerable Adult (elopement) after b for a leave of abser facility. That was re	on 2/25/13, according to the of Suspected Abuse or Neglect form. R89 left with his family eing told there were no orders nce, he did not return to the ported to the director of 2/25/13. The facility did not nt to the SA.				

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
		245387	B. WING			and the second se	C 19/2013
NAME OF F	PROVIDER OR SUPPLIER	kon en son al ness i "refer af fikserer ar referenden.			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	22.22	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 57	F 2	226			
	R55 left the facility	twice without supervision.					
	cognition. R55 requ mobility, dressing a transfers, and set u required assist of o and toilet use, supe up for personal hyg Mental Status (BIM score of 15/15 - wh On 4/25/13, at 11:0 building but did not On 4/26/13, at 8:00 Abuse or Neglect o filled out. Hennepin 4/26/13, at 8:33 a.m was notified (un-tim resident not back ir medical advice disc (undated and un-tim evening hours'' (un- to the facility and H	24/13, indicated intact lired assist of one with bed and toilet use, supervision with up for personal hygiene. R55 ne with bed mobility, dressing ervision with transfers, and set liene. The Brief Interview for S) 4/24/13, indicated a BIMS ich depicted intact cognition. 0 a.m. R55 signed out of the return (first elopement). a.m. a Report of Suspected f Vulnerable Adult form was a County was notified on n. the medical doctor (MD) hed) and gave parameters if a 24 hours to do an against charge. Police were notified med). On 4/26/13, "in the -timed) the resident returned ennepin County and Police return. The elopement was SA.					
	Suspected Abuse of form, R55 left the fa did not return (seco County was notified report to the police attached to the form the resident returned	ng to the (un-timed) Report of or Neglect of Vulnerable Adult acility without supervision, and ond elopement). Hennepin d on 5/7/13, at 2:08 p.m. a (undated and un-timed) was m. On 5/7/13, at 11:34 p.m. ed to the facility. The reported to the SA.					
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: 6QVR1	11	Fac	ility ID: 00260 If continuat	ion sheet F	Page 58 of 298

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT CON	E SURVEY
		245387	B. WING		-	10000	C 19/2013
	PROVIDER OR SUPPLIER	18.4		291	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 58	F 2	26			
	5/31/13, R595 was which included bi-p	dmission Record dated noted to have diagnoses polar adjustment disorder o assessments were					
	not return to the fact the Report of Susp Vulnerable Adult fo 6/3/13, at 8:00 a.m notified on 6/3/13, at the elopement) and	vere going for a walk and did cility (elopement), according to ected Abuse or Neglect of rm which was dated Monday . Hennepin County was at 8:00 a.m. (three days after d the police were notified med). The elopement was not					
	Documentation for provided.	R595 was requested and not					
	identified for abuse report immediately SSD, Hennepin Co an allegation of abu the investigation wa results of the invest administrator, Henn the late reporting was state that she had education on how to continued to work was since the staff wait further stated that so administration not to the SA, even thoug situations. The SSI improvement of the	a.m. the SSD (the person concerns) stated staff would to administrator, the DON, bunty and the SA. If there was use, staff were removed until as completed, and then the tigation were reported to hepin County and SA. When vas discussed, the SSD did created and provided o report for the staff, but she with them on timely reporting for her to report. The SSD she had been directed by prior to report the above cases to the she questioned the D had been working on e abuse tracking log and the SSD further stated that the					

Event ID: 6QVR11

Facility ID: 00260

If continuation sheet Page 59 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/11/201 APPROVE
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	DON investigated of and the SSD invest resident to resident sexual abuse, corpo- investigated. When resident altercations the policy, the SSD policy you'll need to and DON. Bruises of unknown R56's MDS dated 4 cognitive impairment disorganized thinkin assistance of one we eating, dressing, gritoileting. The CAAs	omplaints against the staff igated the others, such as altercations. All allegations of oral punishment, etc. would be asked why the resident to s and elopement were not in stated that's a corporate speak to the administrator	F 22	6		
	that appeared to be on 6/18/13. Six staf and education was proper repositioning determined "most li positioning during c incident report indic shoulder, above the was not reported to R87 was observed sitting and walking v investigate and repo bruises of unknown During observation was noted to have o knuckles of the left	on all days of the survey to be with R82. The facility failed to ort bruises for R87 who had				

1

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE				INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa she fell down the si	-	F	226			
	continued to have t and the right wrist a	on 8/15/13, at 9:16 a.m. R87 the bruising to the left knuckles and another 7 centimeter (cm) was noted to R87's left					
	On 8/19/13, at 10:0 have a dark purple inner forearm.	06 a.m. R87 was observed to , thumb sized bruise on her left					
	being at risk for ha to a diagnosis of de not identify risk for addition R87's care resistive to cares w "When resident be	tted 12/13/12, identified her as rm from self or others related ementia. The care plan does bruising or bleeding. In e plan indicated she was with an approach to include egins to resist care, STOP and ot force to do task."					
	R87 had both shor	DS dated 12/18/12, indicated t and long term memory derately impaired cognitive skills naking.	•				
	a 4 cm x 5 cm bru The immediate inter- monitor and redire from the nurse pra- indicated trial of G and to monitor are to grab hands, just Incident Report da indicated R87 was cm bruise on the l monitor skin daily	nt Report dated 3/27/13, noted ise to R87's outer left hand. erventions were noted as oct and requested Geri-sleeves actitioner. RN assessment eri-sleeves was unsuccessful eas and encourage resident not t hold hands. A Resident ated 6/14/13, 7:00 a.m. a noted to have a 1.5 cm x 2.5 eft wrist. Interventions noted to and monitor for and redirect olding arms/wrists to hold					

At BOILDING C 245387 B. WING 08/19/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 MINNEAPOLIS, MN 55411		OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY
245387 B. WING OB/19/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2P CODE STREET ADDRESS. CITY, STATE, 2P CODE STOLAF RESIDENCE SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS. CITY, STATE, 2P CODE Comparing the	AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	000	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. C/TY, STREE 2/P CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE MORTH IVAND SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDERS PLAN. OF CORRECTION ICAH DEFICIENCY PREFIX TAG PROVIDERS PLAN. OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX F 226 Continued From page 61 hands. F 226 Nurse's Notes were reviewed from 4/13 forward and the following was noted: - On 4/29/13, indicated more bruises noted to body, blue and yellow in color. The last Resident Incident Report was dated 37/21/13. - On 7/6/13, noted multiple bruises on both (unidentified area) remained. - On 7/20/13, indicated RS7 had old bruises on both lower arms. Review of the Resident Incident Reports and the Nurse's Progress notes revealed no documentation regarding these bruises. A Physician's Order dated 7/29/13, directed to monitor skin every shift and document new areas in the nurses notes. RA2's Behavior/Intervention Monthly Flow Record for August 2013, noted R82 was monitored for "abusive to others" which was noted as occurring two to three days on day shift from 6/7 to 8/12/13. When interviewed on 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. During an interview on 8/16/13, at 11:11 a.m. the nurse consultant (O)-D stated bruises are tracked on incident reports. On 8/19/13, at 2:09 p.m. the director of nursing was again asked for documenta			245387	B. WING		08	
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (X) ID PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED BY PLL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIX TAG PROVIDER'S PLAN OF CORRECTIVA (EACH DEFICIENCY) SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMELTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) COMELTION (EACH DEFICIENCY) <	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
Image: Proceeding of the processing	ST OLAF	RESIDENCE				ł	
 hands. Nurse's Notes were reviewed from 4/13 forward and the following was noted: On 4/29/13, indicated more bruises noted to body, blue and yellow in color. The last Resident Incident Report was dated 3/27/13. On 7/6/13, noted multiple bruises on both (unidentified area) remained. On 7/20/13, indicated R87 had old bruises on both lower arms. Review of the Resident Incident Reports and the Nurse's Progress notes revealed no documentation regarding these bruises. A Physician's Order dated 7/29/13, directed to monitor skin every shift and document new areas in the nurses notes. R82's Behavior/Intervention Monthly Flow Record for August 2013, noted R82 was monitored for "abusive to others" which was noted as occurring two to three days on day shift from 8/7 to 8/12/13. When interviewed on 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. During an interview on 8/16/13, at 11:11 a.m. the nurse consultant (O)-D stated bruises are tracked on incident reports. On 8/19/13, at 2:09 p.m. the director of nursing was again asked for documentation regarding assessment and intervention for R87's bruises noted throughout the survey and none was 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLETION
provided.	F 226	hands. Nurse's Notes were and the following w - On 4/29/13, indica body, blue and yell Incident Report wa - On 7/6/13, noted (unidentified area) - On 7/20/13, indica both lower arms. Review of the Resi Nurse's Progress r documentation reg A Physician's Order monitor skin every in the nurses notes R82's Behavior/Int for August 2013, n "abusive to others' two to three days of When interviewed licensed practical n were monitored in During an interview nurse consultant (on incident reports On 8/19/13, at 2:0 was again asked f assessment and in noted throughout the	e reviewed from 4/13 forward vas noted: ated more bruises noted to ow in color. The last Resident is dated 3/27/13. multiple bruises on both remained. ated R87 had old bruises on ident Incident Reports and the notes revealed no parding these bruises. er dated 7/29/13, directed to shift and document new areas s. ervention Monthly Flow Record oted R82 was monitored for ' which was noted as occurring on day shift from 8/7 to 8/12/13. on 8/14/13, at 9:19 a.m. nurse (LPN)-D stated bruises the Nurse's Notes. w on 8/16/13, at 11:11 a.m. the O)-D stated bruises are tracked s. 9 p.m. the director of nursing for documentation regarding ntervention for R87's bruises				
	FORM CMS.	2567(02-99) Previous Versior	ns Obsolete Event ID: 6QVR	11	Facility ID: 00260	If continuation shee	t Page 62 of 2

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second se	ECONSTRUCTION		TE SURVEY
		245387	B. WING	2		C /19/2013
NAME OF F	PROVIDER OR SUPPLIER		S1	REET ADDRESS, CITY, STATE, ZIP CO		113/2013
ST OLAF	RESIDENCE			12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 226 F 241 SS=D	resident's skin con policy was provided 483.15(a) DIGNITY INDIVIDUALITY	dition was requested but no	F 226 F 241		11	
	manner and in an enhances each res	environment that maintains or sident's dignity and respect in is or her individuality.		Canada and Statementation for characteristic in the statement of statement		
a.	by: Based on observa review, the facility t 1 of 1 resident (R6 dignified continenc	NT is not met as evidenced tion, interview and document failed to promote the dignity of 8) related to failure to provide e care, and failure to ensure opropriate fitting clean clothes				
	Findings include:					
•	at 8:30 a.m. provid (NA)-B. Without as assisted the reside pants that were loc stated she just not R68, as they were name and room nu and obtained anoth resident's closet th around the waist, a zipped. NA-B report in R68's closet. The pants partially unzi did not state wheth	tes were observed on 8/14/13, ed by a nursing assistant sking the resident, the NA ent to don a pair of very ill-fitting ose around the waist. The NA iced the pants did not belong to labeled with another resident's imber. She removed the pants her pair of pants from the at were too short and small and could not be buttoned or rted there were no other pants e resident left the room with his pped and unbuttoned. NA-B her the shortage of clothing had nurse or social service				

PRINTED: 09/11/2013

		AND HUMAN SERVICES			FORM	09/11/2013 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 Same	TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245387	B. WING			C 19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	CTION	(¥5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE	(X5) COMPLETION DATE
F 241	nurse (DPRN)-B wa 1:20 p.m. The RN r attended dialysis ar compliant with their	alysis program registered as completed on 8/14/13, at eported R68 regularly nd was generally quite expectations. The RN said he regarding the resident's	F 24	F241 1. Corrective Action: A) The Conservator Resident #68 w and has provide properly fitting	as contacted d him with clothing.	1
	personal hygiene a dirty clothing. There where the resident and there was fece When concerns we hygiene, they alway licensed practical n An interview was co 8/14/13, at 1:45 p.n received reports fro R68 being incontine up for his appointm on the way to dialys resident had dried f she had noticed that personal care seem stated R68 reported facility." An interview was co provider transportat 12:30 p.m. In a very TS reported that ap he had picked up R the resident was no entryway. The drive resident's room. Wi	nd unkempt appearance, and had also been incidents had been incontinent of stool s on the resident's walker. re noted with R68's personal vs reported the issue to the		 2. Corrective Action a to other residents: A) All resident potential to by this define practice. B) All resident needs have evaluated an obtained as C) Nursing state educated on expectation residents wir and appropridressed at al D) The Care Consummary for revised to reliber to quest clothing nee quarterly. E) Nursing stafe educated to Social Service whenever th has clothing she can cont 	s have the be affected cient s clothing been ad clothing necessary. If was the that II be clean iately I times. onference rm was mind the tion resident ds at least f was contact the ce Director e resident needs so	t

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387		PLE CONSTRUCTION	COM	E SURVEY PLETED C 19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 241	feces everywhere. room and observed wall and floor, as w Although the house supervisor observed acknowledged they	age 64 B's bathroom, as there was TS-A entered the resident's d feces all over the bathroom vell as on the bedroom floor. ekeeper and housekeeping ed TS-A enter the room, they v did not attempt to stop him. lying in bed in feces with	F 24	 the request. 3. Date of Completion: 4. Reoccurrence will be by: A) Random audits v 	10/3/2013 Prevented vill be	
	"nothing on other the reported there was the resident. TS-A clothing that had ed driver found an unit informed the staff the assisted to get real staff person said he resident had no clean acknowledged ope saw it contained for TS-A reported there he picked up the real find he had feces of Because he no lone appointments, he with incidents. TS-A stat the social service of and stated he was An interview was of p.m. with a LPN-D times R68 had beet were incidents whe with evidence of stat clothing. She report	han a diaper." He (TS-A) is no linen on the bed to cover also observed a bag of soiled vidence of urine and stool. The dentified nursing staff and he resident needed to be dy for an appointment. The e would have to wait, "as the ean clothing available." TS-A ning the resident's closet and ur pair of pants and six shirts. e were other occasions when esident of an appointment to on his clothing and walker. ger transported the resident to vas unaware of further ted he reported the incident to designee at the dialysis unit, "appalled at what I witnessed." onducted on 8/15/13, at 2:33 The LPN reported that at en uncooperative and there en the resident went to dialysis ool incontinence and in dirty ted she had heard about these		completed weekl then monthly X3 results being pres the QA committee follow up discussion/plann 5. The Correction will be Monitored by: A) Director of N Social Service or their desig	with sented to se for ing. oe lursing or se Director	
	LPN-D denies rece calls from any staff regarding any cond	ange of shift nursing report. eiving any reports or phone at the dialysis program cerns regarding his personal incontinence or not being		р.		

		I AND HUMAN SERVICES E & MEDICAID SERVICES				RINTED: 09/11/201 FORM APPROVEI /IB NO. 0938-039	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A 2010 (A 2010 (H	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245387	B. WING			C 08/19/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY 2912 FREMONT AVENU MINNEAPOLIS, MN	UE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 241	appropriately attire On 8/16/13, at 8:37 room. He was dress hospital gown drap the room with the s wore on 8/14/13. T had no clean pants to the laundry to fir was assisted to do too small and could An interview with F at 2:15 p.m. He stat dressed in ill-fitting of incontinence or not like living at the his children. On 8/19/13, at 9:29 observed sitting or the same pants he R68 reported that bothered him as he in front of others w unzipped. He state but he did not know stated it bothered I enough clothes. R68's significant cl (MDS) dated 7/19/ moderately impaire problems. Althoug inattentive and had displayed no mood		F 2				
FORM CMS-25	이 같은 것 것 같은 것은 것 같은 것 같은 것은 것 같은 것 같은 것	ce of one staff with bed dressing, toilet use and s Obsolete Event ID: 6QVR1	1	Facility ID: 00260	If continuation	n sheet Page 66 of 29	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
		245387	B. WING		C 08/19/2013	
	ROVIDER OR SUPPLIER		29	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 241	personal hygiene. The Care Area Ass on 7/12/13, and ind decline in the reside some improvement declined overall and	essments (CAAs), completed licated the staff had noted a ent's mobility and although t was noted, the resident had d had variations in mobility due lition. He was frequently	F 241			
	10/8/12, indicated F of bowel incontinen medications when	dder plan of care dated R68 had occasional episodes ace at times when on certain his dialysis labs are high. "This and expected to continue to				
	completed with LPI R68 had been unco incidents when the program with evide in dirty clothing. Sh about these incider nursing report. LPN reports or phone ca dialysis program re regarding his perso	5/13, at 2:33 p.m. was N-D, who reported at times opperative and there had been resident did go to the dialysis ence of stool incontinence and he reported she had heard hts in the change of shift N-D denied ever receiving any alls from any staff at the egarding any concerns onal hygiene, reports of t appropriately attired.				
	NA-I acknowledged his personal cares not have enough cl "they are in the lau	06 a.m. NA-I was interviewed. d she had assisted R68 with and the resident frequently did lothing, particularly pants, as ndry." NA-I did not state eported it to a nurse or social		*	: * 2	

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245387	B. WING	s			C 19/2013
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					2912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE				MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	unaware that R68 r that week, and said have been reported An interview with th was completed on a acknowledged it wa resident not to have needed to be made clothing. She also s have left the buildin soiled clothing and validated it was not staff to leave the re feces, uncovered a who was going to c A policy regarding r of the DON on 8/19 policy was received 483.15(g)(1) PROV RELATED SOCIAL The facility must pr services to attain of practicable physica well-being of each This REQUIREMED by: Based on observa review, the facility f related social service elopements from th	erviewed. She reported being needed clothing until the end of the clothing shortage should to her earlier. e director of nurses (DON) 8/19/13, at 5:10 p.m. She as unacceptable for the e clothes that fit and efforts to get the resident more stated the resident should not og when incontinent or with equipment. The DON acceptable for the nursing sident lying on his bed in his nd exposed, while staff decide lean his living area. resident dignity was requested 0/13, at 5:10 p.m. however, no the clothes medically-related social real medically-related social real, mental, and psychosocial		241			

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		245387	B. WING		C 08/19/2013	
				STREET ADDRESS, CITY, STAT 2912 FREMONT AVENUE NO	TE, ZIP CODE	
OLAF	RESIDENCE			MINNEAPOLIS, MN 5541	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE IENCY)	ON
F 250	Continued From pa	age 68	F 2		7	
		f motion (ROM) for (R35), and	i.	F. 250 1. Corrective A	ction:	
		ychosocial services for ncluding altercations for (R8).	1		t #45 has a new wander	
		cility failed to provide social	i.		evice and it is placed in	
	services regarding	investigating bruises for (R56)	1		er area of his w/c. His	
	accordingly.			1 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	n reflects the use of the	
	Findings include:			wander		
					t #45 had an assessment ehavioral needs and his	
		mission Record indicated the			ropic medications now	
		ted to the facility in 9/12 with g dementia, persistent mental			ecific target behaviors	
		ve disorder, and left			ication for use. His care	
		as not provided with medically			lects the target behaviors	
		ces to address repeated		and a set of the set o	ications for use.	
	7/11/13, 7/29/13 ar	ne facility on 7/1/3, 7/2/13, nd 7/31/13			chologist consult for #45 was reviewed and	
			1	5.55575/S	plan was updated to	
		Im Data Set (MDS) dated			he suggested	
		R45's Brief Interview of Mental d to determine cognition) score		interver		
		leted and identified R45 had		D) Resider	nt #45 was assessed for	
	short and long-terr	n memory impairments; R45			ed elopement risk and	
		ssistance with all activities of			plan was updated to	
		The staff assessment of stionnaire (PHQ)-9 (a tool used		to this	his current needs related	
		depression/mood concerns)			nts #55, 599, 598, 85,	
	score was eight (lo	w). The mood assessment		-	d 595 are no longer	
		: little interest or pleasure in			g at St. Olaf's.	
		appetite or overeating; stated ng," and R45 "wishes for death,	1	F) Resider	nt #35 was assessed for	
		n self; R45 was described as		· · · · · ·	g/brace needs and for	
	short tempered 7-	11 days (half or more of the			needs. His care plan was	
		sessment period. The MDS			and now reflects what to	
		layed physical behavioral ection of cares daily.	- 朝	do if he ROM.	e refuses splints/braces or	
	Wandering was no				ychology consult of	
	11 22 C			c) ino po	/O/	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

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ATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C
		245387	B. WING			08/19/2013
IAME OF	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP	
T OLA	RESIDENCE				NT AVENUE NORTH LIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K (EAC	ROVIDER'S PLAN OF CO CH CORRECTIVE ACTIO S-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 250	(CAAs) dated 9/25/12 identified cognitive loss and the inability to make independent decisions, inattention, disorganized thinking, physical behaviors towards others and rejection of cares. The resident had experienced "a difficult time adjusting to the move" and because of suicidal risk was referral to the psychiatrist. The social		F 2		 were added to H) Resident #35 l care plan revie His psychotro now have app 	
	services designee assist the resident "proceed with inapp The CAA for Falls/f dated 10/2/12, reve at times." A quarter indicated R45 had moderate cognitive behavior problems Resident Incident F 7/13 and R45's nur following: 1) R45 was found 5:55 a.m. Thirty mi Wanderguard (a se initiated. The reside and opened the do near the door as he 2) R45 wheeled hir 7/1/13, at 5:30 p.m want to go outside practitioner (NP) w the need for a War received with plans whereabouts every 3) R45 went outside without altering sta placed and 30 min and then one our co	(SSD) was to be available to and family, and staff would propriate behavior care plan." Psychotropic Medication Use ealed R45 "could be impulsive by MDS dated 6/21/13, a BIMS score of 10, showing impairment, and no mood or were identified. Reports (RIRs) from 1/13 to sing notes revealed the by the stairway on 1/6/13, at nute checks and a ecurity alarm system) were ent had removed the stop sign ors. He was "told not to go a may fall down the steps." mself out of the building on . telling the receptionist, "I and see the world." The nurse as paged and asked to revisit inderguard, and an order was is to check on the resident's		2.	 use. I) Resident #8 harevised to refland interventir resident displate behaviors. His contains interwhen he is ag other resident #56 revised to reflate to prevent bruand position of the Residents: A) All residents: A) All residents to be affected practices. B) The Abuse Prevised to increport elopem facility and realtercations. C) All staff was Abuse Prevent 	ad his care plan ect his behaviors ons to use when ays these is care plan also ventions to use gressive toward s. had his care plan lect interventions hising during cares changes. has it applies to have the potential l by these deficient revention Plan was clude the need to nent from the esident to resident educated on the ntion Plan and ientation. Splints

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

PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245387	B. WING		C 08/19/2013
	ROVIDER OR SUPPLIER		29	REET ADDRESS, CITY, STATE, ZIP COU 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
F 250	4) On 7/9/13, at 4:0 the facility and the receptionist who su staff. R45 was vert and attempts to rea The resident contin accompanied him therapeutic recreat to walk with R45 of were to continue. 5) R45 left the bui 7/11/13 (time not nu unsuccessfully atte A nursing staff "ran down driveway ran but came in with th note revealed the leave and the rece assisted him outdo discussed schedul his need for staffs" factors were identia and inability to avor sidewalk. During the all the people who understand non-ver resident's judgment described as "poo 5) A NP note date attempted to leave the last three days in place on his char weather was nice option due to the s resident had little anything, and had history and redired 6) Staff alerted to	00 p.m. R45 attempted to leave Wanderguard alerted the ummoned help from nursing bally aggressive, yelling at staff direct him were "ineffective." hued to yell until someone outside the building. A tion staff person was assigned utside, and one hour checks lding setting off the alarm on noted). The receptionist empted to redirect the resident. In out and caught him going fast np." R45 was argumentative, ne nurse. At 4:00 p.m. another resident was attempting to optionist alerted the staff who bors. In addition, the staff led walks with the resident and assistance. Several unsafe fied including resident speed bid uneven terrain including the he walk R45 talked and sang to passed, and was unable to erbal cues from strangers. The nt in his surroundings was	F 250	updated on care sheets. 3. Date of Completion: 4. Reoccurrence will be A) Random audits we completed week monthly X3 with presented to the for follow up discussion/plann 5. The Correction will by: A) Director of Nurs Services Directo designee's.	: 10/3/13 e Prevented by: will be ly x 4 and then n results being QA committee ting. be Monitored ing or Social

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	St. 199		CONSTRUCTION	(X3) DATE SUR COMPLETE	
		245387	B. WING			08/19/2013	
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			0.000	12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 250	Continued From pa	ige 71	F 2	250			
a:		nt with w/c mobility due to					
	was placed undern however, reasons f 8) R45 went out un p.m. as reported by	30 p.m. a new Wanderguard eath the resident's w/c, for this were not noted. supervised on 7/29/13, at 4:00 y the receptionist. The resident o to the road. Hourly checks					
	were noted and a f Wanderguard was orders. The resider and "became upse his Lt [left] ankle." 9) On 7/30/13, at 4 revealed the reside wanting to leave th by himselfvery re was present and p (anticonvulsant con stabilizer). 10) On 7/31/13, at left the building an blocked the incom incident was withe (LPN)-H and traine and the resident w Interventions were Depakote was incr walking times for F dated 8/1/13, indic well to programV /occupational thera AM & 2:30 [p.m.] a medication." A cor revealed the NP w and indicated R45	ollow up indicated the working and the NP wrote new int denied leaving the building tNew Wanderguard put on :00 p.m. a nursing note ent was "more agitated lately & e bldg. [building] & go around esistant to redirection." The NP rescribed Depakote mmonly used as a mood 9:00 a.m. the resident again d "got stuck on the driveway ing cars from entering." The ssed by licensed practical ed medication aide (TMA)-F as "yelling, uncooperative." to replace the Wanderguard; reased, and follow up with R45. The 24-Hour Follow Up iated, "Resident has responded Vill be working w/ OT [with apist], staff to take out @ [at] 10 as desires. NP to re-evaluate responding nursing note vas notified about the incident was yelling and "doesn't					
	stabilizer). 10) On 7/31/13, at left the building an blocked the incom incident was witne (LPN)-H and traine and the resident w Interventions were Depakote was incr walking times for F dated 8/1/13, indic well to programV /occupational thera AM & 2:30 [p.m.] a medication." A cor revealed the NP w and indicated R45 respond to redirect obtained for the oc	9:00 a.m. the resident again d "got stuck on the driveway ing cars from entering." The ssed by licensed practical ed medication aide (TMA)-F as "yelling, uncooperative." to replace the Wanderguard; reased, and follow up with R45. The 24-Hour Follow Up ated, "Resident has responded Vill be working w/ OT [with apist], staff to take out @ [at] 10 as desires. NP to re-evaluate responding nursing note vas notified about the incident					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVE COMPLETED	
		245387	B. WING		08/19/2013	
	ROVIDER OR SUPPLIER		29	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	outside." Potential behaviora the Social Services forms, however, ne ideation and enteri were not addresse lacked a comprehe root cause analysi strategies for addr indicated the socia "monitor" R45, evi lacking in R45's re accomplished. The Social Service forms from 9/25/12, R4 and sexually inapp of depression and and was being set the house psycho 2) On 1/8/13, the stairwell and was was noted, "1st at social service staf safety." 3) The next note R45 enjoyed sing redirecting R45. 4) Notes revealed history of verbal a not easily re-direct	al concerns were identified on s Meeting/Assessment Update ew concerns such as suicidal ing unsafe areas of the facility ed, and the clinical record ensive assessment including a s to determine appropriate ress the concerns. The forms al service designee would dence of such monitoring was ecord to support how this was es Meeting/Assessment Update 2 through 6/25/13, were as 45 displayed physical, verbal propriate behaviors, a diagnosis a history of suicidal ideation, en on an as needed basis by	F 250			

		H AND HUMAN SERVICES E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT COM	. 0938-039 E SURVEY MPLETED	
		245387	B. WING				C 08/19/2013	
	RESIDENCE	2		291	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	2.2.9	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 250	anxiety, and was on 7/30/13. Review of the Jur Behavior/Interver indicated the follo - The June record mood monitoring (antidepressant) the behavior sect the evening shift behaviors. The day was blank. - The July record monitoring for Pri and tearfulness. Remeron was ind record lacked tar for the use of De - The August record Depakote was in agitation/verbally monitoring for Re target behavior for was increased sa tearfulness. The resident specific to determine indi medications. On 8/15/13, at 1: (RN)-A stated the "anxiety" and ver be monitored for was unclear on t Depakote. RN-A for and explained	increased to 250 mg twice daily ne, July and August 2013 ation Monthly Flow Records owing: d identified target behavior for for the Prozac and Remeron was to be completed. Although ions of the sheets were blank, had documented no mood ay and night shift documentation identified the target mood ozac was increased sadness The target mood monitoring for creased isolation. The clinical get behavior mood monitoring		250			Page 74 of	

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/19/2013	
		245387	B. WING			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH VINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 250	medications). Although the clinical behavioral monitor lacked evidence Re adequately assess specific interventio R45's elopements Depakote was add clinical record lack social services wer mood/behavioral n behavior/mood mo behavioral/mood d care plan. Although for "anxiety" the cli evidence the medi was adequately as medication. The Associate Clin notes indicated the - On 9/24/12, R45 Assessment due to physically aggress who were attempti w/c." The assessm dysthymic disorder disturbance of moo compulsive persor dementia. The Imp Recommendations identified, "Difficult staff instructions m behavior and phys assessment indical showing interest, la	al record lacked evidence of ing and the clinical record 45's elopements were ed, care planned and resident ns were developed to address from the facility, on 7/19/13, led to R45's drug regimen. The ed evidence clinically related re provided to address R45's eeds, such as ongoing target onitoring, analysis of the lata and development of the h R45 was started on Depakote nical record lacked strong cation was warranted and R45 seessed for the need of the	F 250		JA	

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				APPROVE 0. 0938-039
TATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and a state for the second state of the second states of the second stat	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
NAME OF I	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DDE	
ST OLAF	RESIDENCE			12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 250	manage aggressiv recommendations control of R45's w/ his body," and dire himself to locations w/c if needed for lo while continuing to be important." The daily routine prefer and involvements was going to happ to sing barbershop games and "showi likely to have a ber - On 10/8/13, the p was being treated note identified R45 and indicated, "An him to use pro-soc i.e., putting his fee the nursing staff pre expressive modali music or his comp treatment interven The Treatment Pla [R45] will sing for his music with othe this is associated w "4. [R45] may ben program approach him, use upbeat g his music or an int enhancement." - On 7/22/13, the p was seen for "psyn treated for "anxiety compulsive disord related problems,	AND	F 250			

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION	<u></u> ,	(X3) DATE SURV COMPLETED	
		245387	B. WING			08/1) 19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT			
ST OLAF	RESIDENCE			2912 FREMONT AVE MINNEAPOLIS, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 250	program where star possible on commun Plan indicated the f by allowing him to se quartet songs to star decrease anxiety a compliance with car facilitated walks out and serve to decree with social service facilitated walking p curb anxious episo sense of pride in his sharing his life value involving R45 in an to enhance his more notes identified rese enhance R45's more evidence the sugge implemented or att included the walking lacked evidence the notified of R45's ell on 7/11/13. The clino ongoing social serve included integration recommendations clinical record lack were identified as a which warranted in intervention. Althout was notified of the the clinical record of concerns were cor psychiatry/psychology.	was on a "facilitated walk ff accompanied him when unity walks." The Treatment following: "1. [R45] may do well sing one of his barbershop aff in order to improve rapport, nd increase potential for ares." "2. [R45] indicates tdoors are mood enhancing ase anxiousness. I conferred who notes that he is on a program which should help des." "3. [R45] does identify a is son adopting children and ues" the plan included by "adaptive roles" at the facility od. Although the psychology sident specific interventions to ood, the clinical record lacked ested interventions were tempted. Although the notes ng program, the clinical record e psychologist/psychiatrist was opements on 7/1/13, 7/2/13 or nical record lacked evidence of vice assessment, which n of psychiatric service and behavioral concerns. The ed evidence R45's elopements an ongoing safety concern nmediate assessment and ugh R45's primary physician elopements from the facility, lacked evidence R45's safety municated to ogy.		50			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6QVR	11	Facility ID: 00260	If continua	tion sheet F	Page 77 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245387	B. WING				C 19/2013
	RESIDENCE			29	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	"brought up" in the meetings. SSD stat out of the building, R45 was able to be building. SSD confi SSD stated the may was R45 wanted to middle of when stat residents with eatin director of nursng (walking program witimes he was willing out of the building, has been limited." St the mood and behat care plan. SSD corr address R45's elop stated it was a team but then stated, "[W program here. It's to	IDT (interdisciplinary team) ted every time R45 had been the receptionist called and brought back into the rmed R45 had "gotten out." jority of the behavior problem go "now" such as in the ff were assisting other g. SSD stated the interim DON) sat down and created a ith R45, that R45 chose the g to go out and be escorted SSD stated, "My involvement SSD verified she completed avior sections of the MDS and firmed the care plan did not beements from the facility. SSD n effort to address behaviors, Ve] Currently have no behavior being implemented. I need help ne information and then run	F2	250			
	therapist verified R. "community involve therapist stated the approaches with R- in the community." stated R45 did not the nursing staff wa approaches with R- stated therapy staff talk to R45. The oc went out with R45 de explained to R45 w encouraged R45 to not make R45 feel	15 a.m. the occupational 45 was in therapy for ement." The occupational a treatment was to develop 45 while he was out on walks The occupational therapist want staff to be with him and as "confused" on behavioral 45. The occupational therapist f provided teaching on how to cupational therapist stated she on the walks, timed them and thy staff was with him; o choose times and for staff to "isolated" as he was being walks. The occupational					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245387	B. WING	B. WING			C / 19/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 250	potential elopemen to assist with comp the block twice dail therapy had evalua community involver evidence the behave occupational therap behavioral care app R599's Resident Ad 8/20/12, noted R59 mental disorder, alt a right below the kr abnormality, and ad The care plan date required assistance transition from sittin transfers. R599 left the facilit medications during according to the Re Neglect of Vulnera hospitalized (at an secondary to no m On 1/3/13, the elop Hennepin County a discharge after 41 the resident left the not reported to the months. The facilit after the surveyor i R598's Resident A	e therapy was to "prevent" ts and stated the therapy was diance with the walks around y. Although occupational ited and assessed R45 for ment, the clinical record lacked vioral approaches identified by py were integrated into R45's proaches and care plan. dmission Record dated 09 had diagnoses of persistent tered mental status, diabetes, nee amputation, gait ctive drug abuse. d 9/19/12, indicated R599 e of staff to stabilize during ng to ambulation or for y (elopement) without orders or g the week of 11/23/12, eport of Suspected Abuse or ble Adults form. R599 was unknown date and time) edications. Dement was reported to as "against medical advice days." It was unclear what day e building. The elopement was State agency (SA) for eight y did not report the elopement intervened.		25			
	noted 598 to have	diagnoses of liver cirrhosis	1				1

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		045007				С	
		245387	B. WING			08/	19/2013
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			291	REET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	with ascities (enlarg the abdomen), a his congestive heart fa and legs) and diabe The care plan date risk of falls due to le transitions. R598 his symptoms, and had others. R598 left the facility on 1/3/13, accordin Suspected Abuse of form. R598 left in the stating "get me the did not return to the report the elopeme R85 was admitted data base diagnose hypertension, learn socially inappropria The MDS dated 2/7 cognitively intact ar of daily living. The care plan upda care deficit, socially dining room (yelled resisted cares and R85 left the buildin (elopement) during according to the (u Abuse or Neglect of	ged liver with fluid backup into story of heart bypass surgery, ilure (fluid backup into the feet ates. d 8/1/12, noted R598 had a oss of balance during ad verbally abusive behavioral d threatened and screamed at y (elopement), without orders og to the (un-timed) Report of or Neglect of Vulnerable Adult he company of his daughter (profanity) out of here." R598 e facility. The facility did not int to the SA. on 8/14/12, with admission es of chronic kidney disease, ing difficulty, homelessness, ate and disruptive behavior. 19/13, indicated R85 was nd independent in all activities ated 8/5/13, indicated a self y inappropriate behavior in the l and threw things), and	F 2	250			

Event ID: 6QVR11 Facility ID: 00260

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT CON	E SURVEY
		245387	B. WING	;		C 08/19/2013	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 250	to Hennepin Count was added to say t facility on 1/9/13, at was updated on 1/ ² of a police report of	age 80 unclear when it was reported y (un-timed) and a statement he resident returned to the t 7:00 p.m. Hennepin County 10/13. There was no indication f a missing person report being d not report the elopement to	F	250			
	have diagnoses wh fractures from a fall backup into the lun pulmonary disease depression. No assessments w An admission care R597 used a cane R597 left the facilit stay" (elopement) of (un-timed) Report of Vulnerable Adult report the elopement R89's MDS dated 2 impaired cognitive making-decisions p required. R89 required	y, "stating he did not want to on 1/30/13, according to the of Suspected Abuse or Neglect t form. The facility did not					
	A care plan for R8 provided.	9 was requested and not					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and Statement		CONSTRUCTION	COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			1 3 3	12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 250	Continued From pa	age 81	F	250	2		
constant failure	(un-timed) Report of of Vulnerable Adult (elopement) after b for a leave of absen facility. That was re	on 2/25/13, according to the of Suspected Abuse or Neglect form. R89 left with his family being told there were no orders ince, he did not return to the eported to the DON on 2/25/13. report the elopement to the					
	The MDS dated 4/2 cognition. R55 required mobility, dressing a transfers, and set u required assist of c and toilet use, supe up for personal hyg indicated a BIMS s intact cognition. On 4/25/13, at 11:0 building but did not On 4/26/13, at 8:00 Abuse or Neglect of filled out. Hennepin 4/26/13, at 8:33 a.1 (un-timed) and gav back in 24 hours to discharge. Police v un-timed). On 4/26 (un-timed) the resi Hennepin County a	twice without supervision. 24/13, indicated intact uired assist of one with bed and toilet use, supervision with up for personal hygiene. R55 one with bed mobility, dressing ervision with transfers, and set giene. The BIMS 4/24/13, core of 15/15 - which depicted 00 a.m. R55 signed out of the t return (first elopement). 0 a.m. a Report of Suspected of Vulnerable Adult form was n County was notified on m. the MD was notified ve parameters if resident not o do an against medical advice were notified (undated and 6/13, "in the evening hours" dent returned to the facility and and Police were notified of the ment was not reported to the					

If continuation sheet Page 82 of 298

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE 245387 B. WING 08/19/2013 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETED			HAND HUMAN SERVICES E & MEDICAID SERVICES				FOR	D: 09/11/2013 MAPPROVED O. 0938-0391
245387 B. WING 08/19/2013 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2312 FREMONT AVENUE NORTH ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2312 FREMONT AVENUE NORTH (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX STREET ADDRESS, CITY, STATE, ZIP CODE 2312 FREMONT AVENUE NORTH (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) D	ATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (continued From page 82 On 5/6/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form, R55 left the facility without supervision, and did not return (second elopement). Hennepin County was notified on 5/7/13, at 11:34 p.m. the resident returned to the facility. The elopement was not reported to the SA. F 250 R595's Resident Admission Record dated 5/31/13, R595 was noted to have diagnoses which included bi-polar adjustment disorder (mental illness). No assessments were completed. R595's stated they were going for a walk and did not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not			245387	B. WING			0	
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DERICINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 250 Continued From page 82 On 5/6/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form, R55 left the facility without supervision, and did not return (second elopement). Hennepin County was notified on 5/7/13, at 21:08 p.m. a report to the police (undated and un-timed) was attached to the form. On 5/7/13, at 11:34 p.m. the resident returned to the facility. The elopement was not reported to the SA. F 250 R595's Resident Admission Record dated 5/31/13, R595 was noted to have diagnoses which included bi-polar adjustment disorder (mental illness). No assessments were compileted. R595 stated they were going for a walk and did not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not	NAME OF F	PROVIDER OR SUPPLIER						
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) combre DATE F 250 Continued From page 82 On 5/6/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form, R55 left the facility without supervision, and did not return (second elopement). Hennepin County was notified on 5/7/13, at 2:08 p.m. a report to the police (undated and un-timed) was attached to the facility. The elopement was not reported to the SA. F 250 R595's Resident Admission Record dated 5/31/13, R595 was noted to have diagnoses which included bi-polar adjustment disorder (mental illness). No assessments were completed. R595 stated they were going for a walk and did not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. Hennepin County was notified on 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not	ST OLAF	RESIDENCE			with a state of the			
On 5/6/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form, R55 left the facility without supervision, and did not return (second elopement). Hennepin County was notified on 5/7/13, at 2:08 p.m. a report to the police (undated and un-timed) was attached to the form. On 5/7/13, at 11:34 p.m. the resident returned to the facility. The elopement was not reported to the SA.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
5/31/13, R595 was noted to have diagnoses which included bi-polar adjustment disorder (mental illness). No assessments were completed. R595 stated they were going for a walk and did not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. Hennepin County was notified on 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not	F 250	On 5/6/13, accordin Suspected Abuse of form, R55 left the f did not return (seco County was notified report to the police attached to the form resident returned to	ing to the (un-timed) Report or Neglect of Vulnerable Adu facility without supervision, a cond elopement). Hennepin ed on 5/7/13, at 2:08 p.m. a e (undated and un-timed) wa rm. On 5/7/13, at 11:34 p.m. to the facility. The elopemen	of ult and as the	250			
not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. Hennepin County was notified on 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not		5/31/13, R595 was which included bi-p (mental illness). No completed.	s noted to have diagnoses polar adjustment disorder lo assessments were	d				
		not return to the fai the Report of Susp Vulnerable Adult fo 6/3/13, at 8:00 a.m notified on 6/3/13, the elopement) and (undated and un-til	acility (elopement), according pected Abuse or Neglect of orm which was dated Monda n. Hennepin County was at 8:00 a.m. (three days afte ad the police were notified imed). The elopement was r	g to ay er				v.
Documentation for R595 was requested and not provided.			r R595 was requested and n	not				
ROM and splints: R35 was not provided medically related social services for refusals of range of motion (ROM) and refusals of his lower extremity leg splints/braces, foot braces, and the foot buddy for the w/c.	1	R35 was not provid services for refusa and refusals of his splints/braces, foo	als of range of motion (ROM s lower extremity leg)				
On 8/12/13, 8/13/13, and on 8/14/13, R45 was FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260 If continuation sheet Page 83 (Continuation	FORM CMS OF				Eacility ID: (00260	appliqueties at a	t Dege 02 -f 00

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

PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING			C 08/19/2013	
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			2912	EET ADDRESS, CITY, STATE, ZIP CODE FREMONT AVENUE NORTH NEAPOLIS, MN 55411	00/	19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	observed to be with Review of the clinic frequently refused devices. The Diagnoses Re- indicated R35 had dementia, and dep annual MDS asses R35's BIMS score with ADLs. The MD lower extremities. PHQ-9 score was of depression) due to hopeless two to six assessment period no behavioral cond Falls/Psychotropic identified R35 rece medication." The C "Trazadone, Paxil & The CAA indicated [medication] side e effectiveness. His CAA identified R35 and indicated, "No time." The quarterly MDS had a BIMS score MDS indicated R38 and was now zero behavior concerns The Physician's Or apply knee splints to be put on for on- lunch; Ankle Splint	port - Clinical dated 3/31/11, the use of the ordered orthotic port - Clinical dated 3/31/11, the following diagnosis: ression with anxiety. The sment dated 2/13/13, indicated was 12, identified no changes OS identified impairment in both The MDS identified R35's one (low potential for feeling down, depressed, or a days (several days) during the L. The MDS identified R35 had terns. The CAA for Medication use dated 2/27/13, ived an "antidepressant CAA indicated R35 received & Wellbutrin for depression." , "He is monitored for med fifects & observed for med mood has been stable." The 's psychiatrist and psychologist referrals are needed at this 6 dated 5/14/13, indicated R35 of 13 (mild impairment). The 5's PHQ-9 score had improved and indicated R35 had not	F 2	250			

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

Facility ID: 00260

		AND HUMAN SERVICES		H	FORM): 09/11/2013 1 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,		
ST OLAF	RESIDENCE			2912 FREMONT AVENU MINNEAPOLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 250	morning during slee Range of Motion P afternoon during th the ROM program The care plan for A 3/15/10, indicated I program" daily, dire starting 10/4/10. A "Bilateral leg splints when in bed." [Und "Refusing leg splint dated 6/12/13, "Pt guard on w/c behin care plan did not a Although the care splints and threw th lacked behavioral address his refusa The undated Nursi AM/PM directed N knee braces on as directed to comple apply a "foot huggo indicated, "Deman care not provided w "Report non-comp An Associated Clint dated 10/8/12, indi for "clinical depress cognitive restructu primary treatment The Treatment Pla	ep hours. rogram in morning and e day and directed to complete while in R35 was in bed. Alteration in mobility dated R35 had a "hamstring stretch ected to set up for the program hand written update directed, s on 1 hr [hour] after meals lated] An update dated 7/16, ts throws on floor." A note [Patient] refuses leg gard" (leg hd foot pedals added 7/12. The ddress the use of ankle splints. plan identified R45 refused the hem on the floor, the care plan intervention strategies to	t			
EOPMONE	frustration and irrit	ng depressed mood with ability." and identified R35 likes irected, "Care staff may wish to as Obsolete Event ID: 6QVI)	Facility ID: 00260	If continuation sheet	Page 85 of 20

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

PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE DPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE DENTIFICATION NUMBER: A. BUILDING) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
		245387	B. WING			C 08/19/2013	
	ROVIDER OR SUPPLIER	I		2912 F	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT AVENUE NORTH IEAPOLIS, MN 55411	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	assist with channel particularly about o interested in. "2. [R35] may bene newspaper clipping hometown paper" a approached to assi them in protective o enhancement" by s staff and others. "3. [R35] may bene therapy exercises i build strength and therapy exercises i build strength and the Although the psych recommendations general wellbeing, evidence the above or attempted. The o above recommend visits were noted in Review of the Soci Meeting/Assessme through 5/21/13, in R35's behaviors ar - On 11/20/12, the & oriented to perso to make independe [continues] @ time was identified as so and psychologist o - On 2/28/13, the n poor decisions re: I identified a history the behavior care p as "stable" and he depression - SS [so monitor for signs/s	selection, use of reminiscing utcomes of the games he is fit in having some of the past is from the achieves of his and suggested family could be st with obtaining these, placing coverings as a "mood sharing them with residents, fit from follow-up restorative f not already attempted to help focus on his vitality." iologist made resident specific to address R35's mood and the clinical record lacked e interventions were addressed care plan did not reflect the ations. No further psychology in the clinical record. al Services ent Update forms 11/20/12, dicated the following regarding	F2	50			

		AND HUMAN SERVICES			FC	TED: 09/11/2013 DRM APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				NO. 0938-0391 DATE SURVEY COMPLETED
		245387	B. WING			C 08/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E. ZIP CODE	00/10/2010
10 10 2 01 1				2912 FREMONT AVENUE NO		
ST OLAF	RESIDENCE			MINNEAPOLIS, MN 55411		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	그는 그는 것 같은 것 같	ACTION SHOULD BE	COMPLETION
F 250	Continued From pa		F 2	50		14 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	basis. - On 5/22/12, the n changes in behavior monitor." The notest the house psychiat needed basis. - On 8/14/12, the n "behavior care plan behaviors" and "Not depression. SS will indicated R35 was and psychologist of - On 2/19/13, the n to @ times [to] refu- behaviors in the last monitor. Mood is st depression." The n by the house psych as needed basis. - On 5/21/13, the n [history] of refusing behaviors in the last seen on PRN [as n psychiatrist/psychol will cont. to monitod depression." Althor Meeting/Assessme completed regulard refusals of care, st devices, grooming clinical documentar "stable," had "No st	ychologist on an as needed otes identified R35 had "no or or mood - SS will cont. to s indicated R35 was seen by rist and psychologist on an as otes referred to R35's " and, "No sign changes in o signs/symptoms of I cont. to monitor." The notes seen by the house psychiatrist n an as needed basis. otes indicated, "Res. continues use cares but no significant st quarter. SS/Staff will cont. to table. No signs/symptoms of notes indicated R35 was seen niatrist and psychologist on an otes indicated, "Res has a hx g cares. No sign. changes in st quarter. Res [resident] is needed] basis by house ologist. Mood is stable. SS/Staff r for signs/symptoms of ugh the Social Services ent Update forms were ly, the forms did not identify uch as wearing orthotic or range of motion. The tion recapitulated R35 was signs/symptoms of depression," se psychiatrist and psychologist				
	"SS will cont. to me lacked evidence R services, lacked ev mood/behavioral d	basis," and further recapitulated onitor;" the clinical record 35 was monitored by social vidence of analysis of R35's lata and lacked evidence of				
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6QVR	11	Facility ID: 00260	If continuation sl	heet Page 87 of 298

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

PRINTED: 09	/11/2013
FORM API	PROVED
OMB NO. 09	38-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING				C 19/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE	
F 250	root cause analysis behavioral concern of care. In addition evidence outside s as psychiatry/psych and/or therapy recours up on and integrate The Behavior/Intern for August, June, a following: - The record for Jun monitor for "depress intervention of "Re- designee]" for the June documentation second monitoring blank for the mood "0's" were docume evening shift and the clinical record lack monitoring for the - The record for Jun monitor for "Depre "Refer to S.W." for July documentation monitoring records SR were included both blank. The clii R35 was monitore - The record for Au "Document # [num Trazodone. The do the partial month of hours R35 slept was monitoring records and symptoms of]	s and assessment of R35's is, such as refusal or rejection , the clinical record lacked ervice recommendations, such hology recommendations ommendations, were followed ed into R35's care plan. vention Monthly Flow Records and July 2013 indicated the ne directed licensed staff to ssion symptoms" with fer to S.W. [social service use of Paxil. The month of on was all "0's." Although a record for Trazodone was I behaviors to be monitored for, inted 13 times during the wice on the night shift. The ed evidence of mood use of Wellbutrin SR. Ily directed licensed staff to ssion" with intervention of the use of Paxil. The month of n was all "0's." Two more a for Trazodone and Wellbutrin with the monitoring, but were nical record lacked evidence d for sleep in July. ugust directed licensed staff to, aber of] hrs sleep" for boumentation was of "0's" for of August and the number of as not documented. Two is for Wellbutrin SR and Paxil staff to monitor for "S/S [signs	F 2					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260 If continuation sheet Page 88 of 298

1000 000 1 00 00 00 00 00 00 00 00 00 00		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A STATE OF A	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	¥)	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 250	of August. The Beh Flow Records lacke specific depression limited to irritable m care. The records in consistently monito for sleep. In additio evidence R35 was determine monitorin two antidepressant and Paxil) which we diagnosis of depress forms directed to re- designee regarding medication, the clim social service desig Review of the Nurs the following: - On 8/3/13, at 6:30 "Resident refused h not have elbow split 'he doesn't need th about the importan positive outcomes. and still refused." - On 8/4/13 (no tim indicated, "Res [res his splints stated do unable to verbally r - On 8/13, at 4:00 refused splints" - On 8/13/13, at 10 also refused splints be placed on @ all indicated, "Pt refus for meals."	avior/Intervention Monthly ed monitoring for resident symptoms, such as but not nood or refusal/rejection of indicated R35 was not red for efficacy of Trazodone n, the clinical record lacked comprehensively assessed to ng for the concurrent use of medications (Wellbutrin SR ere both prescribed for the ssion. Although the monitoring effer to the social service the use of the antidepressant ical record lacked evidence of gnee involvement. e's Notes for R35 indicated 0 p.m. a note indicated, neel and elbow splints [R35 did nts ordered], Resident stated, em.' Writer informed resident ce of wearing splints, and the Resident acknowledges info, e documented), a note sident] refused to wear any of pesn't need them any more edirect." 0 p.m. a note indicated, "Res s today would not allow them to " At 6:00 p.m. a note ed splints again today, got up 00 p.m. a note indicated,	F 2	50		

Event ID:6QVR11 Facility ID: 00260

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PRINTED: 09/11/2013

		AND HUMAN SERVICES & MEDICAID SERVICES			F	NTED: 09/11/2013 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X:	3) DATE ŞURVEY COMPLETED C
		245387	B. WING _			08/19/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE	
F 250	Although the Nurse refused the splints// record lacked evide the splints/braces of offer the braces afted did not indicate if the to R35 on the days braces. Although the refusals of the splint did not identify R35 On 8/16/13, at 9:30 behavior monitoring behavior or mood p monitoring the SSD been limited." SSD mood and behavior confirmed the care refusals of his orthous extremities. SSD st address behaviors, Currently have no to being implemented the information and R8 was involved in to the television cha antecedent was no developed to minim his peers. In addition show R8 received ff as recommended to alternative to nursint sought as recommended alleged abuse by R	's Notes indicated R35 braces frequently, the clinical ence R35 consistently refused or that R35 was reproached to er a refusal. The clinical record e splints/braces were offered he was observed without the e Nurse's notes identified t/braces, the clinical record had refused ROM. a.m. when asked about g for mood, reporting of problems and target behavior o stated, "My involvement has verified she completed the sections of the care plan and plan did not address R35's otic devices for his lower ated it was a team effort to but then stated, "[We] pehavior program here. It's . I need help on how to gather then run with it." altercations primarily related	F 25			

Facility ID: 00260

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245387	B. WING					C 19/2013
	PROVIDER OR SUPPLIER			2912	EET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2.5	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD E		(X5) COMPLETION DATE
F 250	R85 (the resident w yelling. R8 was lear wheelchair toward l intervened, the resi outburst. The third visible when staff s intervene for potent altercations. On 8/14/13, at 6:00 yelling in the dining Staff present was u DON intervened to R8's Resident Adm revealed diagnoses personality disorde adjustment disorde a stroke with partia R8's care plan initia resident was at risk related to vulnerabl inappropriate beha state, anger with st calling, refusing car common areas, sw room, physically ar and was described angered by other re antecedent (preced altercations was re television channel i antecedent was no care plan with inter altercations. Interve included anti-psych anti-anxiety medica	who alleged abuse by R8) were hing forward repeatedly in his R85 and although staff dent continued his verbal floor dining room was not at at the nurse's station to tial resident to resident p.m. R8 was again observed room during the dinner meal. Inable to redirect R8 and the calm R8. ission Record from 2008 including narcissistic r with anti-social traits, r with depression, anxiety, and	F2	50				

Facility ID: 00260

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a second second	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245387	B. WING	-		C 08/19/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,		
ST OLAF	RESIDENCE			2912 FREMONT AVENU MINNEAPOLIS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROP EFICIENCY)	BE COMPLETION
F 250	was inappropriate, re-enforce capabili remove him to his set limits, leave him verbally aggressive to speak softer, lea common areas, dis to concerns, expre a gentleman, reinfe discuss past roles, puzzles, psycholog inform family of be intervention if R8 of physical abuse." The significant cha revealed a BIMS s cognitive impairme and psychomotor activity). The resid physical behavior three days per we behavioral sympto the CAA narrative Incident reports re between R8 and of cases, R8 was se returned to the fac inaccurately noted previous altercation 1) On 8/27/12, at the television (TV/ R8 struck R78 on centimeter bruise the dining room a prevent R8 from of	attempt re-direction, ties and competencies. room to calm down as needed, in to cool off when he was e and check back, remind him ave space between tables in scuss keeping the peace, listen as appreciation for efforts to be orce positive outcomes, use kindness, encourage gy appointments as needed, thaviors, and call 9-1-1 for crisis displayed "extreme verbal and ange MDS dated 6/7/13, score of 11/15, or moderate ent with evidence of delirium retardation (slowed brain lent displayed verbal and directed toward others one to ek. The CAAs triggered oms, but was not addressed in				
FORM CMS-	2567(02-99) Previous Versio	ns Obsolete Event ID: 6QVF	۲11	Facility ID: 00260	If continuat	ion sheet Page 92 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/11/2013

FORM APPROVED

		AND HUMAN SERVICES			PR	FORM APPROVED
	CONTRACT OF DEFICIENCIES	& MEDICAID SERVICES	000		1	IB NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	1	(X3) DATE SURVEY COMPLETED
		245387	B. WING			C 08/19/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E	(X5) BE COMPLETION IATE DATE
F 250	and a psychiatrist ir also talked to the pr alternative placeme would better suit R& make a referral for appropriate environ lacked documentati made by the SSD. 2) On 9/9/12, R8 as way and when he d R8 became angry a in the arm and atter way. It was noted the requesting Hennepi to assess to see if F group home setting	age 92 In the community. The SSD rimary doctor regarding ent in the community that B's behaviors. SSD planned to relocation services for a more iment, however, the record ion showing the referral was sked R599 to move out of his id not move fast enough, the and elbowed the other resident mpted to push him out of the ne SSD was in the process of in County Relocation Services R8 was appropriate for a and the resident was seen by plogist the following day.	F 2	In the product of a second party		
	with R54 over the T the resident on the I to break the resident intervened and sepa sent to his room and admitted to the crisi keep others safe. The the psychiatrist, med the resident returne The plan was for the resident monthly for documentation to sh appointments was n medical record. The resident's behavior, care plan intervention					
	altercation over the	eport revealed R8 had another TV channel, and he verbally				
ORM CMS-25	67(02-99) Previous Versions (Obsolete Event ID: 6QVR11		Facility ID: 00260 If co	ntinuation s	sheet Page 93 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 AV			(X3) DATE COM	E SURVEY PLETED
		245387	B. WING	·			C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			1.000	912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	threatened R76. R8 for evaluation and t follow up investigat was escorted to his attempting to get re- the in house psychol 1/14/13 to request plan. According to t was to have the res psychiatrist every m The chart lacked do visit on 1/14/13, an behavioral plan tha and how to interver aggressive other th On 8/16/13, at 8:43 unaware of the phy home may not be a and stated she had "ammunition" to giv discharge notice. T behavioral manage by the psychologist removed from the a had refused becaus anything wrong. Th very territorial and n room. SSD was un did not address his than to have the re- facility. The SSD fu acted out, she had when she came ba find him in the dinin (written in the com followed by staff. T	a was sent 9-1-1 to a crisis unit o keep the others safe. The ion on 1/4/13, revealed R8 a room, and the SSD was ecords so he could be seen by atrist. The SSD planned to ogist on his next visit on a more specific behavioral the nurse practitioner the plan sident seen by the in house nonth for the next 3-6 months. ocumentation of a psychiatrist d lacked documentation of a t addressed the antecedents ne when the resident became	F	250			

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
245387		B. WING	-	C 08/19/2013			
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH		
STULAP	RESIDENCE			M	INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	Continued From page 94 out again. The SSD said they attempted to find alternate placement for the resident, but he refused to go stating he and his family wanted him to stay at the facility. The SSD asked, "How can he get away with this behavior?" She added that when 9-1-1 was called, "They do not always take him out to HCMC [local hospital]. If he refuses they leave him here."		F 2	:50			
	cognitive impairment disorganized thinkint assistance of one we eating, dressing, gra- toileting. The CAA s	4/24/13, indicated moderate nt with inattention and ng. R56 required extensive with bed mobility, transfers, ooming, personal cares, and summary indicated R56 had ns of resistive and combative					
ų. Li	that appeared to be on 6/18/13. Six staf and education was proper repositioning determined "most li positioning during c incident report indic	ave bruises on his shoulders in the shape of fingerprints f members were interviewed provided to three staff on g techniques. The injury was kely from assisting with cares." The diagram on the cated bruises on the on the e arm pits bilaterally. The injury the SA.					
	would report immed DON, SSD, Henney was an allegation o until the investigation the results of the inv administrator, Henne the late reporting was	a.m. the SSD stated staff diately to administrator, the oin County and the SA. If there f abuse, staff were removed on was completed, and then vestigation were reported to nepin County and SA. When as discussed, the SSD did created and provided			*		

If continuation sheet Page 95 of 298

PRINTED: 09/11/2013

		AND HUMAN SERVICES & MEDICAID SERVICES		κ	FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DAT CON	E SURVEY
245387		B. WING			C /19/2013	
				STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH		
STOLAF	RESIDENCE			MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ION ILD BE OPRIATE	(X5) COMPLETION DATE	
F 250	continued to work w since the staff wait of further stated that s administration not to the SA, even thoug situations. The SSE improvement of the grievance log. The DON investigated of and the SSD invest resident to resident sexual abuse, corpo- investigated. When resident altercations the policy, the SSD policy you'll need to and DON. 8/16/13 at 8:43 a.m abuse concerns sta immediately to adm Hennepin County a abuse staff were re was complete, then Hennepin County a investigation. When discussed, SSD did and provided educa staff, but she contin timely reporting, sin SSD further stated prior administration to the SA, even tho had been working of tracking log, and th stated that the DON against the staff an	o report for the staff, but she with them on timely reporting for her to report. The SSD she had been directed by prior o report the above cases to h she questioned the D had been working on a abuse tracking log and the SSD further stated that the complaints against the staff igated the others, such as altercations. All allegations of oral punishment, etc. would be asked why the resident to s and elopement were not in stated that's a corporate o speak to the administrator and be so the administrator b. SSD the person identified for ated staff would report inistrator, the DON and SSD, and the SA. If allegation of moved until the investigation on report to Administrator, and SA the results of the note late reporting was d state that she had created ation on how to report for the nued to work with them on the the late report for the nued to work with them on the they wait for her to report. That she had been directed by not to report the above cases ugh she questioned that. SSD on improvement of the abuse e grievance log. SSD further N investigated complaints d SSD investigated the others,	F 25(DEFICIENCY)		
	against the staff an	d SSD investigated the others, resident altercations. All				

Facility ID: 00260

If continuation sheet Page 96 of 298

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		ONSTRUCT		Contraction Contraction	0938-039
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD			(X3) DATE SURVEY COMPLETED C 08/19/2013			
		B. WING						
NAME OF PROVIDER OR SUPPLIER				STRE	ETADDRE	SS, CITY, STATE, ZIP CODE	1 00/	13/2013
ST OLAF	RESIDENCE					T AVENUE NORTH IS, MN 55411		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PRO	OVIDER'S PLAN OF CORRECTIO	NC	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	<	(EACH CROSS-	I CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROI DEFICIENCY)	.D BE PRIATE	COMPLETION DATE
F 250	Continued From pa	ge 96	F 2	50				
	allegations of sexual	al abuse, corporal punishment, igated. When asked why the						
	resident to resident were not in the poli	altercations and elopement cy, SSD explained that it was a						
_	administrator and D	nd "You'll need to speak to the DON."						
	483.15(h)(1)	IFORTABLE/HOMELIKE	F 2	52	F252			
55=D	ENVIRONMENT	IFOR TABLE/HOWELIKE	No. In Constitutes		1.	Corrective Action:		
				1		A) Resident #35 h		
	The facility must provide a safe, clean,					provided with		
	comfortable and homelike environment, allowing					personalize his		
	the resident to use to the extent possib	his or her personal belongings ble.				and make it me like.	ore home	-
		NT is not met as evidenced			2.	Corrective Action as it	applies	
	by:	I is not met as evidenced				to Other Residents:		
		tion, interview, and document		1		A) All residents have		
		ailed to provide a homelike				potential to be affected	by this	
		ersonalize the space for 1 of 4				deficient practice.		
		iewed for activities of daily		i.		B) All resident rooms		
	living.			4		evaluated for a persona	ii, nome-	
	Findings include:					like appearance.		
	in ange morador				3	Date of Completion: 10	0/3/2012	
	R35's room was ob	served on 8/12/13, and the			5.	2 and or completion. It	0/0/2013	
	room only containe	d a bed, bedside dresser,			4.	Reoccurrence will be P	revented	
		n. The walls were void of				by:	u	
		the television (TV) was dusty				B) Random audits wil	1 be	
	picture that was no	Leasily VISIDIE.				completed weekly		
	On 8/12/13 4:57 n	m. R35 stated his belongings				then monthly X3 w		
		R35 verified he had no				results being preser		
	personal items on the wall, and stated he would					the QA committee		
	not mind having pic	tures on the wall. The resident				follow up		
		t informed I could bring the facility when I came here."				discussion/planning	g.	

	OF DEFICIENCIES	& MEDICAID SERVICES	(20) 100			No. of the second s	0. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A St. Venuerenne	TIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED C 08/19/2013		
		B. WING		08			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRE	SS, CITY, STATE, ZIP COD		10/2010
ST OLAF	RESIDENCE			2912 FREMON MINNEAPOLI	T AVENUE NORTH IS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 252	blinds slightly open time. On 8/13/13, at 1:23 observed to be up i transferred to his be being transferred o	ge 97 to be lying in bed awake and . The TV was not on at the p.m. R35 was randomly n his chair, and then was ed by two facility staff. Prior to bserved the blinds completely his room and room lights on.	F 252 5. The Correction will be Monitored by: B) Director of Nursir designee				
	a.m. R35 was obse in bed on his back a observed bed was	random observations at 7:30 rved to be dressed and lying awake with blinds slightly open owered to the floor. R35 sed at 6:30 a.m. and left in					
	from the wheelchair	a.m. R35 was transferred to the bed observed to be inds completely shut and om.					
	observed lying in hi only came out of ro	bservations R35 was s bed most of the time and om during meals. At no time ions was the tv on for R35 to					
	5/14/13, indicated a Status (BIMS) revea	imum Data Set (MDS) dated Brief Interview of Mental aled a score of 13 out of the nitive patterns indicating mild					
	and the environmer verified R35 had no room was not perso	p.m. both the administrator tal service director (ESD)-C pictures on the walls and the malized or homelike. The ed to talk to the social					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387		Contraction and the	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING		C 08/19/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/19/2013
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 252	Continued From pa	age 98	F 2	52	
E 070	wanted on the walls there was family invitems from home.	A to see what the resident s and would check to see if volved to provide personal			
F 279 SS=E	483.20(d), 483.20(l COMPREHENSIVE	CARE PLANS	F 2	1213	
	A facility must use the results of the assessment			1. Corrective Action:	1 4 11 4 5
	to develop, review and revise the resident's comprehensive plan of care.			A) The care plans of resi were reviewed and revise the elopement risk and the	ed to reflect
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			Wander Guard; the use o devices and performance and what to do if the resi refuses; Depakote and th behaviors as well as the for the use of the medica	of ROM dent e target indications tion and
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment).		adjustment difficulties re nursing home placement B) The care plan of resid was reviewed and revise the need for an orthotic of ROM. C) The care plan of #68 reviewed and revised to need for behavioral inter The recommendations fr	lent #35 d to reflect levice and was reflect the ventions.
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care for the use of an orthotic device for 2 of 3 residents (R45, R35); for 1 of 8 residents (R45) who received a psychotropic medication; for 1 of 6 residents (R45) who had eloped from the facility; for 2 of 3			psychologist were added plan. D) The care plan of resident reviewed and revised to resident's comfort needs pain. The pain care plan both non-pharmacologic pharmacological interve	to the care lent #1 was address the related to addresses al and

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	09/11/2013 PPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		112 - Albarana	TIPLE CO	(X3) DATE SURVEY COMPLETED			
		245387	B. WING			C 08/19/2013	
	ROVIDER OR SUPPLIER			2912	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT AVENUE NORTH IEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	particular and the second s	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	Continued From page 99 residents (R45, R35) who received range of motion (ROM) services; for 1 of 1 resident (R68) who displayed behavioral/emotional status; and for 1 of 1 resident (R1) who had pain. Findings include: R45's care plan was not developed to address		F 2	279	 2. Corrective Action as it applied to the Residents: A) All residents have the potential to be affected same deficient practice B) The care plans of a residents receiving orthology devices and ROM were 	the I by the es. II hotic	
	elopements from the splint, left elbow bra (AFO) on the left for not include R45's us stablizing medication The Resident Admi indicated R45 was include vascular de spasms, persistent depressive disorde The annual Minimu 9/25/12, indicated Mental Status (BIN cognition) score co- identified R45 had impairments; R45 walking in and out R45 required supe unit and required e locomotion off the cane and/or a whe devices. The Cognitive Loss Assessment) dated cognitive losses, R decision making sl disorganized thinkit	s not developed to address he facility, application of a left ace, an ankle foot orthotic bot and ROM. The facility did use of Depakote (a mood on) on the care plan. ission Record dated 9/19/12, admitted with diagnoses to ementia, dysphagia, muscle mental disorder, pain, er, and left hemiplegia. Im Data Set (MDS) dated R45's a Brief Interview of IS, a tool used to measure build not be completed and short and long-term memory required limited assistance with of his room and transferring; rvision with locomotion on the extensive assistance with unit. The MDS indicated a elchair were his mobility s/Dementia-CAA (Care Area d 9/25/12, identified R45's t45 was not independent with kills, was inattentive, had ing, physical behaviors towards on of cares. The CAA identified	A statement of the statem		 devices and ROW were reviewed and revised a appropriate. C) The care plans of a residents at risk for eld and in need of Wander devices were reviewed revised. D) The care plans of a residents on psychotroc medications were reviewed to reflect the tablehaviors and the inditional use of the medications for residents with in need behavioral intervention behaviors related to ad difficulties were revier revised to reflect their needs. F) The care plans of a residents being seen b psychologist were revier revised to reflect the sections. G) The care plans of a residents with pain were revised to reflect the revised to r	as II ppement r Guard d and II ppic ewed and arget cation for s. all of ns/target djustment wed and current II by the iewed and auggested all	r d

Event ID: 6QVR11 Facility ID: 00260

		AND HUMAN SERVICES			FORM): 09/11/2013 1 APPROVEL 0. 0938-039
TATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Con Second Second	IPLE CONSTRUCTION	(X3) DA1	C
		245387	B. WING _		08	/19/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	and identified spec risk and referral to of Daily Living (AD Incontinence/Press was able to ambula assistance and a of was R45's primary CAA for Falls/Psyc 10/2/12, indicated was not steady, bu staff assistance. T be impulsive at tim had impaired mobi and contracture of indicated, "He will left hand splint & L Although the CAA contracture and oc and AFO, the CAA brace and did not in The quarterly MDS had a BIMS score impairment); he re with ADLs of trans the unit, dressing a required limited as out of the room. Elopement: The Risk of Elope indicated R45's po elopement were re the following: -On 9/20/12, the re out stairway exits of review indicated R	age 100 t time adjusting to the move" cific physical behaviors, suicidal the psychiatrist. The Acitvities Ls) Functional Status/Urinary sure Ulcers CAA identified R45 ate short distances with staff quad cane, but the wheelchair source of locomotion. The chotropic Medication Use dated R45 had balance problems, at was able to stabilize without he CAA indicated R45 "could nes." The CAA identified R45 ility, spasticity, left Hemiplegia, ins left hand. The CAA further occasionally refuse to wear his LE [lower left extremity] AFO." identified R45 had a ccasionally refused the splint did not identify the left elbow identify a ROM plan. S dated 6/21/13, indicated R45 of 10 (moderate cognitive equired extensive assistance of function on and off and grooming, toilet use; he asistance with walking in and ment/Wandering Review otential risk factors for eviewed. The reviews indicated eview identified R45 "tries to go which have stop signs." The R45 "has Wanderguard on" and t all times. The review indicated	F 27		gical and ventions. bers were to perform to me, apply dered, to sk for to the care luding the tor nent for pain blogical as to follow of the l on the	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	riple construction	(X3) DATE SURVEY COMPLETED C			
		245387	B. WING			/19/2013		
	RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 279	R45 had personal s "frequent monitorin frequency of the mo- On 12/19/12, and R45 was not at risk -On 7/2/13, the revi facility parking lot w want to exercise.' C unsafe without sup comments section "Wanderguard place	safety devices applied, had g" but did not identify the ponitoring and "Wanderguard." 6/15/13, the reviews identified for elopement or wandering. ww indicated, "Leaving into vithout notifying staff. States, 'I Cognitive/physical issues ervision." The additional of the review indicated, ced."	F 2	 Reoccurrence will be I by: A) Random audits will completed weekly then monthly X3 were sults being present the QA committee follow up 	 3. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for 			
	Although the reviews indicated a Wanderguard was applied to R45 after the 9/20/12 review, the clinical record indicated a Wanderguard was "applied" to R45 again on 1/9/13. A note on 2/16/13, indicated the Wanderguard remained on. The clinical record lacked evidence if and when the Wanderguard was removed. Although a Wanderguard was documented as "applied" on 7/2/13, the clinical record did not identify if a Wanderguard was applied on 7/1/13, or after the 7/2/13, elopements from the facility. The clinical record lacked evidence R45's elopements on 7/29/13 and 7/31/13, were reviewed.			Monitored by: A) Director of Nursin	A) Director of Nursing or Social Service Director or			
	A hand written care plan update dated 7/13 indicated, "1 Wanderguard applied [crossed out] initiated - check placement/function per protocol. 2 Post photograph of resident at appropriate place 3 Allow safe mobility in uncluttered environment 4 Encourage movement & exercise in environment 5 Redirect & reorient in gentle manner 6 Offer calm reassurance, 7 Reapproach if resistive 8 Cont [continue] walks outside w/ [with] staff 1-2 x day weather permitting." In addition, the care plan identified R45 could be physically and verbally abusive; he resisted care,							

		AND HUMAN SERVI					FORM AP	PROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	CLIA (X2) M	IULTIPLE CO	DNSTRUCTION		(X3) DATE SI COMPLE	URVEY
		245387	B. WI	NG			C 08/19/	2013
NAME OF F	PROVIDER OR SUPPLIER			1.111.01.01.000	ET ADDRESS, CITY, STATE, Z			
ST OLAF	RESIDENCE			1.000000.000000	FREMONT AVENUE NORT NEAPOLIS, MN 55411	н		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL PRI	D EFIX AG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD I THE APPROPR		(X5) OMPLETION DATE
F 279	of "attempting to ch the care plan identi The care plan did r risk, elopements fro enter unsafe areas stairwell. The care address prevention placement of the w attempts to remove the wanderguard. A a "walking program identify if R45 was or to be escorted w The Elopement Ass dated as revised of policy was to asses potential risk factor identified, "All resid admission and ann residents determin will be assessed qu the completion of the Assessment [Risk Review]." The polic appropriate interve bottom of the form, "elopement preven Depakote and devi The Physician's Or Depakote 125 milli sprinkles by mouth (BID) were ordered Depakote was incr 7/30/13. The order apply/provide the form	rements, and he had a noke self with hand." A fied R45 had a wande not identify R45's elop om the facility or atten of the facility or atten of the facility or atten of elopement, such a anderguard, R45's his the wanderguard, re- Although the program " for R45, the care pla supposed to walk with the R45 used a whee sessment policy and p n 5/15/13, identified the seach resident to ide s for elopement. The lents will be assessed ually for elopement. The lents will be assessed ually for elopement Risk of Elopement Risk of Elopement Risk of Elopement Risk of Elopement wander cy further directed to a ntions from the "list" a , directed to complete tion/management car ces: ders dated 7/31/13, in grams (mg) one caps (PO) were ordered tw for diagnosis of "anx eased to 250 mg PO fis also directed to staff	a history Although erguard. ement hpts to a the ons to as to story of asons for identified an did not a cane elchair. Procedure e facility entify policy on Those opement rected ring pply it the an e plan."	= 279				
FORM CMS-25	567(02-99) Previous Versions	s Obsolete Ev	ent ID: 6QVR11	Facility	ID: 00260	If continuation	sheet Page	103 of 298

	MENT OF HEALTH							FORM AF	PROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S			TIPLE CONSTRUC			(X3) DATE S COMPL	URVEY
		245	5387	B. WING				C 08/19	/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDR	ESS, CITY, STATE, 2	ZIP CODE		
07.01.45	DEDIDENCE				2912 FREMON	NT AVENUE NORT	н		
STOLAF	RESIDENCE				MINNEAPOL	IS, MN 55411			
(X4) ID	SUMMARY STA	TEMENT OF DEFIC	IENCIES	ID	PR	OVIDER'S PLAN OF	CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECE	DED BY FULL	PREFIX TAG				COMPLETION DATE	
F 279	Continued From pa	age 103	and the second sec	F 2	79				
	Left Elbow Splint or AFO Brace to left a								
	bedtime Wash left hand with	n soapy water a	and dry twice						
	daily Range of motion to lower extremity twi		emity and left						
	lower extremity twice daily Ace elastic bandage 4" wrap both legs daily PRN [as needed] to protect skin if using AFQ [sic]								
	brace if pt allows."								
	The care plan date "Impaired Commun dementia - persiste [disorder]ability to understand others	nication r/t impa ent mental d/o o make self-und is impaired." Th	aired cognition, derstood & ne care plan for						
	self-care deficit dat impaired mobility, s contracture of left h The care plan iden refuse to wear his l	spasticity, left h nand & cognitiv tified, "*He will	emiplegia, e impairment. occasionally						
	The care plan did r identify intervention	not address RO ns to address R	M and did not 45's refusals.						
	The care plan did r brace. A care plan dated 1		10-10-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1						
	risk for side effects and identified R45	from psychotro	opic drug use						
	[medication]." The use of Depakote. A	hand written c	are plan for						
	Falls dated 10/21/1 for fall r/t weakness on the left side). Th	s and left hemi	olegia (paralysis					•	
	indicated, "Resider with prior lifestyle i.	nt prefers activi e. walking prog	ties that identify gram" and						
	identified R45 wou AM and 2:30 PM. I	f he is compliar	nt with sticking						
	to these times reso choosing. Resdien	t [sic] to sign a	walking						
FORM CMS-2	567(02-99) Previous Version:	s Obsolete	Event ID: 6QVR1	1	Facility ID: 00260		If continuation	sheet Page	104 of 298

		AND HUMAN SERVICES			FOR	D: 09/11/2013 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		245387	B. WING	ı	0	C 8/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, C		
ST OLAF	RESIDENCE			2912 FREMONT AVE MINNEAPOLIS, M		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	interventions furthe therapy] to work wi community integrat On 8/19/13, at 3:07 elopement risk, the	Igreeing to above." The er directed, "OT [occupational th resdient [sic] (modified tion with behavior mod)." 7 p.m. the DON confirmed a use of splint, brace, AFO, an ie use of Depakote should	I	279		
	or ankle boots. Alth R35 wore splints (b "threw them [splints did not identify inte refusals of the ROI The care plan for A 3/15/10, indicated b program" daily, dire starting 10/4/10. Th to complete the str how many repetition for the stretch. A ha "Bilateral leg splints when in bed." [und "Refusing leg splint dated 6/12/13, "Pt guard on wheelcha added 7/12. The ca use of ankle splints address intervention of the splints, leg g	Alteration in mobility dated R35 had a "hamstring stretch ected to set up for the progra he care plan did not direct ho retch, such as for how long or ons or the type of ROM to app and written update directed, s on 1 hr [hour] after meals ated] An update dated 7/16, ts throws on floor." A note [Patient] refuses leg gard" (le air (w/c) behind foot pedals are plan did not address the s. The care plan did not ons to address R35's refusals guard (foot buddy) or ROM.	i m w bly		2	
	indicated R35 had diabetes mellitus ty gout, obesity, dem	port - Clinical dated 3/31/11, the following diagnosis: ype II, peripheral neuropathy, entia, pre-glaucoma, and				
ORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6Q	VR11	Facility ID: 00260	If continuation sheet	Page 105 of 2

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10.05045080	TIPLE CONST			PLETED
		245387	B. WING			C 08/1	, 9/2013
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				MONT AVENUE NORTH POLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	indicated R35's BIM changes with ADLs impairment in both ADL's/Urinary Incor 2/27/13, indicated F staff for grooming, CAA indicated, "He mobility as needed. The quarterly MDS had a BIMS score of MDS indicated R35 total assistance wit extensive assistance locomotion, eating, hygiene. The MDS lower extremities. The Physician's Or apply knee splints to to be put on for one lunch; Ankle Splints to be applied startin morning during slee Program in morning and directed to com in R35 was in bed. On 8/19/13, at 3:07 was no policy on sp application, assess maintenance. R68 had a physicia Release (XR) 75 m bedtime for depres	xiety. e MDS dated 2/13/13, //S score was 12, identified no . The MDS identified lower extremities. The CAA for ntinence/Pressure Ulcer dated R35 was totally dependent on bathing and dressing. The is assisted with all ADLs &		279			
FORM CMS-2	567(02-99) Previous Versions		11	Facility ID: 0	0260 If continuation	on sheet Pa	ge 106 of 298

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

PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING				C 19/2013
	PROVIDER OR SUPPLIER			291	REET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411	1 00/	13/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	approaches to addi The plan of care, in resident was at risk psychotropic drug u observe for medica for side effects. The use of monthly beh for additional side e psychologist or psy plan also address a related to the reside thrive, cardiovascul kidney disease. Sta resident time when and re-direct as ner address specific moreview of the medic lacked evidence tha by the psychologist interdisciplinary tea the recommended care. The resident was s assessment on 10/ assessment indicat seen to evaluate m status and to assis recommendations. resident's mood ap feeling helpless or difficulty adjusting t The psychologist d evidence of delusic documented R68 d dysfunction and the diagnostic impress		F 2	279			

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

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

	to I of the bio at	CAMEDIONE OFTINOED				110110.0.	
 D.S.Shiniyan and G.S.S.S.S.S. 	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S COMPLI	
		245387	B. WING	÷		C 08/19	/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE	1	
ST OLAF	RESIDENCE			2912 FREMONT MINNEAPOLIS	AVENUE NORTH S, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX (EACH (VIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROP DEFICIENCY)	D BE C	(X5) OMPLETION DATE
F 279	severity of the reside were severe related dysfunction and los psychological asses benefit from involve stimulating activity assistance to includ recommended the approach" where the strategy of "killing" soliciting his input a suggestions on ple might pursue. The showed a tendency The CAA, complete resident declined to process. She indica disorganized thoug CAA also noted R6 was seen by the fa A significant chang 7/19/13. The MDS and short term mer considered modera periods of being in thinking. The MDS concerns or behav indicated R68 was provide him persor An interview was c at 3:15 p.m. he res the edge of his bed resident denied an did not understand did not want to stay	dent psychosocial stressors d to disability issues, cogni as of independent living. The ssment noted R68 might ement with social and sense where structure and de him. The psychologist a "one-minute program eam members used the the person with kindness, and ideas as well as offerin asurable interests that he psychologist noted R68 y toward avoidance. ed on 7/12/13, noted the p participate in the assessmated the resident did have this and was inattentive. The 8's mood was stable and h cility psychologist as needed e MDS was completed on noted the resident had long mory issues and was ately impaired. R68 did exh attentive and disorganized reported R68 had no moo- ioral issues. The MDS cooperative with staff effor	s tive he sory llso llso llso llso llso llso llso lls	279			
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID:	6QVR11	Facility ID: 00260	If continuation	n sheet Page	108 of 298

		AND HUMAN SERVICES					RINTED: 0 FORM AP	PROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Second second	TIPLE CON	STRUCTION		(X3) DATE S COMPLE	
		245387	B. WING				C 08/19/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP C	ODE	00.10	2010
ST OLAF	RESIDENCE			head to guilt and the	REMONT AVENUE NORTH APOLIS, MN 55411			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix (PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE C	(X5) OMPLETION DATE
F 279	three sons. He also understand why he not feel it was "mak An interview with R at 8:30 a.m. R68 w himself sitting on th on but he did not a appeared alert and The resident contin refusals or resistive An interview with R at 9:55 a.m. He ag the edge of his bed sound was very low watching. His conv no obvious confusi continued to deny a resistiveness to pe An interview with s was completed on acknowledged beh not been developed care. She indicated episodes of resistin medications/treatm with medical recom An interview with th 8/19/13, at 12:16 p behavioral and nor mood should be pa She reported the M responsible for the	b reported he did not a was going to dialysis and did king him feel any better." 368 was completed on 8/16/13, vas observed in his room by ne edge of his bed. His TV was ppear to be watching. R68 I oriented to person and place. nued to deny any medication eness to personal cares. 368 was completed on 8/19/13, ain was by himself, sitting on d. The television was on but the w and he did not appear to be rersation was appropriate and ion was noted. The resident any medication refusals or ersonal cares. 361 oriented esignee (SSD)-A 8/19/13, at 12:14 p.m. SSD avioral/mood interventions had d/implemented into the plan of d the resident did have ng care, refusing nents and being non-compliant		279				
		censed practical nurse						
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6QVR	11	Facility ID:	00260 If co	ntinuation	sheet Page	109 of 298

		AND HUMAN SERVICES				RINTED: 09 FORM AP MB NO. 09	PROVED
11251-001-001-002-002-002-002-00-00-00-00-00-00-00-00	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SU COMPLE	
		245387	B. WING			C 08/19/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
STOLAS	RESIDENCE			2912 FREMONT AVENUE	NORTH		
STOLA	RESIDENCE			MINNEAPOLIS, MN 5	5411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROP FICIENCY)	BE CO	(X5) DMPLETION DATE
F 279	coordinator was co p.m. and reported s developing the care issues. She reporte responsible for that monitoring is not be reported that target were not being don	identified as the MDS mpleted on 8/19/13 at 12:33 she was not responsible for e plan for mood/behavioral ed social service was t. LPN-E reported that mood eing done for R68. She also t behaviors for depression	F 2	279	e est mont de la facto de la composition de la composition de la composition de la composition de la compositio		
	3/5/97, specified ea and individualized, required by the res problems identified entire health care to made by the consu- included in the plan regarding the ration recommendation in R1's Resident Adm indicated R1 was a include brain injury care plan was not o identified pain. A patient evaluation dated 12/5/12, and 6/13/13, indicated 1	ach care plan would be unique addressing all services ident to deal with the functional by each assessment of the eam. The recommendations liting psychologist were not n of care or any discussion hale for not including the n the plan of care. hission Record dated 1/16/13, admitted with diagnoses to , lupus, and osteoarthrosis. A developed to include R1's					
	with a treatment pla heat/cold, muscle s The admission MD had occasional, mi dated 4/23/13, india pain which was sev sleep at night, and because of pain. T 7/23/13, indicated	an of spinal adjustments, stimulation and stretch. S dated 1/22/13, indicated R1 Id pain. The quarterly MDS cated R1 had almost constant vere and made it difficult to limited day-to-day activities he quarterly MDS dated R1 did not receive					
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 6QVR	11	Facility ID: 00260	If continuation	sheet Page	110 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245387	B. WING			1.0453-544	C 19/2013
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	non-medication interpain present, and h indicated cognitivel A Physician's note "chronic and ongoin "working on getting electrical nerve stir pain." The Nurse Practition 7/19/13, indicated H posterior aspect of indicted was "tended A Comprehensive Assessment dated pain at the time of pain as moderate. Review of the care revealed pain was goals for pain were interventions for pain The June 2013 Me (MAR), revealed R times daily and reco occasions. Review revealed R1 receive for neuropathic pain Oxycodone 5 mg of The Resident Cent 12/1/08, directed " includes pain or the individual goals for	erventions for pain, had no had a BIMS score of 15 which y intact. dated 6/5/13, indicated R1 had ng back pain" and was a TENS [transcutaneous nulation] unit for her back oner Progress note dated R1 had a wound on the the second toe which R1 er." Pain Data Collection & 7/23/13, indicted R1 had mild the assessment with the worst plan for R1 received 8/16/13, not identified as a problem, e not identified and ain were not developed. dication Administration Record 1 received Neurontin three teived Oxycodone 5 mg on 14 of the August 2013 MAR, red Neurontin three times a day in and seizures, and on 8/17/13. tered Pain Care policy dated Every resident care plan e potential for pain. The pain management are	F 2	279	SANGUN DISENSION		
	individual goals for determined by the						

Facility ID: 00260

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	120-120-220-220-220-220	IPLE CONSTRUCT	00	TE SURVEY MPLETED
		245387	B. WING _			B/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE	011012010
ST OLAF	RESIDENCE			2912 FREMONT	AVENUE NORTH S, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		or each resident and include -drug approaches."	F 27 F 28			
	PARTICIPATE PLA The resident has to incompetent or oth	ANNING CARE-REVISE CP he right, unless adjudged herwise found to be er the laws of the State, to		1.	Corrective Action: A) The care plan of resident # was updated to reflect that the wound has healed and to inclu	ıde
	participate in plann changes in care an A comprehensive within 7 days after comprehensive as interdisciplinary te physician, a regist for the resident, an disciplines as dete and, to the extent the resident, the re legal representativ	ning care and treatment or nd treatment. care plan must be developed the completion of the sessment; prepared by an am, that includes the attending ered nurse with responsibility nd other appropriate staff in ermined by the resident's needs, practicable, the participation of esident's family or the resident's ve; and periodically reviewed eam of qualified persons after			measures to prevent recurrenc The care sheet was reviewed and revised to reflect the resident's current needs relate to prevention and foot wear. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by the same deficient practice. B) The care plans of all residents with current wounds or healed wounds were reviewed and revised to reflect their current needs including measures to prevent worsenin	d s s st
	This REQUIREME by: Based on observa- review, the facility care for 1 of 1 res foot ulcer had hea developing future to wearing shoes. Findings include:	 A second s	3.	or recurrence of wounds. C) Nursing staff was educated to on the need to revise care plans as wounds heal and to a preventative measures to prevent worsening or recurrent of wounds. Date of Completion: 10/3/201	i dd nce	

IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM 245387 B. WING 08/	E SURVEY PLETED
245387 B. WING 08/	0
	19/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATEDEFICIENCY)DEFICIENCY	(X5) COMPLETION DATE
 F 280 Continued From page 112 R49's Resident Admission Record dated 6/12/12, noted R49 to have diagnoses of diabetes and peripheral vascular disease. On 8/19/13, at 9.46 a.m. licensed practical nurse (LPN)-D was overheard to tell the nursing assistant (NA)-J that R49 should not have shoes on, because of her pressure ulcer, NA-J then removed the right shoe. On 8/16/13, at 9.56 a.m. R49 was observed in the wheelchair wearing a shoe on the left foot and a sock on her right foot. She has poor circulation markings on her skin on bilateral lower extremities and was carrying a stuffed animal horse. R49 was calling out quietly "Call the police, call the police!" R49's care plan dated 6/25/12, indicated R49 had a lack of comprehension at times. The potential for alteration in skin integrity related to decreased mobility, incontinence and diabetes. The care plan idi indicated a pressure reduction matress was in place, and skin should be observed for signs or symptoms of breakdown. The care plan lacked mention of the development and healing of the right foot ulcer and any interventions to maintain the skin integrity of the healed right foot ulcer. The Treatment Administration Record (TAR) August 2013 stated "Pt should not wear shoes, just socks or slippers due to ulcers." The TAR lacked evidence the nursing staff were documenting the shoes were being left off from 8/1/13 to 8/16/13. On 8/16/13, the TAR noted the nursing order to not wear was discontinued, however, there was no documentation in the R49's medical record to determine why the 	

		AND HUMAN SERVICES			14	FORM	09/11/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second sec		PLE CONSTRUCTION	COM	E SURVEY IPLETED
		245387	B. WING	;			C 19/2013
NAME OF PROVIDER OR SUPP	PLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE					2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
PREFIX (EACH DEFIC	IENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
On 8/19/13, at conducted. Th Orders stated not wear shoe on feet are ca On 8/16/13, at sheet indicate did "get her dr not put the shi give me my sh sheet had the donning the sh looked unchar On 8/19/13, at stated since "I socks or slipp order, it can b was no longer updated to dis paged through it was here, le documentatio On 8/19/13, at of nursing (O) direct the NA ¹ shoes and ulc On 8/19/13, at the care plan sheets are up manager. LPN	had I 10:22 e Au "Nur s bui used t 10:0 d not esse cores care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care hoes care care care care care care care care	 been discontinued. 22 a.m. a chart review was gust 2013 printed Physician sing orders: Pt [patient] should t wear socks or slippers (ulcer by shoe irritation)." O2 a.m. NA-J stated the care thing about R49's shoes. NA-J ed and put her socks on, but did on her even though R49 cried "NA-J stated "the NA care s listed on the sheet which " and stated R49 foot had that morning. 1 a.m. registered nurse (RN)-A ould not wear shoes, just lue to ulcers", was a nursing continued by nursing when it eeded, and the care plan was inue to order. When RN-A care plan, she stated I thought look, no additional s provided. 41 a.m. the consultant director tated the NA care sheet did not arding the donning of the 		280	a laistait - a an a laise Anno 11 an an 11 an 12 -		

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245387	B. WING			19/2013
NAME OF F	PROVIDER OR SUPPLIER		1.1	STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORT MINNEAPOLIS, MN 55411	Н	2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280 F 282 SS=E	On 8/19/13, at 10:5 wearing shoes had was just removed I shoes again. The p include intervention care to prevent and breakdown of the r 483.20(k)(3)(ii) SEI	50 a.m. RN-A, stated not been on the NA sheet and ast Friday, R49 can now wear blan of care was not revised to its on how staff were to provide d /or minimize potential skin ight foot. RVICES BY QUALIFIED	F 280 F 282			
	must be provided b accordance with ea care. This REQUIREME by: Based on observa review, the facility care and services residents written pl had a Wanderguar the wheelchair for for needed assista residents (R82) wh toileting; for 1 of 4 identified at being a residents (R42) wh assistive devices a residents (R23) for Findings include: R45's Wanderguar	ded or arranged by the facility by qualified persons in ach resident's written plan of NT is not met as evidenced tion, interview, and document failed to ensure appropriate were provided according to the lan of care for 1 of 4 (R45) who d (a security device) placed on security; for 2 of 3 (R35, R17) nce with grooming; for 1 of 4 to needed assistance with residents (R87) who was at risk for falls; and for 1 of 3 no needed assistance with and repositioning; and for 1 of 4 to range of motion services.		J		
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6QVR	11 F	acility ID: 00260	If continuation sheet Pa	age 115 of 298

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	0	X3) DATE COMPI	
			A. BUILDI	NG	-	С	
		245387	B. WING				9/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE I MINNEAPOLIS, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 282	Continued From pa	age 115	F 2	82 F282			
		ted 7/31/13, had a hand written	10000000				
		which directed, "Wanderguard			ective Action:		
		acement/function per protocol."			dent #45 had his		
				Guard E	Bracelet replaced	and it	
		5 p.m. the registered nurse		is now b	being routinely ch	necked	
		Wanderguard should be staff every shift for placement		for place	ement and function	on.	
		verified the device (tester)			ormation is now	on the	
		tion of the Wanderguard was			n and the TAR.		
	missing.		1	B) The f	facility has purch	ased a	1919 -
			11 83	new Wa	nder Guard testir	ng unit	
	On 8/16/13, at approximately 8:00 a.m. the			for staff			
		rmed the facility did not have			lent #35 has been		
		k if the Wanderguards were			with shaving and		
		ninistrator stated the testers would be "arriving today." The			ve been trimmed.		
		rmed the facility's procedure			n and care sheets viewed and revis		
		anderguards checked for					
	function every shift			tasks rou	ne need to perform	m these	
					lent #82 has been		
		ded shaving and nail care			ed related to her	1	
	0 0	ce as directed by the care plan			needs and the ca	no nlon	
	on 8/12/13, 8/13/13	5 and on 6/14/13.			sheets have been		
	On 8/12/13 at 1.1	1 p.m. on 8/13/13, at 1:23 p.m.		updated.		1	
		ations on 8/14/13, from 7:30		÷	ent #87 was reas	conned	
	0	R35 was observed to have		related to	o her fall risk and	sessed 1 the	
		of beard and quarter inch long			prevention meas		
	fingernails with del	bris under the nails. At not time			care plan and care		
		ous observations on 8/14/13,			ave been updated.		
	was grooming assi	istance provided.			ent #42 has been		
	At 10:34 am that	icensed practical purso			ed for repositioni		
		icensed practical nurse I shaving should be completed			ssistive device ne		
		showerday. LPN-H explained	1		device needs and		
			i i				
				been trin	med Her care n	lan	
	should report to he	er if the nails were long, needed		occa um	and the care p	iall	
	nailcares were con showerday and nu should report to he	npleted by the nurse on rsing assistant (NA) staff		toileting	needs. Her nails nmed. Her care p	hav	e

Facility ID: 00260

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245387	B. WING				19/2013
	PROVIDER OR SUPPLIER			291	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	007	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	stated the razor sho the NA staff for a ch himself," but "misse offer to assist and s At 10:25 a.m. both was not offered the nails were not repor razor was visible and R35's care plan date with shaving, low m The care plan direct and included a hand "Res. [resident] war directed, "Assist of razor daily or PRN [further directed, "Na day." On 8/19/13, at appr director of nursing (have been offered t the need for nail can to the LPN for diabe should have been c (8/13/13). R82 was not assisted and forty-one minut The impaired bowel plan dated 7/11/13, program which decr The care plan direct every two hours and cares/pad changes directed staff to ass	re not reported to her. LPN-H build have been plugged in by harge, R35 "trys to shave es a lot" and NA staff need to have patchy areas. NA-H and NA-A verified R35 opportunity to shave, the long ted to LPN-H, verified the id not charged. ed 3/15/10, identified deficits otivation, and fatigues easily. ted to provide total assistance d written note dated 2/12 - hts to be shaved." and 1 to shave w/[with] Electric as needed]." The care plan ail care & skin check on bath oximately 1:30 p.m. the DON) verified R35 should he opportunity to shave and re should have been reported etic nail care. The nail care ompleted on bathday	F 2	282	 and care sheets have been updated to reflect her current needs. G) Resident #17 has been shaven. H) Resident #23 was reassessed for his restorative PROM and ambulation program needs. The care plan and care sheets reflece the current needs and the staff members are documenting about the programs routinely. 2. Corrective Action as it applies to other Residents: A) All residents have the potential to be affected by same deficient practice. B) The care plans and care sheets of all residents receiving restorative PRON ambulation programs were reviewed and revised as appropriate. C) The Restorative Nursing Program Policy was review and revised. D) The care plans and assessments of all residents require toileting assist were reviewed and revised to refitheir current needs. E) The care plans and assessments of all residents 	e t ut to the M and g ved s who e lect	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the state of the	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245387	B. WING			/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		1012010
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 282	Goal Analysis Note "is now toileted & n has changed." During continuous 7:40 a.m. until 11:2 sitting in a chair in floor without being a.m. NA-L was ask NA-L stated she ha use the toilet earlie however, this was n during continuous of approached R82 al go to the bathroom NA-L's question. When NA-L was as does not respond t stated she would te NA-L reported to L R82 to the toilet. LH or assist R82 with not re-approach R8 Upon interview on stated she expecte according to the plan R87 did not have fa directed by the plan	n/assist of two as needed. A d dated 7/11/13, indicated R82 ot prompted, toileting program observations on 8/16/13, from 1 a.m. R82 was observed the dining room on second assisted to the toilet. At 11:21 ed to assist R82 to the toilet. ad asked R82 if she wanted to r and R82 had refused; not observed by the surveyor observations. NA-L nd asked her if she needed to . R82 did not respond to sked what she does if R82 o her toileting prompt, NA-L ell the nurse. At 11:35 a.m. PN-D she was unable to assist PN-D did not respond to NA-L her toileting needs. NA-L did 32. 8/16/13, at 1:03 p.m. the DON ed residents to be toileted an of care.			r current idents at iewed and r current cheeked aven as sidents mmed as c for reassessed evices are is and TAR lect the cement and rchased a ander Nursing reviewed mbers were to read s and group lso	
	and elbow pads wo	orn at all times.		and Nursing Care Sta Policy.	andards	
	The Nursing Assist	tant Assignment Sheet				

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

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ATEMENT D PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245387	B. WING		C 08/19	/2013	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP	CODE		
ST OLAF	RESIDENCE			12 FREMONT AVENUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE	(X5) COMPLETION DATE	
F 282	received 8/15/13, d protectors.	irected elbow and hip	F 282	3. Date of Completi			
	8/13/13, at 1:54 p.m., 8/15/13, at 8:29 a.m.,8/16/13, at 8:12 a.m. without elbow protectors on.RN-A was observed assisting R87 with toiletingX3		A) Random completed weekly x X3 with results bein	 4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up 			
	have hip or elbow	protectors on.		QA committee for fo discussion/planning			
	Administration Rec hip and elbow prot	ly and August 2013, Medication cords were reviewed and the ectors were circled as not the reason given as "don't see		5) The Correction w A) The Dire Designee.	ill be monitored by ctor of Nursing or	<i>r</i> :	
	indicated "Ok to d/ elbow protectors a stockings] d/t [due this order was not when the record w	bhone Orders dated 8/14/13, c [discontinue] hip protectors, nd TED hose [anti-embolism to] non coverage." However, present in the medical record ras reviewed on 8/16/13. There of any alternate fall n place.					
	nurse consultant s protectors and hip the pharmacy or c nurse consultant v	on 8/16/13, at 11:11 a.m. the stated the facility provides elbow protectors are available from ones available in the facility. The verified the elbow and hip ut into place as fall					
	R42 was not posit assistive devices of care.	ioned and did not have applied as directed by the plan					

		AND HUMAN SERVICES			FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT COM	E SURVEY
		245387	B. WING		1.000	C /19/2013
NAME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	10/2010
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	reposition side to si potential for alterati dated 4/6/09, direct hands on at all time when in bed to pres maintain skin integi bladder function ca staff to check resid needed for incontin abrasion due to scr 5/13/10; directed na week. The self-care dated 4/6/09, direct bath days. The Patient Medica included a physicia on at all times-may The Nursing Assist received on 8/15/13 protectors, toileting three hours check a hours AM/PM and p hours, remain off b During continuous 8:11 a.m. until 10:3 sitting in a wheel ch protectors on. At 10 medication aide (Th assisted her into be she had gotten R42 a.m. (a total of three minutes) and she m hours in the wheel	de with no back lying. The on in skin integrity care plan ted bilateral palm protectors to es and bilateral knee splints serve range of motion and rity. The impaired bowel and re plan dated 4/6/09, directed ent every two hours and as ence. The potential for ratching self-care plan dated ails will be trimmed every e deficit in bathing care plan ted nail care to be done on al Care Plan dated 7/29/13, n's order for palm protectors remove for cares and bathing. ant Assignment Sheet 3, directed bilateral palm assist of one every two to and reposition, up for two position side to side every two ack when in bed. observations on 8/15/13, from 3 a.m. R42 was observed nair in her room without palm 0:33 a.m. NA-I and trained MA)-B entered R42's room and ed. When asked, NA-I stated 2 up in the wheel chair at 7:00 e hours and thirty-three epositioned R42 every two chair. NA-I verified R42 did not ors on and stated R42 did not				

DATE BANK OF DEPORTIONS (X) PROVEEWSUPPLIERUA DENTIFICATION NUMBER (X) DUTE SUMMAY A BUILDING (X) DUTE SUMMAY BUILDING (X) DUTE SUMAY BUILDING (X) DUTE SUMAY BUILDING		MENT OF HEALTH							RINTED: 0 FORM AP MB NO. 09	PROVED
245387 B. WING 08/19/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY ULL) PRETAR STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH COMPLETION PALID PRETAR SUMMARY STATEMENT OF DEFICIENCIES (EACH OERCENTY OR ISO DE MET PROCEDED BY ULL) (EACH OERCENTY OR ISO DE MET PROCEDED BY ULL) REGULATORY OR ISO DE MET PROVIDENCE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION (EACH OERCENT) COMPLETION (EACH OERCENT	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUP	PLIER/CLIA	A second a second				(X3) DATE S COMPLE	URVEY
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ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (24) ID PREFIX TAC SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDE BY FULL RESULTIONY OR LSC DENTIFYING INFORMATION) ID PREFIX TAC PROVIDER'S FLACTORY ACTION SOULD BE CROSS-REFERENCE ACTION (EACH ORECTIVE APPROPRIATE DEFICIENCY) COMENTION COMENTION RESULTIONY OR LSC DENTIFYING INFORMATION) ID PREFIX TAC PROVIDER'S FLACTORY (EACH ORECTIVE APPROPRIATE DEFICIENCY) COMENTION COMENTION (EACH ORECTIVE ACTION (EACH ORECTIVE ACTION EACH DEFICIENCY) COMENTION (EACH ORECTIVE ACTION (EACH ORECTIVE ACTION (EACH ORECTIVE ACTION) (EACH ORECTIVE ACTION (EACH ORECTIVE ACTION (EACH ORECTIVE ACTION) COMENTION (EACH ORECTIVE ACTION (EACH ORECTIVE ACTION) COMENTION (EACH ORECTIVE ACTION) </td <td>NAME OF F</td> <td>PROVIDER OR SUPPLIER</td> <td></td> <td></td> <td></td> <td>STREE</td> <td>TADDRESS, CITY, STATE, 2</td> <td>ZIP CODE</td> <td></td> <td></td>	NAME OF F	PROVIDER OR SUPPLIER				STREE	TADDRESS, CITY, STATE, 2	ZIP CODE		
PREERX TAG CEACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTRYNN INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMETTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMETTION SHOULD BE DEFICIENCY) F 282 Continued From page 120 R42 was observed in bed on 8/15/13, at 1:49 m, and did not have palm protectors or knee splints on. F 282 F 282 When interviewed on 8/15/13, at 2:13 p.m. LPN-D verified R42 did not have palm protectors or knee splints on. LPN-D located the knee splints in the closet and stated the NAs should be putting the splints on. LPN-D bated APA thought the palm protectors were taken away and R42 was to have wash clothes in her hands. R42's nails were noted to be ¼ inch long, LPN-D stated she usally cut R42's nails on bath day or when she notices they are long. The bath log was reviewed and indicated R42 received baths on reviewed and indicated R42 received baths on R415/13, at 2:31 p.m. NA-M verified R42 was lying on her back in bed with nothing in her hands. R42's toenails were noted to be ½ inch long. On R416/13, from 7:41 a.m. until 9:24 a.m. R42 was observed hying on her back in bed with nothing in her hands. At 9:24 a.m. R42 was observed stimt nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed stimt nothing in her hands and no splints to her knees. LPN-H was approached by the surveyor on 8/19/13; at 11:14 a.m. LPN-H stated R42 was supposed to have palm protectors in her hands or washcloths. LPN-H located one palm protector in the room which stated she would have to call therapy for a new one. LPN-H stated the NAs were to apply the palm protectors after cares and the nurse cut R42's nails with baths.	ST OLAF	RESIDENCE						ſH	9	
 R42 was observed in bed on 8/15/13, at 1:49 p.m. and did not have palm protectors or knee splints on. When interviewed on 8/15/13, at 2:13 p.m. LPN-D verified R42 did not have palm protectors or knee splints in the closet and stated the NAs should be putting the splints on. LPN-D located the knee splints in the closet and stated the NAs should be putting the splints on. LPN-D stated she thought the palm protectors were taken away and R42 was to have wash clothes in her hands. R42's nails were noted to be ½ inch long, LPN-D stated she thought the splint or LPA-D stated she thought the sually cut R42's nails on bath day or when she notices they are long. The bath log was reviewed and indicated R42 received baths on Wednesday evenings. When interviewed on 8/15/13, at 2:31 p.m. NA-M verified R42 received a bath on 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed with nothing in her hands. At 9:24 a.m. NA-I verified R42 was lying on her back in bed. R42's toenails were noted to be ½ inch long. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed. R42 was approached by the surveyor on 8/19/13, at 1:14 a.m. LPN-H stated R42 was supposed to have palm protectors in her hands. R42's right hand. LPN-H was naple to have palm protectors in her hands or washoldts. LPN-H located one palm protector in the room which she applied to R42's right hand. LPN-H was unable to locate a palm protectors after cares and the nurse cut R42's nails with baths. 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED) BY FULL	PREF		(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD	BE C	OMPLETION
the NAs were to apply the palm protectors after cares and the nurse cut R42's nails with baths.	F 282	R42 was observed p.m. and did not has splints on. When interviewed LPN-D verified R42 or knee splints on. splints in the closed putting the splints of the palm protectors was to have wash nails were noted to she usually cut R42 she notices they ar reviewed and indic Wednesday evenin 8/15/13, at 2:31 p.r a bath on 8/14/13. On 8/16/13, from 7 was observed lying nothing in her hand R42 was lying on h were noted to be ½ On 8/19/13, at 9:52 her back in bed wit splints to her knee observed sitting in her hands. LPN-H surveyor on 8/19/1 R42 was supposed hands or washclott protector in the roor right hand. LPN-H protector for the le	in bed on 8/15/13 ave palm protecto on 8/15/13, at 2:1 2 did not have palm LPN-D located th t and stated the N on. LPN-D stated s were taken away clothes in her han be ¼ inch long, L 2's nails on bath of re long. The bath ated R42 received m. NA-M verified I 2'41 a.m. until 9:24 g on her back in b ds. At 9:24 a.m. N her back in bed. R 2 inch long. 2 a.m. R42 was of th nothing in her h s. At 11:13 a.m. R a wheel chair with was approached 3; at 11:14 a.m. L d to have palm pro- hs. LPN-H located om which she app was unable to loc ft hand and stated	rs or knee 3 p.m. m protectors e knee As should be she thought y and R42 ds. R42's .PN-D stated lay or when log was d baths on ewed on R42 received 4 a.m. R42 ed with A-I verified 42's toenails oserved on ands and no 42 was n nothing in by the PN-H stated otectors in her d one palm lied to R42's ate a palm d she would		282	DEFICIEN			
	EOPM CMS 2	the NAs were to an cares and the nurs	oply the palm prot se cut R42's nails	ectors after with baths.	11	Facility	0.00260	If continuation	a shoot Page	121 - 6 200

		AND HUMAN SERVICES				PRINTED: 0 FORM AF	PROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		245387	B. WINC	B		C 08/19	/2013
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 121	F	282			
	lower chin on 8/12/ 8/15/13, was not pr the facial hairs. The care plan date "self-care deficits re weakness and cog hemiplegia. Care p received assistance bathing. R17 care p be neat, clean & oc On 8/12/13, at 5:39 her bed on her back the lower chin (app length) down her fr On 8/13/13, at 10:0 still not removed. On 8/14/13, at 8:09 continuous observa -At 8:09 to 8:14 a.r wheelchair in her re yellowish-green an was still present. -At 8:15 a.m. NA-G room and brought still observed to ha chin and down the -At 8:24 a.m. obse	9 p.m. observed R17 lying in or with numerous facial hairs proximately a half (1/2) inch in ont neck area. 00 a.m. observed facial hairs 0 to 9:31 a.m. during ations: m. observed R17 up in her oom dressed in a id red print dress. The facial 6 observed entering R17's resident to dining room. R17 we several facial hairs to low neck area. rved NA-G offered R17	nd to n				
	the front. -At 8:25 to 9:30 a.r room eating her br came up to resider no staff offered to		g aff d	Facili	by ID: 00260	tion object Dee	100 -6 000
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 60	JVRII	Facili	ity ID: 00260 If continua	tion sheet Page	e 122 of 29

		AND HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCT		(X3) DA	TE SURVEY MPLETED
		245387	B. WING			08	/19/2013
NAME OF F	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP (CODE	
ST OLAF	RESIDENCE			2912 FREMON MINNEAPOLI	T AVENUE NORTH S, MN 55411	¥0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CO CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 282	-At 9:31 a.m. NA-F resident from the b her room, shut the observed to be car went to the soiled u - At 9:42 a.m. obse facial hairs still the - At 12:15 p.m. obse room table waiting facial hairs. Again a area no one offeren resident. On 8/15/13, at 8:30 dining room table of facial hairs. On 8/16/13, at 9:27 LPN-A regarding the "facility does not hab but once a week st remove resident's up and re-approac it's their right to do have to report to the refusal." On 8/16/13, at 1:03 consultant director expectation was st the resident's daily dignity issue espects a resident refused to assist the resident	came and retrieved the reakfast meal and took R17 to door and then came out rying a plastic bag on her and utility room. erved R17 lying in her bed with	F 2	32			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6QVR	11	Facility ID: 00260	If co	ontinuation sheet I	Page 123 of 298

		AND HUMAN SERVICES			FO	TED: 09/11/2013 RM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		245387	B. WING _			C 08/19/2013
NAME OF F	PROVIDER OR SUPPLIER	Le 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 19		STREET ADDRESS, CITY, STATE, ZIP		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 282	R23 was not provid range of motion se physician and as in care. The undated Nursii AM/PM directed "P motion]-slow stretc [physical therapy] r Review of R23's ca maintenance progr resident to ambula stretching and PRC "will complete prog Current physician of Ambulation 20 to 5 OT/PT [occupation	age 123 led upper and lower extremity rvices as ordered by her idicated in her written plan of ng Assistant Assignment Sheet ROM [passive range of h and Ambulation per PT ecommendations-PM shift." are plan for physical therapy ram dated 1/13, directed te 20 to 50 feet with walker, DM program every day. Goal ram qd [everyday]." orders dated 8/5/13, directed: 0 feet with walker daily hold ial therapy] to assess and <i>I</i> daily - see program	F 28	.2		
	to walk more some doctor had ordered but sometimes he that he would like t he can go with fam residents in the fac On 8/14/13, at 1:48 she had assisted F know where and w complete documer ambulation, NA-G complete the progr On 8/14/13, at 2:12 and stated NAs we	B p.m. interviewed NA-G stated 23 with PROM but did not ho was responsible to ntation. In regards to stated the evening shift was to	"我们是我们的,我们们有一个,我们不是我们的,我们们是我们的,我们们,我们们不是,一个人们一个人们,我们们们一个人们的情况,你们是你们的你们的最后,我们们不是我们			
FORM CMS-2	567(02-99) Previous Version		11	Facility ID: 00260	continuation she	et Page 124 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVI COMPLETED	
		245387	B. WING				C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ST OLAF	RESIDENCE	3			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	treatment administr shift. LPN-B further program was on ho currently working w order dated 7/10/13 from therapy secon On 8/16/13, at 10:1 therapist assistant picked up 5/14/13, after resident had e although original or program. O-H state completed 10/28/12 transferring and de which R23 complet 12/7/12, from thera was not being amb requested an order transfers and R23 s five times weekly u session, R23 had c after two therapists mat in quad positio x-ray was complete through 7/31/13, by therapist as indicate sign-out sheet. On 8/16/13, at 9:27 stated her expectat restorative sheets t documenting the P was completed. RN currently being revi	ration record at the end of the stated the ambulation old as physical therapy was ith R23 despite physician 8, that he had been discharged dary to goals have been met. 4 a.m. certified occupational (O)-H stated R23 had been following a physician order expressed desire to ambulate der was for a restorative ed original evaluation was 2, for ambulation, standing, creased functional mobility ed and was discharged py but later found out that R23 ulated. On 5/13/13, O-H for ambulation and safety with started being seen 5/14/13, ntil 7/10/13. During the complained of left ankle pain had assisted him to the floor n for exercise on 6/4/13, an ed no fractures and issue had er added that staff was ent ambulation program 7/8/13 v PT staff including the physical ed by documentation and a second stated the RN-A tion is to find a place to keep to ensure staff was ROM and ambulation after it V-A stated also the Policy was ewed and documentation will A further stated that the		282			

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And the second second	States and States and all states of	& MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
	ROVIDER OR SUPPLIER		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	REET ADDRESS, CITY, STATE, ZIP CC 2 FREMONT AVENUE NORTH		
STOLAF	RESIDENCE		MI	NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	documentation was shift daily after they assistants had com a.m. O-D concurred On 8/16/13, at 4:06 and O-H stated the between the therap about R23's ambul been restarted aga why it was not bein The Range Motion policy and procedu Assist the resident resident's ability to motion " The procedure to ensur responsible to ensur completed and whe	s completed by the end of their made sure the nursing opleted the task. Later at 11:32 d with RN-A's statement. b p.m. interviewed O-D, RN-A re was a misunderstanding by and nursing departments ation program and when it had in which explained the reason	F 282			
F 309 SS=D	systematic commu therapy and nursing when a resident has therapy and approp continued as restor 483.25 PROVIDE (HIGHEST WELL B Each resident mus	nication channel between the g departments in regards to d been discharged from priate programs to be rative by nursing. CARE/SERVICES FOR EING t receive and the facility must	F 309			
	or maintain the high mental, and psycho	ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment		8		

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245567	D. WING .	OTO		08/	19/2013
	RESIDENCE			291	REET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 309	by: Based on observa review, the facility f services that were resident (R68) who services; the facility 1 of 1 resident (R1 pain; and the faciliti implement interven reviewed who had facility failed to follo administer an antib appointment for 1 of history of cardiac p Findings include: Dialysis: R68's Resident Ad noted R68 had diak kidney disease (Sta Type II. He attende R68's care plan wa developed related followed specific pl dialysis and lacked emergency service R68. On 8/16/13, at 8:48 bright red blood wa sleeve. R86 report bleeding and the n interview with licen was done on 8/16/ the resident's shur	NT is not met as evidenced tion, interview and document ailed to identify dialysis being provided for 1 of 1 was received dialysis (failed to provide services for) who was identified as having y failed to assess, monitor and titions for 1 of 2 residents (R87) bruises of unknown origin; the pw physician's order and biotic prior to dental of 1 resident (R68) who had a	F3	09	F 309 1. Corrective Action: A)The Dialysis care plan resident #68 was reviewe updated to reflect emerge procedures related to the bleeding and what to do it exhibited signs of infection what to do if the resident con not be transported to dialysis due to bad weather or other disasters. His Dialysis diet including foods to avoid and fluid restriction and the need monitor his fluid intake at m times and throughout the resi- the day were reviewed and H care plan was revised. His weights are being checked before and after dialysis as p orders. His blood pressure i being checked before and af- dialysis. The physician has been informed that the resid- frequently refuses his Kione B) Resident #1 pain has been assessed and being re-assess on regular basis. The pharm has been contacted and a pla in place to assure that the resident receives her medications as ordered. C) A reporting system is in place for bruises of unknown	d and ncy shunt f he m; and ould is d his d to neal st of his per s ter ent x. n ed acy n is	

Facility ID: 00260

		AND HUMAN SERVICES			FORM): 09/11/2013 1 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	/19/2013
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		TOTECTO
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	new dressing. She happened to the re- inform the physicial reported that she d program wanted he they wanted to be r bleeding. She verifi emergency service dialysis needs. She emergency, she wo directions from him was bad weather a could not transport would call an ambur reported she was u The plan of care, d resident had dialysi on a therapeutic did diuretic medication centimeters (cc) flu follow the physiciar nutritional supplem weights per physici identification of any approaches/interve plan was implement both at meals and o were no plans in th procedures or sign exhibit which requir consultation/interve bacterium, and sep The Care Area Ass on 7/12/13, noted th	reported that occasionally sident's shunt and she would in about the incident. She also id not know how the dialysis er to treat the bleeding or if notified of a small amount of ed there was no plan for s for the resident and his e indicated that in an buld call his physician and get the resident to dialysis, she ilance to transport company the resident to dialysis, she ilance to transport him. She inaware of any other options. ated 10/8/12, noted the is three times per week, was et as result of this, received a , was a 2000 cubic id restriction, and staff were to n orders for medications, ents, obtain vital signs and an order. There was no v established goals set or entions for dialysis services, no nt for monitoring fluid intake, on the residential unit. There e care plan for emergency s/ symptoms the resident may re medical entions such as infection, bit is shock.	F 3	 origin and resident #87 assessed for further bru The skin care plan of re #87 was reviewed and r reflect her current need D) The MAR and care p resident #68 was review revised to specify the ne Antibiotic Therapy and type/dose to administer dental appointments. Corrective Action as it a to other residents: A) All residents have th potential to be affected deficient practices. B) The Abuse Preventic and Incident Reporting I was reviewed and revise C) All staff members we educated on the Abuse Prevention Plan and the Reporting Policy. D) Nursing staff membe educated on the needs of patients with dialysis. E) The care plans of all residents receiving dialy been reviewed and revis reflect emergency procee including what to do in to of uncontrolled shunt ble signs of infection at the s site and what to do in care 	ising. solution revised to s. plan of ved and eed for what prior to applies e by these on Plan Policy ed. ere Incident rs were f sis have ed to dures he case eeding, shunt	

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DEPARTMENT	OF HEALTH	AND H	IUMAN	SERV	ICES
CENTERS FOR	MEDICARE	& MED	DICAID	SERV	ICES

PRINTED: 09/11/2013	
FORM APPROVED	
OMD NO 0000 0004	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Street and streets	TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		245387	B. WING		08/19/2013			
	ROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE		
	was completed or resident had long and was consider did exhibit periods disorganized think or behavioral issu was cooperative w personal cares. H of one staff with b toilet use and per- dialysis and receiv of that. Although, improvement note MDS, it was deter and due to his por continued need for the potential/expendence	n 7/19/13. The MDS noted the and short term memory issues ed moderately impaired. R68 s of being inattentive and king. He had no mood concerns es. The MDS indicated R68 with staff efforts to provide him e needed extensive assistance ed mobility, transfers, dressing, sonal hygiene. He received wed a therapeutic diet as result there were some areas of ed on the significant change rmined he had declined overall tential for skin breakdown, the or assistance with transfers and ectation he would continue to mobility. It was also	F 3	 the inability to transport the resident to dialysis if there bad weather or any other disaster; fluid and dietary restrictions, fluid intake monitoring, weight monitor and blood pressure monitor per physician orders. E) The Pain Management H was reviewed and revised a nursing staff members were educated on the need to proboth non-pharmacological intervention as ordered. F) Nursing staff has been educated on the need to come ducated on the need to	is ring Policy and e vvide and ons tact			
	medical condition periods of increas R68's Physician C directed staff to w dialysis. A review in the month of Ju before or after dia weight for the mo was not a day the 2013, the records before and after of 7/26/13, and no w of the opportunitie 2013, the weights	Orders, last signed on 8/1/13, reigh R68 before and after of the medical record revealed une, 2013-no weights were done alysis and the only recorded nth was done 6/14/13, which e resident had dialysis. In July, indicated R68 was weighed dialysis only on 7/16/13 and veights were recorded for 42% es. From August 1 to August 13, is were correctly done on two		 the pharmacy immediately in there is a medication ordered but not available to administ and that they must contact the physician if the pharmacy is able to provide a prescribed medication. G) Nursing staff has been educated on the need to commute the physician if the resident refusing medications. H) Nursing staff has been educated on the need to check the MAR and care plan for Antibiotic orders when a 	d ter he not tact is			
	weights were don An interview was	nd August 8, 2013, and no le for 58% of the opportunities. completed with LPN-D on o.m. She reported that was not		resident is to receive dental services.				

Facility ID: 00260

		AND HUMAN SERVICES			PRINTED: FORM A OMB NO.	PPROVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		LETED
		245387	B. WING		08/1	9/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	and after dialysis. S	age 129 Int not being weighed before She also reported all weight documented in the medical	F 30	9	÷.	
	staff to measure Re after dialysis. A rev revealed in June, 2 as ordered on two not taken as ordered July, 2013-the resid taken as ordered o 7/20/13 & 7/30/13) of the time. During resident's blood pre	ers, signed on 8/1/13, directed 68's blood pressure before and iew of the medical record 013-blood pressure was taken days (6/1/13 and 6/6/13) and ed 53% of the time. During dent's blood pressure was n four days (7/6/13, 7/16/13, but not taken as ordered 50% August 1-13, 2013- the essure was taken as ordered 8/8/13, 8/10/13 & 8/13/13) and d 25% of the time.		See Health Addendum com	npletion date	10/3/13
	8/14/13, at 2:25 p.r aware that the resid being taken before by the physician. S pressures taken we record. An interview on 8/1 dialysis program re	ompleted with LPN-D on m. She reported she was not dent's blood pressure was not and after dialysis as ordered he reported all blood build be charted in the medical 4/13, at 1:20 p.m. with the egistered nurse (DPRN). He t the dialysis program				
	contacted the facili 6/22/13, the reside critically high and a local emergency ro the medical record physician ordered s suspension (a med potassium levels)	ty and informed them on nt's potassium level was is result, he was seen at a bom for evaluation. A review of noted on 6/27/13, the facility staff to administer Kionex lication used to treat elevated 15 grams by mouth every day. as written, the resident had		Facility ID: 00260 If contin	uation sheet Pag	

		AND HUMAN SERVICES				FORM A	09/11/2013 PPROVED 938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING			C 08/19/2013	
	RESIDENCE			STREET ADDRESS, C 2912 FREMONT AVE MINNEAPOLIS, M			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	the medical record physician being not take the medication An interview was co 8/14/13, at 2:25 p.m consistently refused just to document th Administration Rec did not know if the of the resident's ref An interview with th was completed on verified the findings The facility policy D directed staff to dee plan for residents a risks and complicat should address free signs, respiratory d seizure activity. It s the shunt or access alteration of fluid vo and care of the acc also address altera integrity and medic scheduling as they goal was to be esta and interventions b provider were com Pain: R1's Resident Adm noted R1 to have d	 (13 and 7/11/13). A review of lacked any evidence of the tified of the resident's refusal to n. ompleted with LPN-D on n. who reported R68 d the Kionex and she were told at on the Medication ord (MAR). She reported she physician had been informed fusal to take the medication. the director of nursing (DON) 8/16/13, at 3:30 p.m. who s. Dialysis, reviewed 8/13/13, velop a comprehensive care and should include potential tions, measurable goals for and monitoring plan for ions. In addition, the care plan quency of monitoring vital listress, chest pain, headache, hould address monitoring of s site for signs of infection, of site for signs of infection, blume, potential for bleeding cess site. The care plan should tion in nutrition and skin ration with appropriate relate to dialysis schedule. A ablished ensuring that goals petween the facility and dialysis 	F3	09			
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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		D. 0938-0391 ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	and the second second second	G		MPLETED
		245387	B. WING		0	C B/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	facility failed to ens program was provid pain. The admission MD had occasional, mid dated 4/23/13, indic pain which was sev sleep at night, and because of pain. The 7/23/13, indicated F non-medication inter pain present, and F Cognitive Status (E indicated cognitive) An undated letter s occupational therap R1 "could benefit fr unit (transcutaneout to help alleviate co- time conventional p successful in allevi why it is imperative TENS unit for her the A nurse practitione 3/13, forward and t - On 3/26/13, indicated gabapentin (used t increased to 600 m a.m. and 2:00 p.m. mg. The nurse pra- warm packs to the while awake. - A NP Progress no	ure a pain management ded for R1 who had chronic S dated 1/22/13, indicated R1 Id pain. The quarterly MDS cated R1 had almost constant vere and made it difficult to limited day-to-day activities he quarterly MDS dated R1 did not receive erventions for pain, had no had a Brief Interview of BIMS) score of 15 which by intact. igned by the certified py assistant (COTA) indicated rom a personal owned TENS us electrical nerve stimulation) nstant back pain" and "At this ohysical therapy has not been ating the back pain and that is a that [R1] receive a personal	F 30	9		
FORM CMS 2		complaining of increased pain ed the bedtime dosing of s Obsolete Event ID: 6QVR1	1	Facility ID: 00260 If c	ontinuation sheet	Page 132 of 20

		AND HUMAN SERVICES				RINTED: 0 FORM AF MB NO: 09	PROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING			C 08/19/2013	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENU MINNEAPOLIS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD ICED TO THE APPROPE DEFICIENCY)	BEC	(X5) COMPLETION DATE
F 309	 pharmacy delivery. On 4/26/13, indication inform staff when sineeded pain relief. On 5/28/13, indication been trialing the uspain and R1 reports alleviate pain issue On 7/19/13, indication posterior aspect of indicted was "tender. On 8/14/13, indication been using the TEN helping her as direct placed one to two to once in the morning note further indicated placed one to two to once in the morning note further indicated the plane of the note indicated placed one to two to once in the morning note further indicated placed one to two to once in the morning note further indicated the plane of the note indicated placed one to two to once in the morning note further indicated the plane of the note indicated placed one to two to once in the morning note further indicated the plane of the note indicated the plane of the note indicated to happen the plane. A PT Daily Treatment of the the spheres and patient evaluation for the plane of the plane of	last two nights related to ated R1 was encouraged to the was having pain and ated physical therapy (PT) had be of a TENS unit for chronic ed the TENS unit for chronic ed the TENS unit was helping is. ated R1 had a wound on the the second toe which R1 er." ated R1 reported she had not NS unit because staff were not cted by the PT department. R1 was to have the TENS unit times per day for 30 minutes, g and once in the evening. The ed R1 reported the current lgesic)she had been trying had dated 6/5/13, indicated R1 had ng back pain" and was g a TENS unit for her back ent Note dated 6/13/13, noted we decreased pain following beech therapy (ST) to Caregivers dated 6/13/13, s or pt [patient] is not tolerating fact therapy department." ated 6/13/13, from the ed R1 was alert and oriented in had no signs of psychosis. A from the neck and back clinic noted as filed in the chart					
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID:6QVR	11	Facility ID: 00260	If continuation	sheet Page	133 of 298

) HUMAN SERVICES					FORMA	09/11/2013 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				PLETED		
245387		B. WING			08/19/2013			
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411					
T BE PRECEDED BY FULL	ID PREFI) TAG		(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD TO THE APPROPR	BE	(X5) COMPLETION DATE		
ad neck and back pain f spinal adjustments, ulation and stretch. charge Summary dated ing staff had been trained resident and will continue r as she requests. ted 6/14/13, directed to TENS unit on R1 one to 0 minutes, one time in the e p.m. Data Collection & 3/13, indicated R1 had mild assessment with the worst rent interventions were (a mild analgesic) and 8/15/13, indicated "offered I she said okay but when she [R1] said no." n for R1 received 8/16/13, identified as a problem, c identified and vere not developed. om April forward noted the ne bedtime dose of all days of the month . and 2:00 p.m. doses of dministered from 4/1 to 3 MAR also revealed an pack to the back of the s tolerated Bid [twice a day]		09						
	IEDICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION) 133 ad neck and back pain f spinal adjustments, ulation and stretch. charge Summary dated ing staff had been trained resident and will continue vas she requests. ted 6/14/13, directed to TENS unit on R1 one to 0 minutes, one time in the e p.m. 1 Data Collection & 3/13, indicated R1 had mild assessment with the worst rent interventions were (a mild analgesic) and 8/15/13, indicated "offered she said okay but when she [R1] said no." n for R1 received 8/16/13, identified as a problem, t identified and vere not developed. om April forward noted the he bedtime dose of all days of the month . and 2:00 p.m. doses of all days of the month . and 2:00 p.m.	IEDICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245387 B. WING 245387 B. WING ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION) ID PREFID TAG 133 ad neck and back pain f spinal adjustments, ulation and stretch. ID PREFID TAG charge Summary dated ing staff had been trained resident and will continue v as she requests. F 3 ted 6/14/13, directed to TENS unit on R1 one to 0 minutes, one time in the e p.m. Data Collection & 3/13, indicated R1 had mild assessment with the worst rent interventions were (a mild analgesic) and 8/15/13, indicated "offered I she said okay but when she [R1] said no." n for R1 received 8/16/13, identified as a problem, ti dentified and vere not developed. om April forward noted the he bedtime dose of all days of the month . and 2:00 p.m. doses of dministered from 4/1 to 3 MAR also revealed an pack to the back of the s tolerated Bid [twice a day]	IEDICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONS A. BUILDING 245387 B. WING 245387 B. WING 245387 B. WING 212 STREET 2912 FR MINNE ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION) ID PREFIX TAG 133 F 309 ad neck and back pain f spinal adjustments, ulation and stretch. F 309 charge Summary dated ing staff had been trained resident and will continue / as she requests. F 309 ted 6/14/13, directed to TENS unit on R1 one to 0 minutes, one time in the e p.m. F Data Collection & 3/13, indicated R1 had mild assessment with the worst rent interventions were (a mild analgesic) and 8/15/13, indicated "offered d she said okay but when she [R1] said no." in for R1 received 8/16/13, identified as a problem, t identified and vere not developed. MAR also revealed an pack to the back of the s tolerated Bid [twice a day]	IEDICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387 IDENTIFICATION NUMBER: 245387 B. WING STREET ADDRESS, CITY, STAT 2912 FREMONT AVENUE NO MINNEAPOLIS, MN 5541 ENT OF DEFICIENCIES TBE PRECEDED BY FULL FENTIFYING INFORMATION) PREFIX TAG PREFIX TBE PRECEDED BY FULL FENTIFYING INFORMATION) PREFIX TAG 133 F 309 ad neck and back pain f spinal adjustments, ulation and stretch. F 309 charge Summary dated ing staff had been trained resident and will continue vas she requests. F 309 Data Collection & 3/13, indicated R1 had mild assessment with the worst rent interventions were (a mild analgesic) and 8/15/13, indicated "offered I she said okay but when she [R1] said no." n for R1 received 8/16/13, identified and vere not developed. 8/15/13, indicated "offered I she said okay but when she [R1] said no." n for R1 received 8/16/13, identified and vere not developed. Amount and 2:00 p.m. doses of dministered from 4/1 to 3 MAR also revealed an pack to the back of the s tolerated Bid [twice a day]	IEDICAID SERVICES OI PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING 245387 B. WING	IEDICAID SERVICES OME BX PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COME 245387 B. WING (X3) DATE COME 245387 B. WING (X3) STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 ENT OF DEFICIENCIES TE E PRECEDED BY FULL ENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION TAG 133 F 309 ad neck and back pain fs pinal adjustments, Julation and stretch. F 309 charge Summary dated ing staff had been trained resident and will continue ras she requests. F 309 ted 6/14/13, directed to TENS unit on R1 one to 0 minutes, one time in the e p.m. Data Collection & 3/13, indicated R1 had mild assessment with the worst rent interventions were (a mild analgesic) and 8/15/13, indicated "Offered is he said okay but when he (R1) said no." n for R1 received 8/16/13, identified as a problem, it dentified and were not developed. om April forward noted the he bedtime dose of all days of the month a. and 2:00 p.m. doses of all days of the month and act of the solverated B1 (Twice a day]		

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
	245387				C 08/19/2013		
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	 May 2013 MAR reapply to back of the tolerated twice per once for the a.m. a evidence the Physi from warm packs to - June 2013 MAR repack to the back of scheduled and was the month of June. revealed R1 receive and received Oxyc - August 2013 revet three times a day fr seizures, and Oxyc 8/17/13. Review of the June written as needed used for the month and August 2013 Nunit was not used. When interviewed stated she had pair hands. R1 stated the TENS unit and it on myself, "she wrot asked and the TENS unit since th When interviewed stated she had pair that doesn't go awa Tylenol and it does 	a.m. and once in the p.m. evealed an order for ice pack e neck for 20 minutes or as shift and was only scheduled nd p.m. There was no cian's Order had changed o ice packs. revealed the order for an ice f the neck did not have a time s not signed as completed for The June 2013 MARs ed Neurontin three times daily odone 5 mg on 14 occasions. ealed R1 received Neurontin or neuropathic pain and codone (a narcotic) 5 mg on e 2013 MAR revealed the order (PRN) and was not signed as of June. Review of the July MARs also revealed the TENS on 8/16/13, at 10:00 a.m. R1 n in her back, neck, leg and he nurses "don't seem to care d she tells the nurses all the n and the "TENS unit went I stated she had asked to use the nurse expected me to put vouldn't." R1 stated she had nurse's have not offered the en. on 8/13/13, at 1:10p.m. R1 n in her back, neck, and legs ay and "they only give me	F 3	09			

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		AND HUMAN SERVICES					FORM AF)9/11/2013 PPROVED 938-0391	
	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
245387			B. WING				C 08/19/2013		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP COL	DE			
ST OLAF	ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			FIX (EACH CORRECTIVE ACTION SHOUL			BE	(X5) COMPLETION DATE	
F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 135 and stated she had ordered a TENS unit back in June 2013 for R1's pain. The NP stated she had to keep R1 on narcotic pain medication because the TENS unit had not been used and R1 still had unresolved pain. Upon interview on 8/19/13, at 9:47 a.m. the COTA stated R1 could not put on the TENS unit herself and the nurses were trained on how to use it. The COTA stated R1 "loved it [the TENS unit] and would be waiting at therapy for treatment." The COTA stated R1 "loved it [the TENS unit] and would be waiting at therapy for treatment." The COTA stated ice was tried for R1's pain and was not as effective. The COTA indicated she was not aware R1 was not using the TENS unit. Licensed practical nurse (LPN)-H was interviewed on 8/19/13, at 11:32 a.m. and stated R1 had not requested the TENS unit when she was working and she had not offered it to R1. The Resident Centered Pain Care policy dated 12/1/08, directed "Every resident care plan includes pain or the potential for pain. The individual goals for pain management are determined by the resident in collaboration with the interdisciplinary team. Interventions for Bruises of unknown origin: R87 was observed on all days of the survey to be sitting and walking with R82. The facility failed to assess, monitor and implement interventions for R87 who had bruises of unknown origin. During observation on 8/12/13, at 5:42 p.m. R87 was noted to have dark purple bruising on the knuckles of the left hand and dark purple bruising to the right wrist area. When asked, R87 reported she fell down the stairs. During observation on 8/15/13, at 9:16 a.m. R87 continued to have the bruising to the left knuckles		F	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF			D BE COMPLETIO		
FORM CMS-2	567(02-99) Previous Version	and another 7 centimeter (cm) s Obsolete Event ID: 6QVR	11	Fa	acility ID: 00260 If conti	nuatior	sheet Page	e 136 of 298	

		AND HUMAN SERVICES				FORM A	09/11/2013 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245387	B. WING			C 08/1	9/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411	TH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE CO			(X5) COMPLETION DATE
F 309	x 4 cm dark purple forearm. On 8/19/13, at 10:0 have a dark purple inner forearm. R87's care plan da being at risk for ha to a diagnosis of de not identify risk for addition R87's care resistive to cares w "When resident be try task later. Do no The admission MD R87 had both shor problems and mod for daily decision m A Resident Inciden a 4 cm x 5 cm brui The immediate inte monitor and redired from the nurse pra indicated trial of Ge and to monitor area to grab hands, just Incident Report da indicated R87 was cm bruise on the le monitor skin daily a when residents hol hands. Nurse's Notes wer and the following w	was noted to R87's left 06 a.m. R87 was observed to , thumb sized bruise on her left ted 12/13/12, identified her as rm from self or others related ementia. The care plan does bruising or bleeding. In e plan indicated she was vith an approach to include gins to resist care, STOP and ot force to do task." S dated 12/18/12, indicated t and long term memory erately impaired cognitive skills haking. t Report dated 3/27/13, noted se to R87's outer left hand. erventions were noted as ct and requested Geri-sleeves ctitioner. RN assessment eri-sleeves was unsuccessful as and encourage resident not hold hands. A Resident ted 6/14/13, 7:00 a.m. noted to have a 1.5 cm x 2.5 eft wrist. Interventions noted to and monitor for and redirect iding arms/wrists to hold e reviewed from 4/13 forward	F3	309			
FORM CMS-2	567(02-99) Previous Version		1	Facility ID: 00260	If continuation	sheet Pag	e 137 of 298

AND PLAN OF CODRECTION		RVEY	
		(X3) DATE SURVEY COMPLETED	
245387 B. WING _	08/19/2	2013	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CON CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) MPLETION DATE	
 F 309 Continued From page 137 body, blue and yellow in color. The last Resident Incident Report was dated 3/27/13. On 7/6/13, noted multiple bruises on both (unidentified area) remained. On 7/20/13, indicated R87 had old bruises on both lower arms. Review of the Resident Incident Reports and the Nurse's Progress notes revealed no documentation regarding these bruises. A Physician's Order dated 7/29/13, directed to monitor skin every shift and document new areas in the nurses notes. R82's Behavior/Intervention Monthly Flow Record for August 2013, noted R82 was monitored for "abusive to others" which was noted as occurring two to three days on day shift from 8/7 to 8/12/13. When interviewed on 8/16/13, at 11:11 a.m. the nurse consultant (O)-D stated bruises are tracked on incident reports. On 8/19/13, at 2:09 p.m. the director of nursing was again asked for documentation regarding assessment and intervention for R87's bruises noted throughout the survey. A policy regarding ongoing monitoring of resident's skin condition was requested but no policy was provided. 			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.11.11.12.13.11.13.13.13	IPLE CONSTRUCTION		(X3) DATE COMPI	
				4G		С	
		245387	B. WING			08/19	9/2013
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE			
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NOF MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 309	appointment on 8/1 given. A significant change 7/19/13. The MDS and short term mer considered modera periods of being ina thinking. He had no issues. The MDS in with staff efforts to A Dental CAA was indicated R68 was teeth. The CAA also and did not wear de CAA recommended with oral cares as n Resident was seen the plan was to tran dentures. The dent antibiotic prophylac appointment and al The resident's phys recommendation of was on renal dialys and known underly in his heart) on a pr also noted R68 had which was complicat the resident at risk his dental issues an	e MDS was completed on noted the resident had long mory issues and was ately impaired. R68 did exhibit attentive and disorganized o mood concerns or behavioral ndicated R68 was cooperative provide him personal cares. completed on 7/12/13, and missing some upper and lower o noted R68 had poor dentition ental partials or dentures. The d the staff assist the resident needed. by a dentist on 8/5/13, and nsition the resident to complete ist recommended R68 have stically before the next II appointments in oral surgery.	F 30	99	7		
	The physician wrote	e an order on 8/9/13, for					

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ST SALETAN		E CONSTRUCTION	COM	E SURVEY
		245387	B. WING			1	C 19/2013
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLA	F RESIDENCE				912 FREMONT AVENUE NORTH		
	CLIMMADY CTA	ATEMENT OF DEFICIENCIES	ID	IV	IINNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORRECTIO		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE		
F 309	Amoxicillin (an anti hours prior to denta transcribed and pla was transcribed and The MAR was revie MAR as "Antibiotic and the date of 8/10 the date the medica transcribed order d was prescribed, wh was to be given. On 8/16/13, at 8:55 appeared on the nu- he was to take the appointment. LPN- the time and the re- was questioned reg antibiotic prior to the resident leaving the no antibiotic ordere specific notation on the LPN-D but state procedure that was unsure of what pro- indicated she did no going to be done on The resident left the dental consult repo The dental consult the need for prophy dental appointment was the written phy had verified regard The consultant regi contacted and she	biotic) 2 grams orally two al procedures. The order was aced on the MAR. The order d noted by two facility LPNs. ewed and appeared on the before dental appointment" 6/13, was boxed to indicate ation was to be given. The id not specify which antibiotic nat dose, what route or when it o a.m. a transport driver ursing station and announced	F3	309			

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC	Sector Medical	CON	E SURVEY IPLETED
		245387	B. WING				0 19/2013
	PROVIDER OR SUPPLIER			2912 FREMON	SS, CITY, STATE, ZIP CODE T AVENUE NORTH IS, MN 55411		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311 SS=D	IMPROVE/MAINTA A resident is given t services to maintair specified in paragra This REQUIREMEN by: Based on observat review, the facility of resident (R68) was activities of daily live of decline in ability a care. Findings include: R68 was not encou personal cares and provided. During the observation 8/14/13, at 8:30 was observed to wa face. No attempts w resident to do this fi observation, the resi observed to be very curved to the right. observation and ind check them weekly and nursing staff was R68's face. No attempt	TMENT/SERVICES TO IN ADLS the appropriate treatment and n or improve his or her abilities uph (a)(1) of this section. T is not met as evidenced ion, interview, and document lid not ensure that 1 of 1 encouraged to assist with ing (ADLs) to minimize the risk and to provide appropriate raged to actively participate in appropriate nail care was not tion of R68's personal cares a.m. nursing assistant (NA)-B ash and dry the resident's vere made to encourage the or himself. During the sident's toe nails were / long, darkened in color and NA-B acknowledged the dicated the nursing staff was to when the resident had a bath as to cut them as needed. of morning personal cares on observed to wash and dry mpts were made to encourage for himself. An interview with	F3	2.		e s d. cre ff on s s ne hen t be	

		AND HUMAN SERVICES & MEDICAID SERVICES			ON		PROVED 938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE S COMPL	
		245387	B. WING			C 08/19	/2013
	RESIDENCE			2912 F	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT AVENUE NORTH EAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	NA-C indicated that and when she care washed him, as she refused to wash his The plan of care, in deficit of self-care in	t assisted R68 occasionally s for the resident, and she e had been told that he s own face. hitiated on 10/8/12, noted a related to the resident's	FS	311	 4. Recurrence will be prevented by: A) Random audits will be completed weekly a 4 and then monthly X2 with results being presented to the QA committee for follow discussion/planning. 	x 3	,
1.1	goal was for R68 to face and hands after care items. The ap to encourage the re- face and hands and necessary. The car for alteration in skin remain free of press was developed 7/2 directed staff to ob cares and refer to a	nd weakness. An established o continue to wash and dry his er the staff set up his personal proaches specified staff were esident to wash and dry his d they were to assist as re plan also noted the potential n integrity and the skin would sure ulcers. The problem area 6/13. The interventions serve the feet and skin with a podiatrist as needed.			 Completion will be monitored by: The Director of Nursing o Designee 	r	
	was completed on resident had long a and was considered did exhibit periods disorganized thinki or behavioral issue was cooperative w personal cares. He	e Minimum Data Set (MDS) 7/19/13. The MDS noted the and short term memory issues of moderately impaired. R68 of being inattentive and ng. He had no mood concerns es. The MDS indicated R68 ith staff efforts to provide him a needed extensive assistance ed mobility, transfers, dressing, onal hygiene.			3		
	on 7/12/13, noted thospitalized from 6 although there were a significant change	sessments (CAAs), completed that the resident had been 6/11/13 to 6/14/13, and re some areas of improvement le MDS was completed as it e had declined overall and due					

		AND HUMAN SERVICES				FORM): 09/11/2013 APPROVED): 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED	
		245387	B. WING	÷		08	C / 19/2013	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
ST OLAF	RESIDENCE		2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 311	need for assistance potential/expectation variations in mobilit status was variable condition, dialysis, f increased weakness The undated Nursin instructed one nursing with dressing and g the need to encours independent. The N Sheet did not given (nail) care. An interview with lice (LPN)-D was comp She reported was a very long but she with them, as he was dia resident would need who would address reported she did not the podiatrist. An interview with ref (RN)-A on 8/15/13, She reported she with being long. She revithen reported she did not then reported she with being long. She revithen then reported she with and if there was an documentation of th reported no docum	skin breakdown, continued e with transfers and the on he would continue to have ty. It was also documented his related to his medical fragile status and periods of ss. Ing Assistant Assignment Sheet sing assistant to assist resident grooming and did not identify age R68 to remain Nursing Assistant Assignment any instruction regarding foot censed practical nurse leted on 8/15/13, at 9:30 a.m. aware that R86's toenails were vas not responsible for cutting abetic. She indicated the d to be seen by a podiatrist, a the length of his toenails. She of know if he had been seen by egistered nurse care manager at 10:15 a.m. was completed. vas unaware of R68's toenails viewed the medical record and did not believe the podiatrist ent and R68 should have been d the condition of resident's e monitored every two weeks issue, there should be his in the medical record. She entation was found.	F	31				
	An interview with th	e director of nurses (DON) on						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		a decrea				С
		245387	B. WING			/19/2013
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
T OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE	COMPLET DATE
F 311	Continued From pa	age 143	F 31	1		
	· · · · · · · · · · · · · · · · · · ·	m. was conducted. The DON				
		of care should have been				
		ould have been referred to the				
	podiatrist for care of	or his leet.				
		Activity of Daily Living, did not				
		or involving resident in				
E 040	performing person		F 04			
F 312 SS=D	483.25(a)(3) ADL (DEPENDENT RES	CARE PROVIDED FOR	F 31	2		
55-D	DEFENDENTIKE	BERTO				
		inable to carry out activities of				
		s the necessary services to				
	and oral hygiene.	ition, grooming, and personal				
	and ordiniygiche.					
	This REQUIREME	NT is not met as evidenced				
	by:					
		ation, interview and document				
		failed to ensure 3 of 3 residents eceived assistance to complete				
	activities of daily liv					
	Findings include:					
	-	1 . 1				
		ded grooming assistance with are on 8/12/13, 8/13/13 and on				
	8/14/13.					
	0-04040	A manufacture of the state				
		1 p.m. during observation and				
		s observed to be lying in bed ximately one to two days	5			
		35's fingernails were long				
	(approximately a q	uarter inch past the tips of the				
	fingers) and had a	dark colored debris under the				
	nails of both hands	s. R35 initially stated he liked to				-

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DAT COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
	ROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE AVENUE NORTH 5, MN 55411	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH C	/IDER'S PLAN OF CORRECTIC CORRECTIVE ACTION SHOUL EFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	cut his own nails be cares when he coul razor" and pointed to electric razor was of table. On 8/13/13, at 1:23 observed to be up it transferred to his be mechanical lift. R35 days growth of bear soiled and long. On 8/14/13, R35 wa 7:30 a.m. until 10:2 - At 7:30 a.m. althous scheduled for 8/13/ evidence the showe observed to be mar on both hands had approximately quar already dressed and covers. - At 7:50 a.m. two m NA-A entered R35's - At 7:53 a.m. R35 w transferred to the w combed and R35 w dining area. At the to unplugged recharge observed on the ow near empty can of s powder, an open pa observed on the be - At 8:01 a.m. R35 w his wheelchair in the When asked when cares, R35 stated h	cause he liked to do his own d. R35 stated he had a "safety to the over bed table. An bserved to be on the over bed p.m. R35 was randomly n his chair, then was ed by two facility staff and a bwas observed to have many rd, his fingernails remained as continuously observed from 5 a.m. ugh R35's shower day was 13, the clinical record lacked er was refused. R35 was hy days unshaved, the fingers brownish/black debris under ter inch long nails. R35 was d laying on top of the bed hursing assistants (NA)-H and s room with a mechanical lift. was observed to be heelchair. R35's hair was as immediately wheeled to the time of the observation, an eable electric razor was erbed table next to the bed. A shaving cream, a bottle of ackage of wipes were	F3	2.	Corrective Action: A) Resident #35 has been shaven and nail care has been provided B) Resident #17 has been shaven. C) Resident #42 has been provided nail car	t ly	

Facility ID: 00260

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		AND HUMAN SERVICES			FORM	09/11/2013 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMI	0938-0391 E SURVEY PLETED
		245387	B. WING		08/1	C 19/2013
	RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	offered to assist hir discussed shaving told me they'd try to wasn't charged. Th When asked if naik was offered. - From 8:01 a.m. un the dining room for - At 9:13 a.m. R35 and pushed himsel transported R35 ou room. NA-H moved R35's reach. R35 s wheelchair. The rat table and remained - At 9:24 a.m. R35 overbed was his pe power. R35 picked on button, the razo - At 9:27 a.m. R35 with the mechanica - At 9:35 a.m. NA-A with all R35's groor stated R35 "shaves an electric razor. N bedside was for R3 on and confirmed t NA-A stated the rat asked R35 where t R35 pointed to the table. NA-A found t razor. NA-A stated during his cares, an and soiled on both - At 10:34 a.m. the (LPN)-H explained as needed and on nailcares were com	n with shaving, R35 stated he with the staff yesterday, "They o shave me, but the razor ey need to plug in the razor." care was offered, R35 denied it ntil 9:13 a.m. R35 remained in breakfast. completed the breakfast meal f away from table. NA-H it of the dining room and to his d the overbed table within stat at the bedside in the zor remained on the overbed d unplugged. verified the razor on the ersonal razor and it had no up the razor and pushed the r did not operate. was transferred back into bed al lift by NA-H and NA-A. A stated she was completed ming and washing needs. NA-A s himself" and stated he used A-A confirmed the razor at the 35, attempted to turn the razor he battery charge was dead. zor needed to be charged and the charger cord was located. top drawer of the bedside the charger and plugged in the she did not look at R35's nails ind confirmed they were long		 A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow u discussion/planning. 5. Completion will be monitored by: Director of Nursing or Designee 		

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	No. 11 States of the second			CON	TE SURVEY MPLETED
		245387	B. WING				C / 19/2013
NAME OF F	PROVIDER OR SUPPLIER			- 12	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	were long, needed LPN-H stated R35's not reported to her. should have been p charge; R35 "trys to a lot" and NA staff r shave the "patchy a - At 10:25 a.m. both was not offered the nails were not repo razor was visible ar R35's care plan dat with shaving, low m The care plan direct and included a han "Res. [resident] wai directed, "Assist of daily or PRN [as need directed, "Nail care The Diagnoses Rep indicated R35 had diabetes mellitus ty gout, obesity, demed depression with an: The quarterly Minin 5/14/13, indicated F Mental Status (BIM impairment). The M non-ambulatory, re transfers and toilet bed mobility, locom personal hygiene. T impairment in both A Nurse's Note for	trimming or were soiled. Is long and soiled nails were LPN-H stated the razor olugged in by the NA staff for a p shave himself," but "misses need to offer to assist and areas." In NA-H and NA-A verified R35 opportunity to shave, the long rted to LPN-H, verified the nd not charged. ted 3/15/10, identified deficits notivation, and fatigues easily. ted to provide total assistance d written note dated 2/12 - Ints to be shaved." and 1 to shave w/ Electric razor eeded]." The care plan further & skin check on bath day." port - Clinical dated 3/31/11, the following diagnoses: pe II, peripheral neuropathy, entia, pre-glaucoma, and xiety. num Data Set (MDS) dated R35 had a Brief Interview for IS) score of 13 (mild MDS indicated R35 was quired total assistance with use; extensive assistance with notion, eating, dressing and The MDS identified R35 had	F	312			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	101100000000		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING				C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH		
				- 1	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ae 147	E 2	312			
1 012	NAR [nursing assis	tant registered] unable to ates, 'I wanna shave when I	Εš	012			
	get my shower."					1	
	AM/PM identified R (8/13/13) evening d did not address sha "Demandingverba provided when he v non-compliance wit On 8/19/13, at appr director of nursing (have been offered t	oximately 1:30 p.m. the DON) verified R35 should the opportunity to shave and re should have been reported					
	lower chin on 8/12/	to have facial hair on her 13, 8/13/13, 8/14/13 and ot provided with assistance to airs.					
	identified R17 had o extensive assistant Assessment (CAA) Status/Urinary Inco dated 6/29/13, iden	ntinence/Pressure Ulcers/Falls tified R17 received extensive L's as needed (dressing and					
	"Self-care deficits r weakness & cogniti hemiplegia." The ca received assistance	d 7/8/13, identified R17 had, elated to impaired mobility, ve impairment -left sided are plan further indicated R17 e with dressing, grooming and plan focus goal identified she,				5	

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 - Manufacture		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	Continued From pa "Will be neat, clean		F 3	312			
	in her bed on her b	p.m. R17 was observed lying ack with numerous facial hairs pproximately a half (1/2) inch front neck area.					
	On 8/13/13, at 10:0 still not removed.	0 a.m. observed facial hairs					(4)) (4)
	had always had the how she felt about family relatives inclu- the facility shaving R17 to take the fac	3 p.m. family (F)-A stated R17 facial hair and was not sure it. F-A further stated other uding F-A usually brought to cream and razor and assisted ial hair off but no specific when family came to assist					
	continuous observa -At 8:09 a.m. to 8:1 wheelchair in her ro yellowish-green and at surveyor to assis but NA-F assisted r -At 8:15 a.m. NA-G room and brought r	4 a.m. observed R17 up in her oom dressed in a d red print dress. R17 gestured of her with her wrist bracelet resident then left the room. observed entering R17's esident to dining room. R17 we several facial hairs to lower			Ť		
	-At 8:19 to 8:23 a.m and other residents cleanse hands befor -At 8:24 a.m. obser clothing protector a the front. -At 8:25 to 9:30 a.m dining room eating	n. NA-G observed to offer R17 at the dining room wipes to					

Facility ID: 00260

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	22	LTIPLE CONSTRUCTION	(X3) DAT CON	E SURVEY
	245387	B. WING	9		C / 19/2013
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE			2912 FREMONT AVENUE NORTH		
ST OLAF RESIDENCE			MINNEAPOLIS, MN 55411		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
-At 9:31 a.m. NA-F from the table and t door and then came a plastic bag and we On 8/14/13, at 9:42 her bed with facial h On 8/14/13, at 12:11 the dining room tabl to still have facial ha dining room area no facial hair for reside On 8/14/13, at 1:51 to resident room wit not in the room. NA surveyor that she ha dressing, applied loi for her after washing also had assisted R to brush her teeth a and had left the rooi interview NA-F men resident facial hairs On 8/15/13, at 8:30 dining room table ea facial hairs. On 8/15/13, at 10:43 the ground level bei into the elevator still On 8/15/13, at 2:00 had numerous facia neck area, stated her	f offered to remove facial hair. came and picked resident cook R17 to her room, shut the e out observed to be carrying ent to the soiled utility room. a.m. observed R17 lying in hairs still there and visible. 5 p.m. observed R17 sitting in le waiting for lunch observed airs. Again several staff in the p one offered to remove the ent. p.m. interviewed NA-F went th LPN-B to verify but R17 was -F explained to nurse and ad assisted resident with tion, applied socks and shoes g up. NA-F stated that she 17 to the toilet and set her up nd helped to clean up after m. Not at any time during the tioned she had removed for R17. a.m. observed R17 in the ating breakfast still had the 3 a.m. observed resident in ng assisted by a staff to get	F3	312		

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ALL REPORTS		PLE CONSTRUCTION G	CON	E SURVEY IPLETED
		245387	B. WING	<u> </u>		50000000	C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 312		The second	F	312	2		
	needed when they	see it immediately.					
	nurse (RN)-A and I RN-A stated the, "F hair removal policy around and ask to Staff was to follow resident refused, it	I a.m. interviewed registered PN-A regarding the facial hair, Facility does not have a facial but once a week staff go remove resident's facial hair. up and re-approach resident if 's their right to do so then have to report to the nurse to sal."					
	consultant director expectation was st the resident's daily dignity issue espec reported all staff war re-approach if a re- nurse if not able to	B p.m. interviewed the of nursing (O)-D stated her aff to remove the facial hair for and as needed as this was a sially for female residents. O-D as supposed to continue to sident refused and report to assist the resident with cares. to follow each resident's plan the care plan.					
	toenails 8/15/13, 8/ During observation a.m. R42's toenails The self-care defic 4/6/09, directed na days. The potentia	to have long finger and /16/13 and 8/19/13. of cares on 8/16/13, at 9:24 s were noted to be ½ inch long. it in bathing care plan dated il care to be done on bath I for abrasion due to scratching d 5/13/10, directed nails will be					
	The quarterly MDS had severely impai	dated 6/20/13, indicated R42 red cognitive skills for daily nd required total assist with					

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245387	B. WING	;		~	C 19/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			5	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 F 314 SS=G	personal hygiene. On 8/15/13, at 2:13 to be ¼ inch long, I R42's nails on bath are long. The bath indicated R42 rece evenings. When int p.m. NA-M verified 8/14/13. When interviewed of LPN-H verified R42 the nurses cut R42 483.25(c) TREATW PREVENT/HEAL P Based on the comp resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores rec services to promote prevent new sores This REQUIREMEN by: Based on observa review, the facility f	 a. p.m. R42's nails were noted LPN-D stated she usually cut day or when she notices they log was reviewed and ived baths on Wednesday terviewed on 8/15/13, at 2:31 R42 received a bath on b. 8/19/13, at 11:14 a.m. 2's nails were long and stated 's nails with baths. b. 12NT/SVCS TO 'RESSURE SORES b. orehensive assessment of a or must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and a healing, prevent infection and from developing. NT is not met as evidenced tion, interview and document 		312	2		
	breakdown for 1 of pressure ulcers. Th	1 resident (R42) reviewed for his practice resulted in actual acquired three new pressure					

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		AND HUMAN SERVICES					APPROVED	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT CON	E SURVEY	
		245387	B. WING			C 08/19/2013		
NAME OF	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE		19/2013	
ST OLAF	RESIDENCE				2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314	Continued From pa	age 152	F 3	14	F 314			
	and was not reposi minutes on 8/15/13 revised and/or follo Stage 2 ulcers (par involving epidermis superficial and pre- blister, or shallow of On 8/15/13, from 8 was observed sittir without being reposi (NA)-I and trained entered R42's roor When asked, NA-I in the wheel chair a hours and thirty-thr repositioned R42 e chair. R42's buttoc cares and an open buttock. A white co the open areas and present. On 8/16/13, from 7 was observed lying a.m. NA-I verified F bed. On 8/16/13, at 2:01 observed with licer and the consultant stated the coccyx a the area as 2.2 cer	of recurring pressure ulcers itioned for three hours and 33 8. The plan of care was not wed to promote healing of the rtial thickness skin loss s, dermis, or both. The ulcer is sents clinically as an abrasion, erater). :10 a.m. to 10:33 a.m. R42 ng in a wheel chair in her room sitioned. Nursing assistant medication aide (TMA)-B n and assisted her into bed. stated she had gotten R42 up at 7:00 a.m. (a total of three ree minutes) and she every two hours in the wheel ks were visualized during area was observed on each lored ointment was noted to d no other dressing was :41 a.m. until 9:24 a.m. R42 on her back in bed. At 9:24 R42 was lying on her back in I p.m. R42's buttocks were nsed practical nurse (LPN)-A nurse. The consultant nurse area was open and measured ntimeters (cm) x 0.3 cm. LPN-A was "probably just open from 'A 1 cm x 1 cm dark red area			 Corrective Action A) Resident #42 and a new Skin a completed to deter repositioning nee bed. Preventative promote healing were reviewed and care plan and car reviewed and reve physician has bee the condition of the Corrective Action to others: A)All residents ve ulcers have the p affected by the sa practice. B) The Pressure Care Policy has the and revised. C) Nursing Staff been educated or Ulcer/Skin Care need to follow the individualized or plans for treatme and pressure relia- including turning and off-loading person 3. Completion Date 	was reasses ssessment v ermine ds while in e measures of her ulcen id revised. e sheet wer ised. The en updated he wounds in as it appli with pressur otential to b ume deficie Ulcer/Skin been review members he the Pressur Policy and e ders and can nt of wounder f measures /reposition ressure.	was to rs Her re on ies re be mt ved have ire the ure ds s,	

Facility ID: 00260

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CONTRACTOR STATES	anti-construction and a finite and a second	& MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	CON	TE SURVEY MPLETED
		245387	B. WING _			C /19/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 314	Continued From page 153 consultant stated the area to the right buttock was not open, was just fragile. After returning to the nursing station, LPN-A told LPN-D to get a Duoderm (a hydrocolloid dressing) order for R42. The left buttock was noted to have scar tissue from prior pressure ulcers. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed.		F 31	 4 4. Recurrence will be preverence will be preverence will be preverence will be completed weekly x 4 and monthly X3 with results presented to the QA comfor follow up discussion/planning. 	e d then being	
	directed staff to off wound, and to limit physician's order d right and left buttoo A Wound Care Spe dated 1/2/13, indic ulcers to the right a dated 1/9/13, indic both buttocks had 2/6/13, noted R42 of the left buttock. R42 had Stage 2 p left buttock and rec minutes." A physician's Prog R42 had sacral are buttock and one or care and offloading integrity was not re of limiting sitting to assignment sheet The Weekly Woun Sheets (WWDPS)	ecialist Evaluation (WCSE) ated R42 had Stage 2 pressure and left buttocks. A WCSE ated the pressure ulcers to resolved. A WCSE dated had a Stage 2 pressure wound A WCSE dated 2/13/13, noted pressure ulcers to the right and commended "limit sitting to 60 ress note dated 1/17/13, noted ea decubitus, one on the right in the left buttock which required g. The care plan for skin evised for the physician's orders o every 60 minutes and the NA		 Completion to be monito Director of Nursing or D 	red by: esignee	

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second		CONSTRUCTION	COM	E SURVEY
		245387	B. WING				C 19/2013
NAME OF I	PROVIDER OR SUPPLIER		·	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	was noted as heale 8/1/13, indicated R- ulcer to the right bu healed on 8/14/13. provided. A Worksheet for SH Prominences-Lying 3/16/13, and indica hours. An additional completed when R- multiple open areas R42's Care Area As annual MDS dated were not provided. A Braden scale (and determine pressure noted R42 was at w breakdown. A Pres 6/16/13, indicated R the sacrum, heels at R42's quarterly Min 6/20/13, revealed F cognitive skills for of total assist of two s and toileting, and w and had no pressure did not indicate the the sacrum, heels at	ed on 5/8/13. A WWDPS dated 42 had one Stage 2 pressure httock which was noted as No other WWDPS were and Sitting was completed on ted no redness after two al assessment was not 42 was identified as having s on 7/29/13. ssessments (CAAs) for the 3/20/13, were requested and assessment used to e ulcer risk) dated 6/14/13, very high risk for skin sure Point Assessment dated R42 had pressure present at and ear. htmum Data Set (MDS) dated R42 had severely impaired daily decision making, required ttaff for bed mobility, transfers vas at risk for pressure ulcers re ulcers present. The MDS R42 had pressure present at	F3	14			
ž	practitioner was, "N bottom on (L) [left] [unclear] breakdow	ated 7/26/13, noted the nurse lotified of breakdown on & (R) [right] cheek (inner) on to area, 2 new O/A's (L)] 3 cm W [wide] and (R) cheek					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

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		AND HUMAN SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		245387	B. WING		08	8/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
					CTION	(20)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 155	F 31	14		
17	open area to buttoo side to side with no open area on butto noted as resolved & restarted 8/16/13. T reposition R42 even was not revised to 1/3/13 to limit R42's A nurse practitionen R42 had two open which measured ap and 3 cm x 1 cm w not measurable an	e plan dated 7/29/13, indicated cks and directed reposition back lying, and Duoderm to cks Stage 2. The area was 3/14/13, and the Duoderm was The care plan directed staff to ry two hours. The care plan reflect the physician's order of s sitting up for 60 minutes. r note dated 7/29/13, indicated skin areas to the left buttock oproximately 3 cm X 2.5 cm ith superficial depth that was d two areas on the right sured 3 cm x 2.5 cm and 2.5				
	Cleanse with norma prep to intact peri w dressing every 3 da wound on buttocks (wounds on buttocks side, every 2 hours buttocks) 2) Air ma buttocks)." A physic directed "Calmosep moisture barrier] ap excoriated/irritated with incontinent pac integrity)."	areas on buttocks perineum d changed 3 times daily (skin ant Assignment Sheet				
	one every two to th reposition, up for tw	3, directed toileting assist of ree hours check and vo hours AM/PM and position wo hours, remain off back				

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PRINTED: 09/11/2013

	RS FOR MEDICARE	& MEDICAID SERVICES		E CONSTRUCTION	OMB NO.	0938-03 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:			COM	PLETED
		245387	B. WING			19/2013
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD		
T OLAF	RESIDENCE			912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
F 314	Continued From pa	age 156	F 314			
	when in bed. The a	assignment sheet conflicted that directed staff to reposition	1.014			
	indicated R42's bu	ted 8/16/13, at 1:00 p.m. ttocks were open and a				
	update regarding a Notes dated 8/16/1	with the nurse practitioner to applying Duoderm. A Nurse's 3, at 2:10 p.m. noted R42's 3 cm x 0.3 cm area on buttock.		3		
	LPN-D stated R42	on 8/14/13, at 2:13 p.m. should still be getting essure sores on the buttocks.				
	stated R42 only ha buttock and the op was new. When in p.m. LPN-D stated	on 8/16/13, at 2:21 p.m. LPN-A d open areas to the right en area (o/a) to the coccyx terviewed on 8/16/13, at 2:39 both the coccyx and the right but she did not measure them.				
	registered nurse co	on 8/16/13, at 2:21 p.m. the onsultant only confirmed the d. No further comment was				
	Problems Policy ar 3/26/09, directed s the affected area if area.	taff to position the resident off there was a Stage 2 pressure				
F 315 SS=D		HETER, PREVENT UTI, DER	F 315			
	assessment, the fa	lent's comprehensive acility must ensure that a is the facility without an				

		(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		
IND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		APLETED C
		245387	B. WING _			/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 315	Continued From page 157 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.		F 31	 F315 Corrective Action: A)Resident #82 has been reassessed for her toiletin needs. Her care plan and care sheet was updated to reflect her needs. Nursin staff members have been educated on the need to toilet her according to the 	g	
	review, the facility f assistance with toil reviewed for urinary Findings include: The Resident Statu noted R82 was cor extensive assist of not assisted to the forty-one minutes. During continuous 7:40 a.m. until 11:2 sitting in a chair in floor without being a.m. nursing assist assist R82 to the to asked R82 if she w and R82 had refus asked her if she ne R82 did not respon NA-L was asked w not respond to her she would tell the r	tion, interview and document failed to provide timely eting for 1 of 3 residents (R82) y incontinence. US Summary dated 11/21/12, ntinent of bowel and required one staff for toileting. R82 was toilet for three hours and observations on 8/16/13, from c1 a.m. R82 was observed the dining room on second assisted to the toilet. At 11:21 tant (NA)- L was asked to bilet. NA-L stated she had vanted to use the toilet earlier ed. NA-L approached R82 and beded to go to the bathroom. ad to NA-L's question. When hat she would do if R82 does toileting prompt, NA-L stated nurse. At 11:35 a.m. NA-L d practical nurse (LPN)-D she		 care plan and to provide incontinence care and pa changes as the need arise 2. Corrective action as it applies to others: A) All residents who experience incontinence and/or need assistance w toileting have the potent to be affected by this deficient practice. B) The Bowel and Blad. Policy was reviewed and revised as appropriate. C) Nursing staff member were educated on the need to follow the care plan as care sheets in order to m the toileting needs of the residents. 3. Date of Completion: 10/3/13 	d es. vith ial der d ers eed and neet	

Facility ID: 00260

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the strength		CONSTRUCTION	COM	E SURVEY PLETED
		245387	B. WING			C 08/19/2013	
	ROVIDER OR SUPPLIER	L		291	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH	1 00/	10/2010
OTOLA	REGIDENCE			MI	NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	not respond to NA- toileting needs. NA R82's significant ch Set (MDS) dated 7 severely impaired o decision making, re	L or assist R82 with her -L did not re-approach R82. mange in status Minimum Data (5/13, revealed R82 had cognitive skills for daily equired extensive assist of one s frequently incontinent of	F 3	15	 Recurrence will be prevented by: A) Random audits will be completed weekly x 4 an then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 	d	
	incontinence dated decreased wetness toileting every two plan dated 7/11/13, program which dec The care plan direc every two hours an cares/pad changes directed staff to ass needed and if resis another staff perso Goal Analysis Note " is now toileted & n has changed." Upon interview on director of nursing to be toileted accor 483.25(e)(2) INCR IN RANGE OF MO Based on the comp resident, the facility with a limited range	essment (CAA) for urinary 7/5/13, indicated R82 had s/incontinence episodes with hours during waking hours. el and bladder function care noted R82 was on a toileting treased bowel incontinence. ted staff to check resident d provide incontinence as needed. The care plan sist of one with toileting as tive to cares, re-approach with n/assist of two as needed. A d dated 7/11/13, indicated R82 not prompted, toileting program 8/16/13, at 1:03 p.m. the stated she expected residents rding to the plan of care. EASE/PREVENT DECREASE TION orehensive assessment of a v must ensure that a resident e of motion receives ent and services to increase	F 3	118	 Completion will be monitored by: Director of Nursing or Designee 		

Facility ID: 00260

If continuation sheet Page 159 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245387	B. WING			08/	19/2013
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				IT AVENUE NORTH IS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACI	OVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	range of motion and decrease in range of This REQUIREMEN by: Based on observat review, the facility f motion (ROM) plan implemented; splint foot orthotic) device the physician for 4 R23) in the sample Findings include: R45's Resident Adr indicated R45 was include vascular de spasms, osteoporo pain, depressive dis hemiplegia. was no provided with a left or a left AFO. In ad develop a ROM pla of a left hand contra R45 was observed left hand on 8/12/13 observed to have le not wearing a splint On 8/13/13, at 1:12 nurse (LPN)-C stat ankle to be applied	d/or to prevent further of motion. NT is not met as evidenced tion, interview and document ailed to ensure range of s were developed and ts, braces and AFO (adaptive es were applied as ordered by of 4 residents (R45, R35, R42, reviewed for ROM. mission Record dated 9/19/12, admitted with diagnoses to ementia, dysphagia, muscle sis, persistent mental disorder, sorder, hypertension, and left it consistently offered or hand splint, a left elbow brace dition, the facility failed to in to prevent potential decline acture. to have a contracture to the 3, at 3:48 p.m. R45 was eft sided weakness and was		318 F3 1		AFO binn thas be essed for event UI is and hi current reassessive and for heeds. He wed and hat to do ROM, bin ation. eing and pali- current s reassess lation ne	een r a LE s s eed oot fis o if race m ssed eds
FORM CMS-2		the evening. LPN-C stated the nned as refused." LPN-C Obsolete Event ID:6QVR	11	Facility ID: 00260	If continuation	sheet Pa	160 of 201

IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM 245387 B. WING 08/ NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE (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) F 318 Continued From page 160 stated R45 had a contracture of the left side elbow and hand. F 318 2. Corrective Action as is applied to others: A)All residents in need of splints/braces, ROM, and ambulation have the potential	E SURVEY MPLETED C 19/2013
245387 B. WING 08/ NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (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 (EACH CORRECTIVE ACTION SHOULD BE (ACH COR	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE ST OLAF RESIDENCE (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) F 318 Continued From page 160 stated R45 had a contracture of the left side elbow and hand. F 318 2. Corrective Action as is applie to others: A)All residents in need of splints/braces, ROM, and ambulation have the potential	(X5) COMPLETION DATE
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (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) F 318 Continued From page 160 stated R45 had a contracture of the left side elbow and hand. F 318 2. Corrective Action as is applied to others: A)AII residents in need of splints/braces, ROM, and ambulation have the potential	COMPLETION DATE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 318 Continued From page 160 stated R45 had a contracture of the left side elbow and hand. F 318 2. Corrective Action as is applie to others: A)All residents in need of splints/braces, ROM, and ambulation have the potential	COMPLETION DATE
stated R45 had a contracture of the left side 2. Corrective Action as is applied to others: elbow and hand. A)All residents in need of splints/braces, ROM, and ambulation have the potential	
 be affected by these deficient practices. be affected by these deficient practices. b) The Restorative Nursing as sheep skin hand splint was observed to be in the opened top drawer of the bedside stand. R45 stated he was supposed to wear the splint "all the time." R45 stated the uning assistent (NA) staff " usually forgets" and he calls to remind them to apply the splint. R45 stated the NA staff did not offer to assist him and he expressed he "shouldn't have to ask." R45 was unclear if he received ROM, denied wearing an elbow splint and stated the AFO was "In the closet." At 1:55 p.m. NA-H stated she usually asks R45 if she can apply the splint, and if R45 allows, she will apply it. "But we cannot force it." NA-H stated R45 should heave been applied "anytime" and R45 should wear it as much as possible. NA-H verified the splint should be done with application of the braces or splints. NA-H was unclear what kind of ROM was provided, such as passive or active and was unclear on how many repetitions of the ROM should be provided. At 1:59 p.m. LPN-H stated the splint should have been applied and if R45 refused 	y.

		AND HUMAN SERVICES				APPROVE 0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a state of the second stat			TE SURVEY
		245387	B. WING	2	08	C /19/2013
	RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP COE 912 FREMONT AVENUE NORTH	DE	
				/INNEAPOLIS, MN 55411		View mark
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 318	cares/treatments, s would explain risk t risk and benefit edu in the nursing notes not wear the AFO of was unclear if R45 - At 2:13 p.m. the do observed to be par knocked on the door R45 was observed independently in hi was not wearing th His left foot was ob a flopping sound w (W/C) was near the repeatedly, "Where your arm rest?" and R45 kept asking, "V both NA staff began the dresser near the are you going throu "We're looking for y for your walk after determined the NA splint, R45 stated t drawer of the beds as they searched the splint to the R45's splint application a stated the left hand unclear when the s verified the splint w The annual Minimu 9/25/12, indicated M	staff should report it, and she benefits to R45. LPN-H stated ucation should be documented s. LPN-H confirmed R45 did or elbow splint consistently, but received ROM. loor to R45's room was tially open. NA-K and NA-H or and entered R45's room.				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.14.990.31.7993.777		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING				C / 19/2013
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAI	FRESIDENCE				12 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318	identified R45 had impairments; R45 m walking and transfe lower functional lim body. The Cognitive Loss Assessment (CAA) R45's cognitive loss independent with d was inattentive, had physical behaviors of cares. The Activi Functional Status/L Ulcers CAA identifies spasticity, left Hem left hand. The CAA occasionally refuse LLE [lower left extra identified R45 had refused the splint a identified R45 had refused the splint a identified R45 had left hemiplegia, cor cognitive impairme "He will occasionall splint & LLE AFO." ROM and did not ic R45's refusals. The of or refusal of the The Occupational T dated 2/1/13, indica positioning in W/C self-propel within fa	short and long-term memory equired limited assistance with erring; R45 had both upper and itations on one side of his /Dementia-Care Area dated 9/25/12, identified ses and that R45 was not ecision making skills, that R45 d disorganized thinking, towards others and rejection ties of Daily Living (ADLs) Jrinary Incontinence/Pressure ed R45 had impaired mobility, iplegia, and contracture of his further indicated, "He will to wear his left hand splint & emity] AFO." Although the CAA a contracture and occasionally nd AFO, the CAA did not w brace and did not identify a elf-care deficit dated 10/9/12, impaired mobility, spasticity, itracture of left hand and nt. The care plan identified, y refuse to wear his Left hand The care plan did not address lentify interventions to address e care plan did not identify use	F3	318			

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		AND HUMAN SERVICES				FORM	09/11/20 APPROVI 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a second second		LE CONSTRUCTION	COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 318	Continued From pa due to refusals.	age 163	F 3	318			
	Administration Rec Administration Rec hand splint, left elb washing left hand v daily (BID), ROM to lower extremity BID documented as co brace, AFO and RC documented as ap through 8/14/13, w observed to not be The MDS Note: Re Clarification dated splint) - (ROM) - (left The Occupational 7/4/13, indicated R for LUE [left upper Therapy Evaluation was seen for safet Therapy notes did	esident ADL Status/Summary 6/21/13, identified, "(hand eg wraps) Wanderguard." Therapy Evaluation dated 45 was seen for "Positioning extremity]." The Occupational n dated 8/5/13, indicated R45 y & community Reintegration. not address R45's use of AFO devices and did not					
	staff to apply/provid "Left Hand Splint of Brace to left ankle/ Wash left hand with daily; Range of mo left lower extremity bandage 4" wrap b	dated 7/31/13, directed the de: n in AM, off at bedtime; AFO leg on in AM, off at bedtime; h soapy water and dry twice tion to left upper extremity and twice daily; and Ace elastic oth legs daily PRN [as needed] sing AFQ [sic] brace if pt					

Facility ID: 00260

If continuation sheet Page 164 of 298

		AND HUMAN SERVICES		*	FORM	: 09/11/2013 APPROVED . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a choice of the second of	IPLE CONSTRUCTION	CON	E SURVEY
		245387	B. WING			C 19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	the second se	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 318	Brace Assistance F included AFO Brace elbow splint for Nov clinical record lacke program being perf The undated Nursin AM/PM directed R4 sheet directed NA s protector" and "Leff "AFO brace to left I further directed, "R extremity] and LE [I the sheet directed t did not specify whe sheet did not specify	 application Restorative Splint or Program Daily Documentation e application, L hand splint, L vember 2011 to present. The ed evidence of the restorative formed. ang Assistant Assignment Sheet 45's specific care needs. The staff to apply "Left palm to elbow splint and to apply ower extremity." The sheet OM to left UE [upper lower extremity] BID." Although to apply the devices, the sheet in to remove the devices. The fy the type of ROM, such as obtion and did not specify the d sets. b p.m. the registered nurse ated R45 should get ROM to mity and left lower extremity he ROM was "usually done Id not verify the type of ROM. c. RN-A stated she thought the bught in by the family and e applied PRN. RN-A stated K45 should need to talk e brace and stated she was DM was to be provided with r stated, "Therapy usually which is placed in the closet." 	F 31	18		

Facility ID: 00260

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
		245387	B. WING			С
						/19/2013
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIC
F 318	Continued From pa	age 165	F 318			
	the AFO. RN-A com been applied to R4 binder directing RC unclear where the c confirmed it was no - At 2:45 p.m. RN-A occupational theray the splint/brace and R45 had a splint, b as ROM, but was u evaluated and was ordered. OT stated had an elbow splint could not find it. OT AFO was ordered. further contracture hemiparesis, "Anyo at risk; he would be lot of his own ROM case load for custo - At 3:08 p.m. OT s with the hand splint were from prior to a stated R45 was no function or ROM an program for ROM an program for ROM an program for the custo not measure the co confirmed there wa was unclear if phys ROM program for t were aware of a pla she was unaware custo and was not aware	pist (OT) regarding the ROM d AFO and the OT confirmed race and AFO ordered, as well unclear when R45 was unclear when R45 was unclear when they were t she was informed today R45 t ordered and confirmed she T was unclear on the when the OT verified R45 was at risk for development due to left one with affected arm would be e low risk because he does a 1." OT stated R45 was still on om W/C seating. stated R45 came to the facility t and the elbow brace and they admission to the facility. OT t seen by their department for nd they did not develop a or splinting. OT stated she did ontracture of the hand and as no elbow contracture. OT sical therapy (PT) developed a the lower extremity or if they an with the AFO. OT stated of physician's orders for ROM e of a protocol being developed n't know what nursing has for				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		С	
NAME OF	PROVIDER OR SUPPLIER	240007	- And and and and the Co	REET ADDRESS, CITY, STATE, ZIP CO		/19/2013
ST OLAF	RESIDENCE			12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 318	stated she discusse was unclear if there was unclear on the brace or AFO. OT s ROM program, she to develop a ROM again there was no contracture, but sta (R45 would not allot today) and stated it moisture." OT state not appear to have OT verified the han On 8/19/13, at apped director of nursing R35's braces and h consistently offered the facility had an " and splint/brace ap therapy departmen applying braces an program." A policy orthotic devices wa 3:07 p.m. the DON splint/brace or AFO planning or mainter brace and AFO sho stated refusals sho DON verified R45 s therapy and a ROM	ed the ROM with nursing and a had ever been ROM for R45, status of the splint, elbow stated since there was no clear assessed R45 and was going plan for him. OT confirmed measurements of R45's hand the she checked the hand w hand check from surveyor "smelled" and had "a lot of ed the skin was intact and did any signs of breaking down. d was not cleaned that day. "roximately 1:30 p.m. the (DON) verified application of his ROM should have been and completed. DON stated ongoing problem" with ROM plication. DON stated the t used the term "program" for d splints, but it truly "was not a for splints, but it truly "was not a for splints, braces or other is requested at the time. At verified there was no policy on o application, assessment, care hance. DON verified the splint, buld have been applied. DON uld have been documented. should have been seen by	F 318			

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
		245387	B. WING	;		0.00000	C 19/2013
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAI	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	On 8/12/13, at 4:43 lying in bed on his in bent at approximate knee and were cross confirmed he had " stated he did not re- had worn a brace a not apply it anymore brace was last worn a pillow between hi observed to be toue 4:52 p.m. R35's im was observed to he On 8/14/13, the foll - At 7:30 a.m. R35' and lying in bed. Hi bent at the knees, s R35 was not wearin - At 7:50 a.m. two h room with a mecha - At 7:53 a.m. R35' transferred to from Both NA's tried to p pedals, they did no just off the floor and R35's chair and we the floor behind the combed and he wa room. - At 8:01 a.m. R35 the W/C in the dinin he was dressed at - At 8:09 a.m. R35 R35 confirmed his behind the foot ped "didn't fit the wheel offered ROM. R35	a p.m. R35 was observed be right side. His legs were both ely 90 degree angles at the ssed at the ankles. R35 contractures" in both legs and eceive ROM. R35 stated he at one time, but stated staff did e. R35 was unclear when the n. R35 denied that staff placed s legs, as both knees were ching against each other. At mediate room environment ave no brace or splints.	F	318			

Facility ID: 00260

		AND HUMAN SERVICES & MEDICAID SERVICES					09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMF	SURVEY
		245387	B. WING			08/1	; 9/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
STOLAS	RESIDENCE			2912 FI	REMONT AVENUE NORTH		
STULAF	RESIDENCE			MINNE	EAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318	R35 denied that sta or that he had refus - From 8:09 a.m. th remained at the tab room. - At 9:13 a.m. R35 of pushed himself awa transported R35 ou room. - At 9:27 a.m. R35 of to the bed. - At 9:35 a.m. NA-A with all R35's groon she would come ba incontinence brief a hours. - At 10:34 a.m. the with cares and state refused by R35. LP nor ROM were repo- - At 10:25 a.m. both about ROM and the braces for his legs, would remove them The NA's stated RC they used to apply to and the braces wer NA were able to state such as number of	it stated, "They didn't work." off offered to apply the braces sed the braces. rough 9:13 a.m. R35 ole for breakfast in the dining completed the breakfast meal, ay from table and NA-H t of the dining room and to his was transferred from the W/C a stated she was completed ning and washing. NA-A stated ick and check R35's and change him every two LPN-H stated ROM was done ed the braces were often N-H stated neither the braces orted as refused to her. n NA-H and NA-A were asked but stated he refused them, n and throw them on the floor. DM was only provided when the brace. Both verified ROM e not offered to R35. Neither the how much ROM to provide, repetitions and were not clear	F3				
	passive ROM or ac The care plan for A 3/15/10, indicated F program" daily, dire starting 10/4/10. A I "Bilateral leg splints	I to provide for R35 (such as tive assistive ROM). Iteration in mobility dated R35 had a "hamstring stretch ected to set up for the program hand written update directed, s on 1 hr [hour] after meals ated] An update dated 7/16, Obsolete Event ID: 6QVR1		Facility ID	00000		ge 169 of 298

		AND HUMAN SERVICES	64 72				FORM AF)9/11/2013 PPROVED 938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 25-25 (20 C 10 C		ONSTRUCTION	(7	X3) DATE S COMPL	
		245387	B. WING				C 08/19	/2013
	ROVIDER OR SUPPLIER			2912	EET ADDRESS, CITY, STATE, ZIP COD FREMONT AVENUE NORTH NEAPOLIS, MN 55411)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 318	dated 6/12/13, "Pt r [sic] on w/c behind care plan did not ad The Diagnoses Reg indicated R35 had diabetes mellitus ty gout, obesity, deme depression with an The comprehensive indicated R35's BIN changes with ADLs impairment in both quarterly MDS date a BIMS score of 13 indicated R35 was assistance with tran assistance with bed dressing and perso identified impairme The CAA for ADL's Ulcer dated 2/27/13 dependent on staff dressing. The CAA all ADLs & mobility The Physician's Or apply knee splints to to be put on for one lunch; Ankle Splints to be applied startin morning during slee On 8/1/13, the physician's Or	es throws on floor." A note refuses leg gard [sic]" (leg gard foot pedals added 7/12. The ddress the use of ankle splints. port - Clinical dated 3/31/11, the following diagnoses: pe II, peripheral neuropathy, entia, pre-glaucoma, and xiety. MDS dated 2/13/13, //S score was 12, identified no 5. The MDS identified lower extremities. The ed 5/14/13, indicated R35 had 6 (mild impairment). The MDS non-ambulatory, required total nsfers and toilet use; extensive d mobility, locomotion, eating, onal hygiene. The MDS nt in both lower extremities. //Urinary Incontinence/Pressure 3, indicated R35 was totally for grooming, bathing and indicated, "He is assisted with as needed." ders dated 7/28/13, directed to to both legs. The splints were a hour after breakfast and s both heel/elbow boots were ing at 2:00 p.m. thru the	F 3	318				
0010000		M During Daily Care (While in			ID: 00260 If contin			170 of 29

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 - 180 - 1908, 11 - 1918 - 1990 - 1990 - 1990 - 1990 - 1990 - 1990 - 1990 - 1990 - 1990 - 1990 - 1990 - 1990 -		LE CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		245387	B. WING			C 08/19/2013	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RESIDENCE			2	2912 FREMONT AVENUE NORTH		
STULAP	RESIDENCE			P	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Bed)." Then the ord Program In AM & P Complete Program The undated NA As directed NA staff to braces on as direct to complete "Hams "foot hugger plate" indicated, "Demand care not provided w "Report non-compli The TARs for June reviewed. The follor -The June 2013 TA "PROM [passive ra while in bed. The T documented daily (twice daily). The an as applied twice da - The July 2013 TA opportunities, the k refused 25 times. T documented 12 tim circled as refused 4 three times out of 3 was documented b twice daily. - The August 2013 knee splints for one lunch. The splints v indicating refused 1 splints were only of The ankle splints b 2:00 p.m. not signe	der directed, "Range of Motion M During Daily Cover. While in Bed AM & PM." ssignment Sheet AM/PM apply R35's bilateral knee ed by the care plan, directed tring stretch daily," to apply a on the wheelchair. The sheet ding - verbally abusive when when he wants it done." and, iance with cares to nurse." , July and August 2013 were wing was noted: .R directed staff to complete nge of motion] twice daily AR indicated knee splints were even though directed to apply ikle splints were documented ily. R indicated out of 62 nee splints were not les. The ankle braces were 4 times and not documented at opportunities. The ROM y the licensed nurse as given TAR directed to apply the e hour after breakfast and vere documented as a circle, 12 of 15 opportunities. The fered once daily in August. oth heel/elbow boots starts is d at all for the month of program in AM and PM was	FS	318			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH		
				N	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	age 171	F	318	molten inn men i 14 mer 1821 Franz de men e Marie e i mitter eret et de la Franz de de la		
	Review of the Nurs the following: - On 8/3/13, at 6:30 "Resident refused I not have elbow spli 'he doesn't need th about the importan positive outcomes. and still refused." - On 8/4/13 (no tim indicated, "Res [res his splints stated do unable to verbally r - On 8/8/13, at 4:00 [patient] had refuse - On 8/13/13, at 4:00 [patient] had refuse - On 8/13/13, at 10 also refused splints be placed on @ [at indicated, "Pt refuse for meals." - On 8/15/13, at 7:0 "Refuses splints to Although the Nurse refused the splints/ record lacked evide the splints/braces of	 be's Notes for R35 indicated b) p.m. a note indicated, heel and elbow splints [R35 did ints ordered], Resident stated, em.' Writer informed resident ce of wearing splints, and the Resident acknowledge info, e documented), a note sident] refused to wear any of oesn't need them any more redirect." b) p.m. a note indicated, "Pt ed splints" :50 a.m. a note indicated, "Res s today would not allow them to t] all." At 6:00 p.m. a note red splints again today, got up 00 p.m. a note indicated R35 (braces frequently, the clinical ence R35 consistently refused or that R35 was re-approached 					
	record did not indic offered to R35 on t without the braces, identified refusals of record did not iden On 8/16/13, the fol - At approximately certified occupation stated R35's bilate measurements we	after a refusal. The clinical cate if the splints/braces were he days he was observed Although the Nurse's notes of the splint/braces, the clinical tify R35 had refused ROM. lowing was noted: 12:15 p.m. the OT and hal therapy assistant (COTA) ral knee contracture re 30-50 degrees on 3/7/13; 22/13, R35's knee contracture					÷

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00000000		PLE CONSTRUCTION 3	CON	E SURVEY
		245387	B. WING	<u>، </u>			C 19/2013
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	knee and 101 degr - At 12:38 p.m. OT therapy assistant (I and ankle contracti measured at 94 de The knee flexion m degree improveme ankles were addres were identified as of inversion. PTA stat were are 67 degree degrees plantar fle verified there were contracture to com At the time of the of checked R35's clos guard for the W/C shelf, along with bo The ankle braces w the guard (foot buo W/C because R35 and it was intended flexing back under contracture "could buddy. While all the R35 was asked by them to apply the b allowed the braces application, was co discomfort. R35 was were applied "To st Stated to the ocupa (OTR) he would we Denied pain or disc time of the observation	re 95 degrees at on the right ees on the left knee. , COTA, and the physical PTA) measured R35's knee ures. The right knee was grees; the left was 98 degrees. heasurements indicated a one ant on the right knee, three ant on the left. PTA stated the ssed at the time of therapy, but contracted at an angle of ed the current measurements es plantar flexion on the left; 60 xion on the right. The PTA no measurements of the	F	318			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT COM	E SURVEY
		245387	B. WING			C / 19/2013
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 318	the book was to dim the braces to R35's boots (ankle splints created by therapy pictures and directi R35's orthotics. OT include directions of "hamstring stretch." A Nurse's Note date p.m. indicated, "Re min [minutes]" alt removed, the note braces to remain of The RehabCare PT Recommendations indicated, "Pt has c extremities & needs addressed by aides contractures." The splint after breakfast directed to refer to proper application. 4/18/13, identified, both lower extremit schedule to be add directed to don both p.m. shift though a. The form directed to book for proper appl On 8/19/13, at app director of nursing R35's braces and h	ect the proper application of a legs and R35's heel float b). OT stated the book was to direct the staff through ons on how to properly apply verified the book did not on completing ROM or a ' ed 8/16/13, written at 12:50 s removed splints [after] 20 hough R35 had the braces indicated R35 allowed the n for part of the time. T/OT/ speech therapy (ST) to Caregivers dated 4/18/13, contractures on both lower s a splinting schedule to be	F 318	DEFICIENCY)		

Facility ID: 00260

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL A. BUILDING COMPL 245387 B. WING 08/19 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			AND HUMAN SERVICES				PRINTED: FORM A OMB NO. (PPROVED
245387 B. WING 08/11 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, ZIP CODE STREET ADDRESS, CITY. STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 PROVIDERS PLAN OF CORRECTION A (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIFFICIENCY F 318 Continued From page 174 applying braces and splints, but it truly "was not a program." A policy for splinthrace or orthotic devices application, assessment, care planning or maintenance. DON stated refusals should have been documented. R42 did not have splints and paim protectors applied during observations on 8/15/13, 8/16/13 and 8/19/13. F 318 During continuous observations on 8/15/13, 8/16/13 and 8/19/13, an. R42 was observed in bed on 8/15/13, at 1:49 p.m. and did not have paim protectors or IUpon interview on 8/15/13, 8/16/13 and 8/19/13, form 7:41 a.m. until 9:24 a.m. R42 was observed jung on her back in bed with nothing in her hands. On 8/16/13, 10m 7:41 a.m. until 9:24 a.m. R42 was observed on her back in bed with nothing in a wheel chair in her mads and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. No 8/16/13, at 1:49 p.m. and did not have any splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral paim protectors to hands on at all times and bilateral knee splints when in bedo to preserve range of The potential f				10-12-12-12-12-12-12-12-12-12-12-12-12-12-			(X3) DATE COMPI	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CTV, STATE, ZP CODE ST OLAF RESIDENCE 212 FREMONT AVENUE NORTH (MAID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ER PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D F 318 Continued From page 174 applying braces and splints, but it truly "was not a program." A policy for splints, braces or other orthotic devices was requested at the time. At 3:07 p.m. the DON verified the facility had no policy for splint/brace or orthotic device applied turing observations on 8/15/13, 8/16/13 and 8/19/13. F 318 During continuous observations on 8/15/13, 8/16/13 and 8/19/13. F 318/13. During continuous observations on 8/15/13, 8/16/13 and 8/19/13. F 318 On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed in the do they palm protectors or knee splints on. On 8/16/13, at 1-9.52 a.m. R42 was observed on her back in bed with nothing in her hands. On 8/19/13, at 9:52 a.m. R42 was observed on her back. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of			245387	B. WING			-	9/2013
ST OLAF RESIDENCE MINNEAPOLIS, MN 55411 (X1)D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES RECOULTORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENTIFYING INFORMATION) PROVIDENTIFYING INFORMATION) F 318 Continued From page 174 applying braces and splints, but it truly "was not a program." A policy for splints, braces or other orthotic devices was requested at the time. At 3:07 p.m. the DON verified the facility had no policy for splint/brace or orthotic device application, assessment, care planning or maintenance. DON stated refusals should have been documented. F 318 R42 did not have splints and paim protectors applied during observations on 8/15/13, from 8:11 a.m. until 10:33 a.m. R42 was observed sitting in a wheel chair in her room without paim protectors on ad stated R42 did not have paim protectors or knee splints on. F 318 On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed with nothing in her hands. On 8/16/13, at 1:49 p.m. and did not have paim protectors to hands on tail litmes and bilateral knee splints to her knees. At 11:13 a.m. R42 was observed on her back in bed with nothing in her hands. N 8/19/13, at 9:52 a.m. R42 was observed on her back in bed with nothing in her hands.	NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
Data book SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Defersion (FER Continued From page 174 applying braces and splints, but it truly "was not a program." A policy for splints, braces or other orthrotic devices was requested at the time. At 3:07 p.m. the DON verified the facility had no policy for splint/brace or orthotic device application, assessment, care planning or maintenance. DON stated refusals should have been documented. F 318 During continuous observations on 8/15/13, 8/16/13 and 8/19/13. During continuous observations on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on at stated R42 did not have palm protectors on there splints on. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed with nothing in her hands. On 8/16/13, to 7:41 a.m. until 9:24 a.m. R42 was observed on her back in bed with nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of	ST OLAF	RESIDENCE						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG C(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 318 Continued From page 174 applying braces and splints, but it truly "was not a program." A policy for splints, braces or other orthotic devices was requested at the time. At 3:07 p.m. the DON verified the facility had no policy for splint/brace or orthotic device application, assessment, care planning or maintenance. DON stated refusals should have been documented. F 318 During continuous observations on 8/15/13, 8/16/13 and 8/19/13. During continuous observations on 8/15/13, from 8:11 a.m. until 10:33 a.m. R42 was observed sitting in a wheel chair in her room without palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors or knee splints on. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed with nothing in her hands. R42 was observed on her back in bed with nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to nands on at alt limes and bilateral knee splints when in bed to preserver range of		4.4 5.5 5 6 5 6 5 6 5 4 9 5 5			N			
 applying braces and splints, but it truly "was not a program." A policy for splints, braces or other orthotic devices was requested at the time. At 3:07 p.m. the DON verified the facility had no policy for splint/brace or orthotic device application, assessment, care planning or maintenance. DON stated refusals should have been documented. R42 did not have splints and palm protectors applied during observations on 8/15/13, 8/16/13 and 8/19/13. During continuous observations on 8/15/13, form 8:11 a.m. until 10:33 a.m. R42 was observed sitting in a wheel chair in the room without palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors or and stated R42 did not have palm protectors or and stated R42 did not have palm protectors or so and stated R42 did not have palm protectors or so and stated R42 did not have palm protectors or so nell splints on. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed on her back in bed with nothing in her hands. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at altitle splint with nothing in her hands. 	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION DATE
 maintenance. DON stated refusals should have been documented. R42 did not have splints and palm protectors applied during observations on 8/15/13, 8/16/13 and 8/19/13. During continuous observations on 8/15/13, from 8:11 a.m. until 10:33 a.m. R42 was observed sitting in a wheel chair in her room without palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on and stated R42 did not have any splints for her legs. R42 was observed in bed on 8/15/13, at 1:49 p.m. and did not have palm protectors or knee splints on. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed on her back in bed with nothing in her hands. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors thands on at all times and bilateral knee splints when in bed to proserve range of 	F 318	applying braces an program." A policy to orthotic devices wa 3:07 p.m. the DON policy for splint/brace	d splints, but it truly "was not a for splints, braces or other s requested at the time. At verified the facility had no ce or orthotic device	F	318			
 8:11 a.m. until 10:33 a.m. R42 was observed sitting in a wheel chair in her room without palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on and stated R42 did not have any splints for her legs. R42 was observed in bed on 8/15/13, at 1:49 p.m. and did not have palm protectors or knee splints on. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed with nothing in her hands. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed with nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of 	÷	maintenance. DON been documented. R42 did not have s applied during obse	stated refusals should have plints and palm protectors					
 was observed lying on her back in bed with nothing in her hands. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed with nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of 		8:11 a.m. until 10:3 sitting in a wheel ch protectors on. Upon 10:33 a.m. NA-I ve protectors on and s splints for her legs. 8/15/13, at 1:49 p.m.	3 a.m. R42 was observed hair in her room without palm in interview on 8/15/13, at rified R42 did not have palm stated R42 did not have any R42 was observed in bed on n. and did not have palm					10 9
her back in bed with nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of	12	was observed lying	on her back in bed with					
plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of		her back in bed wit splints to her knees observed sitting in	h nothing in her hands and no s. At 11:13 a.m. R42 was					
motor and maintain our mogny.		plan dated 4/6/09, o protectors to hands knee splints when i	directed bilateral palm s on at all times and bilateral n bed to preserve range of					
A Physician's Progress note dated 1/17/13, noted ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260 If continuation sheet Pag								

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A PARTICUL PROPERTY		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
	<i>k</i>	245387	B. WING				C 19/2013
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH		
	CUMMADY CTA		10		/INNEAPOLIS, MN 55411 PROVIDER'S PLAN OF CORRECTION	J	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	age 175	F 3	18			
1 010	R42's hands have l	braces because she contracts	, .	10			
	her wrist and finger	S.					
		al Care Plan dated 7/29/13,					
		n's order for palm protectors remove for cares and bathing.					
	received on 8/15/13	ant Assignment Sheet 3, directed bilateral palm not include direction for the					5 - 1
	knee splints.						
	LPN-D verified R42 or knee splints on. splints in the closet putting the splints of the palm protectors	on 8/15/13, at 2:13 p.m. 2 did not have palm protectors LPN-D located the knee and stated the NAs should be on. LPN-D stated she thought were taken away and R42 clothes in her hands.					
	LPN-H stated R42 protectors in her ha located one palm p applied to R42's rig locate a palm prote stated she would h	ewed on 8/19/13, at 11:14 a.m. was supposed to have palm ands or washcloths. LPN-H protector in the room which she ght hand. LPN-H was unable to ector for the left hand and ave to call therapy for a new the NAs were to apply the er cares.					
	range of motion se	led upper and lower extremity rvices as ordered by the idicated in the written plan of			×.		
	required extensive both on and off the	dated 6/24/13, identified R23 assistance for locomotion, unit. The MDS indicated R23 en moving from a seated to a					

Event ID: 6QVR11

Facility ID: 00260

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARI					FORM	09/11/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. Contract (1. Contract)		PLE CONSTRUCTION	COMF	SURVEY
	245387	B. WING	÷		08/1	9/2013
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
 able to stabilize winnoted to have imparison in the able to stabilize winnoted to have imparison in the able to have the able to have imparison in the able to have imparison in the able to have imparison in the able to have the able to have the able to have the able to have imparison in the able to have the have the able to have the have to have the have the have the have the have the have t	and while walking, and was only th human assistance. R23 was airment on one side of the 23 also had functional to the upper extremity hs in ROM. al Status/Urinary sure Ulcers CAA dated d R23 required extensive d mobility, transfers, walking in g, toilet use, grooming and e with bathing. The CAA's impaired mobility due to accident (CVA) in 2001 with hd related right upper extremity tified R23 wore an AFO brace extremity when he ambulated. dicated R23 had a PROM as well as an ambulation are plan for physical therapy ram directed resident to et with walker, stretching and very day. The goal was, "will	F	318	3		

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second second		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	J.	(26)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	ge 177	F3	318			
	caregiver assistance	e .					
	2. Resident met go assistance/stand by	al of transfers with caregiver s					
	3. Resident does w	ell with exercise Active					
		Motion (AAROM) right upper and ARROM left upper and					
	lower extremity,	and ANNOW left upper and					
		al of 30 feet daily with W/C sist and resident met goal of					23
		and floor staff had been trained					
		structions for transfers/gait					
	documentation.	igned off on the training per			2		
	Summary dated 5/ R23 presented with with graded therape Education of staff for	ccupational Therapy Discharge 16/13, to 6/21/13, revealed in increased activity tolerance eutic exercises and PROM. or PROM restorative program mity to decrease contracture was provided.					
	from 7/10/13 throug program from 6/1/1 the following:	AR for the ambulation program gh 8/15/13, and PROM 3 through 8/15/13, revealed					2
	7/10/13 despite he therapy for restorat initials from 7/10/13	n program was on hold since had been discharged from ive program. Staff circled 3, through 7/31/13, and for an					
	arrow drawn across 2. R23's Stretching completed sixty six	s the TAR "HOLD" for August. & PROM program was not					
		ircled initials as not completed					
		gned physician telephone pational and physical therapy					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245387	B. WING	i			C 19/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		7
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	orders were obtained 5/15/13, 5/16/13, 7/ a telephone order w during chart review directed "Ok for PT The undated NA As directed "PROM-ske PT recommendation On 8/12/13, at 4:40 to walk more some doctor had ordered but sometimes her stated, he would lik that he could go wir residents in the fac On 8/14/13, at 1:48 she had assisted R know where and wir complete document ambulation NA-G s completing the prog On 8/14/13, at 2:12 nursing assistants the PROM then rep TAR at the end of t the ambulation profit the profit assistant profit the profit assistant pr	ed on 5/3/13, at 1:30 p.m., /10/13, 7/17/13 and on 7/18/13 which was not in the chart but was provided later for transfers & ambulation." assignment Sheet AM/PM ow stretch and Ambulation per ons-PM shift." 0 p.m. R23 stated he would like times as the therapist and the him to walk at least twice daily never walks. R23 further to be able to walk more so th family and outings like other ility. 8 p.m. interviewed NA-G stated R23 with PROM but did not ho was responsible to itation. In regards to stated the evening shift was		318	8		

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED
		245387	B. WING			1987-328	C 19/2013
0.000.000.000	PROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 012 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	1 00,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	desire to ambulate a restorative progra evaluation was con ambulation, standir functional mobility v discharged on 12/0 it was later found th ambulated. Per O-I an order for ambula and R23 started be weekly until 7/10/13 complained of left a had assisted him to for exercise on 6/4/ no fractures and is added that staff wa ambulation program by physical therapy therapist as indicat sign-out sheet. On 8/16/13, at 9:27 (RN)-A stated her et to keep restorative documenting the P was completed. RN currently being revi would be addresse nurses were expect documentation was shift daily after they assistants had com Later at 11:32 a.m. nursing (O)-D cond On 8/16/13, at 4:06	although original order was for am. O-H stated the original npleted on 10/28/12, for ng, transferring and decreased which R23 completed and was 07/12, from therapy. O-H stated nat R23 was not being H on 5/13/13, O-H requested ation and safety with transfers sing seen on 5/14/13, five times 3. During the session, R23 had ankle pain after two therapists to the floor mat in quad position /13, an x-ray was completed sue had resolved. O-H further is educated on resident m on 7/8/13 through 7/31/13, of staff including the physical ed by documentation and Y a.m. the registered nurse expectation was to find a place sheets to ensure staff was ROM and ambulation after it V-A stated also the policy was ewed and documentation d. RN-A further stated that the ted to make sure all s completed by the end of their y made sure the nursing		318			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

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		AND HUMAN SERVICES				FORMA	09/11/2013 PPROVED)938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.		CONSTRUCTION	(X3) DATE COMP	SURVEY
		245387	B. WING				9/2013
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	ambulation program restarted again whi was not being com On 8/16/13, at 4:09 O-H was not aware and that had not be therapy departmen	n and when it had been ch explained the reason why it	F	318			
F 323 SS=J	The ROM active ar procedure revised a "Assist the resident resident's ability to motion" The procedure to ensur responsible to ensur completed and whe completed accordir Additionally, the po systematic commu- therapies and nursi when a resident ha therapy and approp- continued by restor 483.25(h) FREE O HAZARDS/SUPER The facility must er environment remai as is possible; and adequate supervisi prevent accidents.	ad passive policy and 8/13/13, directed staff to, t as necessary and assess the perform active range of policy lacked a systematic e staff was aware who was ure all documentation was are documentation was to be ng to the frequency ordered. licy lacked an on-going nication channel between the ing departments in regards to d been discharged from priate programs to be rative nursing. F ACCIDENT	F	323			
	67/00 00) Dec inc. March				- ID. 00000		
ORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 6QVR1	1	Facilit	ty ID: 00260 If continuation	sheet Pag	e 181 of 298

EAX of any and provides and the second se			AND HUMAN SERVICES				: 09/11/2013 APPROVED
ULAN OF CORRECTION DEMTIFICATION NUMBER: A. BUILDING COMPLETED 245387 B. WING C.008/19/2013 EE OF PROVIDER OR SUPPLIER 2312 TREEMONT XERUE NORTH MINNEAPOLIS, NN 55411 C.009/19/2013 2323 Continued From page 181 by: Based on observation, interview and document review, the facility failed to provide adequate supervision to prevent 16 for eldents (R45), who was identified as an elopement risk, from unsafely eloping from the facility. Athom to failer the facility failed to provide adequate supervision to prevent R45 from eloping from the facility applied to his wheelchair (W/O), the dominately eloping from the facility. Athom to have left the facility and on 773/173. F 323 F323 In addition, the facility. Athom to have left the facility failed to provide adequate supervision that was not an U for 2 of 2 residents (R65, R77) to prevent Date form eloping from the facility failed to provide supervision that was not an U for 2 of 2 residents in mediate jeopardy (U) for R45 who was known to have left the facility failed to develop and implement a behaviori potential accidents and implement a behaviori potential accidents and implement a behaviori from the facility and was identified on 071/5173, at 615 p.m. for lack of supervision of assistive devices. The administrator and director of nursing (DON) were notified of the U at 622 p.m. the DON was notified the J was removed, but noncompliance remained at the lower scope and severity level (J, which indicated no actual harm with potential for more than minimal harm with potential for more than minimal harm with potential for more than minimal harm with potential to resolate usiden for need and functioning. All residents with wa							
245387 B. WMG 08/19/2013 E OF PROVIDER OR SUPPLER STREET ADDRESS. CITY, STATE, 2/P CODE 2912 FREMONT AVENUE NORTH MINNEAPOLLS, NN 55411 OLAF RESIDENCE D PROVERS FLAW OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFYNIC INFORMATION) D PROVERS FLAW OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFYNIC INFORMATION) D PROVERS FLAW OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMECTION (EACH ORRECTIVE ACTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMECTION (EACH ORRECTIVE ACTION (EACH ORRECTIVE ACTION (EACH ORRECTIVE ACTION (EACH ORRECTIVE ACTION (EACH ORRECTIVE ACTION Was identified as an elopement risk, from was identified as an elopement risk, from was identified to as an elopement risk, from was identified to insumediate (R45), who was identified to insume the facility. This resulted in an immediate (POL) facility. This resulted in an immediate (POL) (IJ) for R45 who was known to have left the facility. This resulted in an immediate ipopardy (IJ) for R45 who was known to have left the facility. This resulted in an immediate ipopardy (ID) for R45 who was known to have left the facility. This resulted in an immediate ipopardy (R45, R73) to prevent Detrial accidents and implement a behaviore. The analleged perpetrator. b. Resident # 65 has been discharged from facility. This resulted in an immediate ipopardy (R45, R73) to prevent potential accidents and inpures and the facility failed to provide supervision of assistive devices. The administrator and director of nursing (DON) were notified of the LJ at 6.23 p.m. On 8/16/13, at 2.23 p.m. the DON waso faile						CON	MPLETED
OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 910 EFX AG ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR USC DENTERING INFORMATION) D PROVINES PLAN OF CORRECTION (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULTORY OR USC DENTERING INFORMATION) PROVINES PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BE CROSS REFERENCE) TO THE APPROPRIATE DEFICIENCY Come Construction (EACH ORRECTIVE ACTION (EACH ORREC			245387	B. WING		1	
OLAF RESIDENCE MINNEAPOLIS, MN 56411 910 SUMMARY STATEMENT OF DEFICIENCIES (REGULATORY ON LSC DENTERING INFORMATION) PDEFX PAC PREFX REGULATORY ON LSC DENTERING INFORMATION) PDEFX PAC 323 Continued From page 181 by: Based on observation, interview and document review, the facility failed to provide adequate supervision to prevent 1 of 6 residents (R45), who was identified as an elopement risk, from unsafely eloping from the facility. Although R45 had a Wandry and (a system used to alert facility, This resulted in an immediate jeopardy (U) for R45 who was known to have left the facility. This resulted in an immediate jeopardy (U) for R45 who was known to have left the facility. This resulted in an immediate jeopardy (U) for R45 who was nown to have left the facility. This resulted in an immediate jeopardy (U) for R45 who was nown to have left the facility. This resulted in an immediate jeopardy (U) for R45 who was nown to have left the facility. This resulted in an immediate jeopardy (U) for R45 who was nown to have left the facility. Resident #87 had wander guad implement a behavioral management plan to prevent alleged abuse from occurring that was not an LI for 1 of 1 (R5), identified as an alleged perpetrator. b. Resident #87 had wander guad resident to resident transfers to reduce risk of bruising. 2. Corrective action as applies to inflied on 8/15/13, at 6/15, pm, for lack of supervision of assistity edvices. The administrator and director of nursing (DON) were notified of the U at 6/23, pm. On 8/16/13, at 2/28 pm. the DON was notified the LI was removed, but noncompliance remained at the lower scope and severity level (J) which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. c. Corrective action as applies to other residents with wander guard	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
Building and the second seco	ST OLAF	RESIDENCE					
If EACH DEFICIENCY MUST BE PRECEDED BY FULL AGG PREFIX TAG If EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG If EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Construction is a construction of the property is and the provide adequate supervision to prevent 1 of 6 residents (R45), who was identified as an elopement risk, from unsafely eloping from the facility. Although R45 had a Wanderguard (a system used to alert facility staff when residents attempt to leave the facility tate to ensure the Wanderguard was functional to prevent R45 from eloping from the facility (failed to ensure the Wanderguard was functional to prevent R45 from eloping from the facility (failed to ensure the Wanderguard was functional to prevent R45 from eloping from the facility (failed to ensure the Wanderguard was functional to prevent potential accidents and inpierem a behavioral management plan to prevent alleged abuse from occurring that was not an 1J for 1 of 1 (R8), identified as an alleged perpetrator. System. The immediate jeopardy level of the LJ was removed, but noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with poferitital for more than minimal harm that is not imm		CUMMADY CTA				PRECTION	
 by: Based on observation, interview and document review, the facility failed to provide adequate supervision to prevent 1 of 6 residents (R45), who was identified as an elopement risk, from unsafely eloping from the facility. Although R45 had a Wanderguard (a system used to alert facility aff when residents attempt to leave the facility affer the residents attempt to leave the facility and to ensure the Wanderguard was functional to prevent R45 from eloping from the facility. This resulted in an immediate jeopardy (IJ) for r45 who was not an LJ for 2 of 2 residents (R65, R87) to prevent potential accidents and injuries and the facility failed to provide supervision that was not an LJ for 2 of 2 residents (R65, R87) to prevent potential accidents and injuries and the facility failed to develop and injuries and the facility failed to forwide supervision that was not an LJ for 2 of 2 residents (R65, R87) to prevent potential accidents and injuries and the facility failed to movide supervision of assistive devices. The administrator and director of nursing (DON) were notified of 16 H J at 6:23 p.m. On 8/16/13, at 2:28 p.m. the DON was notified the LJ was removed, but noncompliance remained at the lower scope and severity level of D – isolated, scope and severity level which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 	(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
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 a. Resident #45 has had new wander guard a. Resident #45 has had new wander guard b. Resident #45 has had new wander guard c. Resident #45 has had new wander guard placed and care plan has been updated. All staff immediately educated on wander guard guard facility failed to ensure the Wanderguard was functional to prevent R45 from eloping from the facility. This resulted in an immediate jeopardy (i) for R45 who was known to have left the facility (eloped) on 7/1/13, 7/2/13, 7/11/13, 7/29/13 and on 7/31/13. In addition, the facility failed to provide supervision that was not an U for 2 of 2 residents (R65, R87) to prevent potential accidents and injufies and the facility failed to develop and implement a behavioral management plan to prevent alleged abuse from occurring that was not an U for 1 of 1 (R8), identified as an alleged perpetrator. The immediate jeopardy began on 7/1/13, when R45 successfully leoped from the facility and was identified on 8/15/13, at 6:15 p.m. for lack of supervision of assistive devices. The administrator and director of nursing (DON) were notified of the U at 6:23 p.m. On 8/16/13, at 2:28 p.m. the DON was notified the LJ was removed, but noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level of D - isola		Based on observat			1 Corrective Action:		
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	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
	245387	B. WING			02036	_ 19/2013
ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		10/2010
RESIDENCE						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa The clinical record is successfully eloped the month of July of 7/29/13, and again lacked evidence R4 alert system) was of placement and func- know where R45's Vande staff accompanied outside the facility t 2:30 p.m. to reduce the facility lacked a system to potentiall from the facility. Review of the facility. Review of the faciliti (RIRs) from Januar months), and R45's following: - On 1/6/13, at 5:55 [resident, R45] - ye door inside the SE by his side & holdin report identified R4 did not indicate wha prior to the incident injury and the interv prevent further incident	indicated R45 had from the facility five times in n 7/1/13, 7/2/13, 7/11/13, on 7/31/13. The clinical record 45's Wanderguard (departure consistently monitored for ction; the nursing staff did not Wanderguard was placed on lacked the equipment to erguard for function. Although R45 on scheduled walks wice daily at 10:00 a.m. and a attempts to leave the facility, functional Wanderguard by prevent R45's elopements ty's Resident Incident Reports by 2013, thru July 2013 (six a clinical record revealed the 6 a.m. an RIR indicated, "Res lled for help. Was found by the [southeast] Stairway; his cane by the door knob." Although the 5 was interviewable, the report at R45 was attempting to do c. R45 did not fall, sustained no ventions implemented to dents were, "30 mins [minutes]		323	 DEFICIENCY) reviewed every day with stand up and all incidents are immediately reporte the DON. c. All residents are to b kept safe in their environment. If any resident has outburst that potentially could cause harm to others immediately sent via 911 out of building. Completion date: 10/3/13 Recurrence will be prevented A) Random audits will be completed weekly x4 then monthly x3 with findings be presented to the QA commit for follow up discussion/planning. Completion will be monitored 	l d to be t d s is i by: ing tee	
	Correction ROVIDER OR SUPPLIER RESIDENCE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa The clinical record successfully eloped the month of July o 7/29/13, and again lacked evidence R4 alert system) was of placement and fund know where R45's his W/C; the facility check R45's Wand- staff accompanied outside the facility t 2:30 p.m. to reduce the facility lacked a system to potentiall from the facility. Review of the facility (RIRs) from Januar months), and R45's following: - On 1/6/13, at 5:55 [resident, R45] - ye door inside the SE by his side & holdin report identified R4 did not indicate what provent further incident provent further	IDENTIFICATION NUMBER: 245387 245387 ROVIDER OR SUPPLIER RESIDENCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 182 The clinical record indicated R45 had successfully eloped from the facility five times in the month of July on 7/1/13, 7/2/13, 7/11/13, 7/29/13, and again on 7/31/13. The clinical record lacked evidence R45's Wanderguard (departure alert system) was consistently monitored for placement and function; the nursing staff did not know where R45's Wanderguard was placed on his W/C; the facility lacked the equipment to check R45's Wanderguard for function. Although staff accompanied R45 on scheduled walks outside the facility twice daily at 10:00 a.m. and 2:30 p.m. to reduce attempts to leave the facility, the facility lacked a functional Wanderguard system to potentially prevent R45's elopements from the facility. Review of the facility's Resident Incident Reports (RIRs) from January 2013, thru July 2013 (six months), and R45's clinical record revealed the following: - On 1/6/13, at 5:55 a.m. an RIR indicated, "Res [resident, R45] - yelled for help. Was found by the door inside the SE [southeast] Stairway; his cane by his side & holding the door knob." Although the report identified R45 was interviewable, the report did not indicate what R45 was attempting to do prior to the incident. R45 was attempting to do prior to t	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245387 B. WING ROVIDER OR SUPPLIER 245387 B. WING RESIDENCE ID PREFI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 182 F 3 The clinical record indicated R45 had successfully eloped from the facility five times in the month of July on 7/1/13, 7/2/13, 7/11/13, 7/29/13, and again on 7/31/13. The clinical record lacked evidence R45's Wanderguard (departure alert system) was consistently monitored for placement and function; the nursing staff did not know where R45's Wanderguard was placed on his W/C; the facility lacked the equipment to check R45's Wanderguard for function. Although staff accompanied R45 on scheduled walks outside the facility twice daily at 10:00 a.m. and 2:30 p.m. to reduce attempts to leave the facility, the facility lacked a functional Wanderguard system to potentially prevent R45's elopements from the facility. Review of the facility's Resident Incident Reports (RIRs) from January 2013, thru July 2013 (six months), and R45's clinical record revealed the following: - On 1/6/13, at 5:55 a.m. an RIR indicated, "Res [resident, R45] - yelled for help. Was found by the door inside the SE [southeast] Stairway; his cane by his side & holding the door knob." Although the report identified R45 was interviewable, the report did not indicate what R45 was attempting to do prior to the incident. R45 did not fall, sustained no injury and the interventions implemented to prevent further incidents were, "30 min	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	OF DEFICIENCIES CORRECTION (X1) FROUDERSUPPLIER(LIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BULDING 245387 B. WING RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS OF CORRECTIVE ACTION SHOULD CROSS-REFERENCE TO THE APPROPY (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 182 F 323 reviewed every day with stand up and al incidents are immediately reporte the month of July on 7/1/13, 7/1/1/3, 7/1/1/3, 7/29/13, and again on 7/31/13. The clinical record lacked evidence R45's Wanderguard (departure alert system) was consistently monitored for placement and function; the nursing staff did not know where R45's Wanderguard mas placed on his W/C; the facility lacked the equipment to check R45's Wanderguard for function. Although staff accompanied R45's on scheduled walks outside the facility acked a functional Wanderguard system to potentially prevent R45's elopements from the facility. 3. Completion date: 10/3/13 Review of the facility's Resident Incident Reports (RIRs) from January 2013, thru July 2013 (six months), and R45's clinical record revealed the following: 3. Completion wealty satimizes interviewable, the report idin to incident. R45 was attempting to do prior to the incident. R45 family was 5.	production (X1) PROVIDENSUPPLIEVICUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DAT A BUILDING 245387 B. WING (X3) MULTIPLE CONSTRUCTION A BUILDING (X3) DAT A BUILDING RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X6) MULTIPLE CONSTRUCTION A BUILDING (X6) MULTIPLE CONSTRUCTION A BUILDING (X6) MULTIPLE CONSTRUCTION A BUILDING RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (X6) MULTIPLE CONSTRUCTION A BUILDING (X6) MULTIPLE CONSTRUCTION A BUILDING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY USE BE PRECIDED OF YULL REQULATORY OF LISC IDENTIFIVING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 Continued From page 182 F 323 PREFIX TAG PREFIX (EACH DEFICIENCY USE AND ADDRESS, CITY, STATE, ZIP CODE CONTINUE (POPORT ON HE facility five times in the month of July on 7/1/13, 7/2/13, 7/11/13, 7/29/13, and again on 7/31/13. The clinical record lacked evidence R455 Wanderguard (departure hacked evidence R455 Wanderguard (departure hacked evidence R455 Wanderguard Was placed on the WOC; the facility lacked the equipment to coutside the facility weat of function. Although the facility lacked a functional Wanderguard system to potentially prevent R45's elopements from the facility lacked in the incleant Reports (RIRs) from January 2013, ftru July 2013 (six month)s, and R45's clinical record revealed the following: - On 1/6/13, at 5:55 a.m. an RIR indicated, "Res this side & holding the door knob." Alt

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			FORM OMB NC	D: 09/11/2013 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second second	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245387	B. WING		08	C 3/19/2013
	PROVIDER OR SUPPLIER	a.		STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	R45. The RIR was 1/9/13 (three days a corresponding Nurs incident, indicated R sign and opened th indicated, "He was he may fall down th lacked evidence 30 completed. - On 2/16/13, at 7:0 indicated R45 was and "Wanderguard - On 7/1/13, at 5:30 "Resident [R45] wh building," indicated by the receptionist, outside and see the "NP paged to revisi received to place W Follow Up section of indicated, "Wander placed, new 30 mir report was signed B (three days later). T indicated a "VA [vul had "N/A [not applic corresponding Nurs time) indicated staf the building," the N voicemail was left t Wanderguard. Alth applied on 1/6/13, at 3:00 "Resident [R45] we alerting staff." The went outside for free	signed by the administrator on after the incident). A se's Note recapitulated the R45 had removed the stop e doors. The note further told not to go near the door as the steps." The clinical record minute checks were 00 p.m. a Nurse's Note confused, was up in his W/C intact." 0 p.m. an RIR indicated, eeled himself outside the the elopement was witnessed and R45 stated, "I want to go e world." The report indicated, t for Wanderguard. Order Vanderguard." The 24-Hour of the form dated 7/2/13, ed outside, new Wanderguard on checks implemented." The by the administrator on 7/3/13 The section of the form which nerable adult, investigation]"	F3	23		

Facility ID: 00260

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TATEMENT		KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	. 0938-0391 TE SURVEY MPLETED
ND FDAN C	FORRECTION			ING		C
		245387	B. WING			/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE MINNEAPOLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 323	Continued From pa	age 184	F 3	323		
	unwitnessed. "New v 's [checks] for PM The 24-Hour Follow "No further wander was documented a	Wanderguard placed. 30 min A shift then 1 hr [hour] checks." v Up dated 7/3/13, indicated, ing." The new Wanderguard s "placed on w/c d/t [due to] place on body stated only on				
	w/c would be allow the administrator o indicated the incide	ed." The report was signed by n 7/3/13, and the report ent was not reported to State clinical record did not reflect				
	documentation of t dated 7/3/13, at 10 every one hour che indicated R45 had 1/9/13, the Wander and a new Wander the 7/2/13 incident Wanderguard was Although a Nurse's	he incident. A Nurse's Note :00 p.m. indicated R45 was on ecks. Although documentation a Wanderguard applied on rguard was "intact" on 2/16/13, guard was applied on 7/1/13, report indicated another applied to R45's W/C. 5 Note indicated R45 was on "1 clinical record lacked evidence				
	R45 was on 30 mir - On 7/9/13, at 4:00 R45 was attemptin Wanderguard alert requested nursing indicated R45 was staff and attempts "ineffective." The n yell until staff accor- building. A therape was assigned to wa indicated, "Will cor - On 7/11/13 (no tir indicated, "Res left	nute or one hour checks.) p.m. a Nurse's Note indicated g to leave the facility and the ed the receptionist "who staff assistance." The note verbally aggressive, yelling at to redirect R45 were ote indicated R45 continued to mpanied him outside the utic recreation staff person alk with R45 outside. The note ntinue 1 hr checks." ne written), a Nurse's Note building setting off alarm." The		Ť		
	redirect R45 verba nursing staff "ran o down driveway ran	receptionist attempted to Ily, but was ineffective. A but and caught him going fast np." The note identified R45 mentative but came in with the				

	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Constanting		OMB NO. 093 (X3) DATE SUI COMPLET	
			A. BUILDING		C	
		245387	B. WING		08	/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	-	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 185	F 32	3		
	nurse. The clinical	record lacked an RIR for the				
	the Nurse's Notes,	the elopement was identified in the clinical record lacked				
		ement was reported administrator, lacked evidence				
		put in place to prevent				
	potential future elopements and lacked a root cause analysis of the incident, such as how R45					
	Was able to leave to Wanderguard syst	he building and the employed and the				
		00 p.m. another Nursing Note "attempting to leave facility"				
	and the Wandergu	ard alerted the receptionist				
	이 것 없었는 것 같은 것같은 것같은	station." The note indicated outside for "fresh air &				
		e indicated staff discussed with alks and the need for staff				
	accompanying R4	5 outside. The note further				
		several unsafe factors including nability to avoid uneven area,				
	environmentally th	e sidewalk very uneven [with]				
		ne incline that required vriter to assist resident." The				
		o "talked to all people that er described R45 "singing to				
	people & unable to	understand non-verbal ques				
	[sic] from stranger surrounding is poo	s. Judement [sic] in r."				
	- On 7/18/13 (no ti "Alerted to residen	me), a Nurse's Note indicated,				
	Wanderguard." Th	e note indicated R45 required				ł
	several staff to ass mobility due to inc	sist with half a block of W/C reased fatigue.				
	- On 7/24/13, at 7:	30 p.m. a Nurse's Note Vanderguard" was placed				
	underneath and or	the right side of R45's W/C.				
	The note did not in	dicate why a new placed on the W/C.				
	- On 7/29/13, 4:00		t			1

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	0938-0391 E SURVEY IPLETED
		245387	B. WING			C 08/19/2013	
NAME OF I	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	"Resident [R45] we unsupervised repor report indicated R4 road but I was at th The interventions s "On hour Check." T dated 7/30/13, indic working no problem here see New Order the administrator or incident was not rep corresponding Nurs indicated a voicema practitioner regardin unsupervised. The leaving the facility a indicated, "New Wa ankle." Although a R45's chair on 7/24 evidence why the V the W/C versus on - On 7/30/13, at 4:0 indicated R45 was wanting to leave the by himself." The no resistant to redirect Depakote (a medic was prescribed for record indicated De diagnosis of anxiety evidence R45 was Depakote and lacke clinical indications f - On 7/31/13, at 9:0 "Resident [R45] we stuck on the drivew from entering. With practical nurse (LP	nt outside the building ted by the receptionist." The 5 stated, "I didn't go to the e side walk they lied on me." ection of the report indicated, The 24-Hour Follow Up section cated, "Wanderguard is n with behavior tonite N.P. ers." The report was signed by n 7/31/13, and indicated the ported to the SA. A se's Note written at 9:35 p.m. ail was left for the nurse ng R45 leaving the building note indicated R45 denied and "became upset." The note anderguard put on his Lt [left] Wanderguard was placed on /13, the clinical record lacked Vanderguard was placed on	F	323			

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Facility ID: 00260

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/11/20 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
245387		B. WING		08	/19/2013	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2010
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	"Yelling, uncoopera exited the facility at interventions sectio Wanderguard, Dep NP f/u [follow up] w The 24-Hour Follow "Resident has resp report was signed b and indicated, "Will [with/occupational t [at] 10 AM & 2:30 [p re-evaluate medica incident was not rep corresponding Nurs indicated the NP wa leaving the building propelling self-block R45 was yelling and redirection." A note R45 had an OT ord outside." Although th not easily redirected evidence the Wand evaluated for function evidence the Wand and placement by th Throughout the sur 8/14/13, R45 was of first and ground floo independently with observed to go to th independently for m observed to be affix under the seat. The was observed to ha	tive." The RIR indicated R45 the "back door." The n indicated, "Replace akote increased yesterday by / walking times w/ resident." / Up dated 8/1/13, indicated, onded well to program." The by the administrator on 8/1/13,	F 3	23		

Event ID: 6QVR11

Facility ID: 00260

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 09/11/2013 APPROVED D: 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. WING		08	/19/2013
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP C 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	doors opened to a l doors opposite eac lead to the street si sloping driveway ra door to the left lead the facility parking I from the building. A	ge 188 preezeway leading to two h other. The door to the right de of the building which had a mp leading to the street. The to the back of the facility and ot approximately 30 to 35 feet Il three doors were observed uard device next to the door	F3	323		
	was admitted to the diagnoses to includ dysphagia, muscle persistent mental d hypertension, and l Minimum Data Set indicated R45's BIN Status, a tool used could not be comple short and long-term required limited ass transferring; require on the unit and required with locomotion off cane and/or a W/C The Cognitive Loss Assessment) dated cognitive losses an with decision makin disorganized thinkin towards others and identified R45 had ' move'' and identifie suicidal risk and ref	ssion Record indicated R45 e facility on 9/19/12, with e vascular dementia, spasms, osteoporosis, isorder, depressive disorder, eft hemiplegia. The annual (MDS) dated 9/25/12, AS (a Brief Interview of Mental to measure cognition) score eted and identified R45 had n memory impairments; R45 sistance with walking and ed supervision with locomotion uired extensive assistance the unit. The MDS indicated a were his mobility devices. /Dementia-CAA (Care Area 19/25/12, identified R45's d R45 was not independent ng skills, was inattentive, had ng, had physical behaviors rejected cares. The CAA 'a difficult time adjusting to the d specific physical behaviors, ferral to the psychiatrist. The ng (ADLs) Functional ntinence/Pressure Ulcers CAA				

Facility ID: 00260

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) [IO. 0938-0391 DATE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	C	OMPLETED	
		245387	B. WING			C 08/19/2013	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT				
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NO MINNEAPOLIS, MN 5541			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 323	distances with staff but the W/C was Re- locomotion. The CA- Medication Use date balance problems, to stabilize without a indicated R45 "could The quarterly MDS had a BIMS score of impairment); he red with ADLs of transfe the unit, dressing, of required limited asso out of the room. The Risk of Elopern indicated R45's pot elopement were rev the following: - On 9/20/12, the re- out stairway exits w review indicated R4 a tabs alarm on at a R45 had personal s "frequent monitoring frequency of the mo- - On 12/19/12, and R45 was not at risk - On 7/2/13, the rev facility parking lot w want to exercise.' O unsafe without supe comments section of "Wanderguard plac Although the review was applied to R45 clinical record indice	assistance and a quad cane, 45's primary source of A for Falls/Psychotropic ed 10/2/12, indicated R45 had was not steady, but was able staff assistance. The CAA Id be impulsive at times." dated 6/21/13, indicated R45 of 10 (moderate cognitive quired extensive assistance erring, locomotion on and off grooming, and toilet use; he sistance with walking in and hent/Wandering Review ential risk factors for viewed. The reviews indicated eview identified R45 "tries to go which have stop signs." The 15 "has Wanderguard on" and all times. The review indicated eview identified R45 "tries to go which have stop signs." The 5 "has Wanderguard on" and all times. The review indicated safety devices applied, had g" but did not identify the ponitoring and "Wanderguard." 6/15/13, the reviews identified for elopement or wandering. view indicated, "Leaving into vithout notifying staff. States, 'I cognitive/physical issues ervision." The additional of the review indicated,	F3				

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Compare and the second	RS FOR MEDICARE OF DEFICIENCIES		(X2) 1411				0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				40-5029-10-201-1-	LETED
		245387	B. WING			C 08/19/2013	
NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	RESIDENCE				2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	 ² 323 Continued From page 190 2/16/13, indicated the Wanderguard remained on. The clinical record lacked evidence if and when the Wanderguard was removed. Although a Wanderguard was documented as "applied" on 7/2/13, the clinical record did not identify if a Wanderguard was applied on 7/1/13, or after the 7/2/13, elopements from the facility. The clinical record lacked evidence R45's elopements on 7/11/13, 7/29/13 and 7/31/13, were reviewed. 		F 3	323			

Event ID: 6QVR11

Facility ID: 00260

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387	A second statement of the second statement of	LE CONSTRUCTION	CO	TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	in environment 5 R manner 6 Offer cal if resistive 8 Cont [1-2 x day weather care plan identified verbally abusive; h	courage movement & exercise redirect & reorient in gentle Im reassurance, 7 Reapproach continue] walks outside w/ staff permitting." In addition, the R45 could be physically and e resisted care, made negative had a history of "attempting to	F 323			
	Wanderguard. The R45's elopement ri facility or attempts facility, such as the lacked intervention elopement, such a Wanderguard, R45 remove the Wander Wanderguard, nurs elopement attempt identified a "walkin plan did not identifi with a cane or to b W/C. The care plan related to elopement assessment sched	plan identified R45 had a e care plan did not identify isk, elopements from the to enter unsafe areas of the e stairwell. The care plan is to address prevention of s placement of the 5's history of attempts to erguard, reasons for the sing interventions to address is. Although the care plan g program" for R45, the care y if R45 was supposed to walk e escorted while R45 used a in lacked safety consideration ints, such as safety lules or R45 refusing to allow thed while out on the walking				
	Sheets AM/PM for "Wanderguard-und "Mobility program v assistant] to assist directed to set asid	ng Assistant (NA) Assignment R45's team directed, derside of w/c" and directed, with resident- CNA [nursing outside of facility." The sheet le "30 min" for the activity.				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Contraction of the second			(X3) DAT COM	E SURVEY IPLETED
	245387 B. WING			C 08/19/2013			
	NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH WINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	key locked service delay with the main the parking lot on the observed to have a plugged into the way quickly wheeled out the door independe front of R45 and qui held the door and F parking lot. At no tin the Wanderguard d door to the facility. to be at a decline to the parking lot was observed to roll, pic decline across the street. R45 did not momentum and rol cued R45 to "wait for and made no indica NA-K was observed just before he react and side walk. NA- touching the W/C) is sidewalk and off the - At 2:37 p.m. recept both interviewed. R shift and both confit shift. Both stated R once" per their reco eloped from the fact "It was my fault; I d supposed to leave. and stated R45 had and was "in the par other facility staff for receptionists stated believed it was app	elevator (due to a service elevator). A door leading to be back of the facility was "Wanderguard, Inc." device ill to the left of the door. R45 to f the elevator and towards ently. NA-K quickly moved in ickly opened the door. NA-K R45 wheeled out quickly into me during the observation did levice alarm or lock the back The parking lot was observed oward the street, the surface of uneven. R45's W/C was cking up speed, down the parking lot and towards the make an effort to slow the I of the W/C. NA-K verbally or her," but R45 did not comply ation he had heard NA-K. d to run to catch up with R45 hed the end of the parking lot K then escorted (without R45 to the left down the e facility property. btionists (R)-J and R-K were -K stated she worked the day rmed R-J worked the evening 45 had "gotten out [eloped] bllection. R-K stated R45 last cility "months ago" and stated, idn't know [R45] wasn't " R-K pointed to the front door d "made it out" of the facility king lot." R-K stated she called		323			

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245387	B. WING			08/	_ 19/2013
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			1.1.1.1.1	12 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 193	F	323			
		not. Both stated they were					
		nd in writing of any changes in f new residents were admitted.					
		explained the Wanderguard					
		door" and in order for R45 to					
		they had him remain back from opened the door for him					
	manually. The rece	ptionist explained if "staff went		Ì			
		pened the door, R45 would be					
	able to leave the facility. When asked during the interview, the receptionists were unclear if the						
	Wanderguard syste	em alarmed. When asked					
		edure for if a resident the facility (elope), both					
		the procedure was to call for					
		rified she did not attempt to					
	stop R45 from leav	ing the facility. Idmissions coordinator (AC)					
		sation with R-J/R-K and stated					
		with pictures of all residents					
		pt at the receptionist desk. AC nist were aware which					
		d could not leave the facility.					
	AC further stated a	Il residents' picture and					
		tion were in the binder at the o resident information could					
		to the Police as needed. AC					
	stated if there were	changes to a resident's status					
		ity, the receptionist staff were					
	- At 2:45 p.m. the r	egistered nurse (RN)-B					
	verified she usually	worked on R45's unit. When					
		sponsible for checking the					
		ction of R45's Wanderguard, n't know, Q [every] shiftthe					
	aides [nursing assi	stants, NA's] can do it too."					
		as sometimes "busy" and had					
		the Wanderguard. When nderguard system was					

Event ID: 6QVR11

Facility ID: 00260

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DEPARTMENT	OF HEALTH AN	D HUMAN	SERVICES
CENTERS FOR	R MEDICARE &	MEDICAID	SERVICES

PRINTED:	09/11/2013
FORM	APPROVED
OMB NO	0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387	1. (Ref. / 12-0.000 / 0.000	ING			
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1 00	/19/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
F 323	checked for function "little box" to the W see if it was working working." RN-B stat the nursing station looked for the box. not here." RN-B ch nursing station, bu Wanderguard was	on, RN-B stated "they" carried a Vanderguard and checked it to ag, "If it [the box] lights up, its ated the box was in a drawer at . RN-B opened a cabinet and RN-B stated, "Of course, it's necked several drawers at the t the box for checking the not located. RN-B was unclear	F 3	323			
	function. - At 2:49 p.m. R45 NA-K thanked R45 room. NA-K stated facility through the alarm did not soun facility. NA-K did m locked and stated door opened. NA-H alarm when she ar verified the door di opened the door find should have locked was usually assign - At 5:10 p.m. the I on R45's unit the p asked why R45 has stated R45 was at safety judgment." I remain on the prop leave the property. gets "fanciful ideas predict. LPN-F stat parking lota cou being in the parkin When asked abou was located, LPN- LPN-F was uncleas	puard was last checked for returned to the unit with NA-K. 6, R45 then wheeled into his R45 was returned to the front door and confirmed the d when R45 entered the ot recall if the facility door she went before R45 and the K verified the back door did not nd R45 left the facility and d not lock. NA-K verified she rst, but was unclear if the door d or alarmed. NA-K verified she red to R45. _PN-F confirmed she worked previous day (8/13/13). When d a Wanderguard, LPN-F risk for injury and had "bad _PN-F stated R45 would not perty and would "attempt to " LPN-F further explained R45 s" which were not easy to ted R45 "got stuck in the ple weeks ago" and explained g lot was unsafe for R45. t where R45's Wanderguard F stated she "wasn't sure." r about when and how the checked for function.					

Facility ID: 00260

STATEMENT	OF DEFICIENCIES	KANNER STATE STREAM STREA		PLE CONSTRUCTION G	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245387	B. WING _		08	C 19/2013	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		10/2010	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa	age 195	F 32	3		and the second second	
	(Physician's Order 7/31/13, all directe placement & functi	ent Medical Care Plan s) dated 11/15/12, through d, "Wanderguard check ion every shift." A Telephone , at 8:00 a.m. indicated, "OK					
		re by Medica form dated m. indicated R45 was seen by					
	a NP. The form ide increased wanting the last 3 days has building independent to place a wander [patient] states the is not an option as A/P [assessment/p "Vascular Demention Pt has little tolerand has low frustration redirection often definition	entified, "Multi-infarct dementia: to go out for 'exercise'. Over attempted to leave the ently so staff has now needed guard on his w/chair. Pt weather is nice and the porch people 'smoke out there."' The blan] section indicated R45 had, a uncomplicated: status; with behaviors and depression. ice for waiting for anything. He tolerance by hx [history] and oes not work."					
	(MARs) and Treatr (TARs) from March indicated the follow - The months of M the Wanderguard placement and fun by the licensed nu - The months of M include documenta placement or funct - The month of Jul placement checks function checks wa	arch and April 2013 indicated was assigned to be checked for action every shift and signed off rsing staff. ay and June 2013 did not ation of Wanderguard					

Facility ID: 00260

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 09/11/2013 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	TE SURVEY
		245387	B. WING		08	C 3/19/2013
	ROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	was applied to the - The MAR/TAR for documentation of V function checks. Th Wanderguard was function until the ev checks were added the documentation.	7/24/13, a new Wanderguard <i>N</i> /C. August 2013 lacked Vanderguard placement and the MAR/TAR indicated R45's not checked for placement or rening shift of 8/14/13, and the l after the surveyor questioned The MAR/TAR indicated re scheduled to begin on	F 323			
	the surveyors at the The administrator h and stated he was reported the Wand administrator carrie front entrance and accordion doors loc away from the door opened after an ap The administrator as front door and an a administrator was a of the facility would exit. The administrator transponder was a device as R45. The R45's Wanderguar have caused the do On 8/15/13, at 9:53	anclear if the other entrances alarm when R45 attempted to ator verified the Wanderguard new device and not the same administrator was unclear if d was functional and would bor to alarm.				
	assistant staff chec placement in the m	ked the Wanderguard orning. NA-H stated she s before R45 was in the W/C				

and showed the Wanderguard transmitter was out of R45's reach. The Wanderguard was observed to be affixed with a short strap, under

Event ID: 6QVR11

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		245387	B. WING	;		Street St.	C 08/19/2013	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1917	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	Continued From pa	A Charles and the second	F	323				
	W/C. NA-H stated s make sure it was th to take it off." NA-H "could be checked" and see if it was fun this had been done there was a device the transmitter. NA-	ed to the metal frame of the she checked the transmitter to here and stated R45 would "try stated the Wanderguard by taking the W/C to the door nctional, but was unclear when last. NA-H was unclear if used to check the function of -H stated the Wanderguard nly good for "30 days." The						
	On 8/15/13, at 1:41 had worked in the f elopements. RN-A Wanderguard was RN-A stated R45 w the order for the Wa 8:00 a.m. on 7/2/13 Wanderguard was eloped from the fac RN-A verified Wand function daily and p described checking using a "box thing" the Wanderguard was stated staff could be check for function of explained R45 had Wanderguard missi RN-A verified the cl documentation of the and function checks Wanderguard was a the W/C seat on 7/2 was found to have b 7/2/13, RN-A stated	p.m. the RN-A confirmed she acility at the time of the stated she believed the applied to R45 on 7/2/13. as placed on "checks" 7/1/13, anderguard was obtained at but was unclear when the applied. RN-A verified R45 which at 5:30 p.m. on 7/2/13. derguard policy was to "check lacement every shift." RN-A function was completed by which had lights to indicate if vas functional. RN-A also ring R45 near the door to of the Wanderguard. RN-A been found to have the ing, but was unclear when. inical record did not include the Wanderguard placement s. RN-A stated the moved from the wrist to under 24/13, after the Wanderguard been removed by R45. On the Wanderguard did not go the system had a "15 second						

Facility ID: 00260

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/11/2013 1 APPROVED). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. WING		0.0	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		/19/2013
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	the Wanderguard. F the outside of the m arrived. RN-A states 7/29/13 elopement. indicated R45 left vi R45 actually left the (accordion) doors, k building via the doo building and parking unaware of R45 exi door, but was uncle sound or turn off aff On 8/15/13, at 3:35 the "back door" R45 not the door the sur The consultant state time of the elopeme surveyor observed the two opposite do before the accordio facility. The consultat from the receptionis doors) the breezew. "front door" which le to the left was the "H parking lot. Wander on both doors. The surveyor to the end parking lot and state [R45] (approximated doorway)" and point ramp in the parking parking lot area was many grooves and p consultant indicated traffic on 7/31/13, w parking lot traffic, le	RN-A stated R45 had reached hain door by the time staff had d it was the same for the RN-A stated although the RIR ia a "back door," RN-A stated e facility via the main but left the breezeway and r leading to the back of the g lot. RN-A stated she was ting the facility via any other ar if the alarm continued to	F3			

Event ID: 6QVR11 Facility ID: 00260

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STEW CONTRACTOR	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE			0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	- Marca M. 1967-005			C	
		045007					
		245387	B. WING			08/1	19/2013
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				I2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	3 S 1	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION
F 323	Continued From pa	age 199	F	323			
		The second					
	surveyor observed on 8/14/13, was only accessible by elevator (with a key) and the door						
	leading to the back	aspect of the facility had a					
		ce connected to it. The	1				
		surveyor observed the door					
		ding at on 8/14/13. The door					
		y area (and leading to another erved to have a Wanderguard					
		side of the door. The					
		ctor was observed to be					
	checking the wiring	of the Wanderguard to the					
		area. The environmental					
		Wanderguard at the back					
		ng home (used as an exit for a					
		R45 on 8/14/13) should have door should not have locked.					
		derguard on the "front" and					
		the door but should "alarm."					
		services director stated the					
		for the magnetic lock on the					
		em on the second floor and did					
		nt of the facility exits. The					
		ctor stated staff should be					
	aware of the different						
		em including the location of the environmental director					
		derguard on the door observed					
	on 8/14/13, "Should						
	On 8/16/13, at app	roximately 8:00 a.m. the					
		rmed the facility did not have	ŧ.				
	the testers to chec	k if the Wanderguard bracelets		1			
	 Manual Statistics and a summarial statistical function 	e administrator stated the					
		ed and would be "arriving					
		strator confirmed the facility's					
	checked for function	nave the Wanderguard					
		d the Wanderguard devices on					
		e breezeway were removed					

Facility ID: 00260

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

PRINTED: 09/11/2013
FORM APPROVED
OMB NO 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and a compare	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		BERN WARDEN.	A. BUILD	ING		C	
		245387	B. WING		08	08/19/2013	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page 200 and the main accordion door to the breezeway directly in front of the reception desk was the last point of entry/exit for the Wanderguard system. The administrator was unclear how staff was checking R45's Wanderguard for function without the tester. On 8/16/13, at 9:30 a.m. the social service designee (SSD)-A stated she was involved with the elopements when they were brought up in the UDT linterdiciplinant team! meetings SSD A		F 3	323			
	the elopements will IDT [interdisciplinal stated every time I building, the recep to be brought back confirmed R45 had stated the majority R45 wanted to go situation, such as assisting other res stated the interim down and created SSD-A stated R45 to go out and be e SSD-A further stat limited." SSD-A ve and behavior secti confirmed the care elopements from t	hen they were brought up in the ary team] meetings. SSD-A R45 had been out of the tionist called and R45 was able in the building. SSD-A d "gotten out [eloped]." SSD-A of the behavior problem was "now," and described a in the middle of when staff was idents with eating. SSD-A DON (the consultant RN) "sat a walking program" with R45. chose the times he was willing scorted out of the building. ed, "My involvement has been rified she completed the mood ons of the care plan and e plan did not address R45's he facility.					
	interviewed regard facility. The admin notified via telepho events" and stated he was notified. Th not consider the tin "reportable" or "elo receptionist called	46 a.m. the administrator was ling R45's elopements from the istrator stated he was usually one regarding "reportable I he did not keep a log of when he administrator stated he did mes R45 left the facility as opements" because the and notified staff R45 was and "staff were on their way to					

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

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	D: 09/11/2013 APPROVED D. 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	TE SURVEY MPLETED
		245387	B. WING			08	C /19/2013
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				FREMONT AVENUE NORTH IEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 201	F 3	323			
	incidents when R45 7/2/13, 7/11/13, 7/2	trator added he viewed the 5 left the facility on 7/1/13, 9/13 and 7/31/13 as not					
	while he left the build asked if R45 was b	se R45 was being "observed" ilding and was "safe." When eing escorted by staff out of					
	physically with R45 administrator furthe	ministrator stated staff was not in those times. The er stated he was not sure if					à)
	administrator expre was considered an was not notified of elopement was not stated his signature reports were when	out of the building." The essed he disagreed with what elopement and confirmed he the incidents because the reportable. The administrator e and date on the incident he had "reviewed the incident indicate when he was dent."					
	surveyor observed speak to LPN-C. LI watching a car acci on the corner of 29 from the West wind simultaneously stat always tell you guys going outside. We's	roximately 12:50 p.m. a NA-H and NA-A come and PN-C was observed to be ident which had just occurred th Ave N and Emerson Street low on 2nd floor. Both NA staff red to LPN-C, "This is why we is that [R45] should not be ve seen him go down that way.					
	interviewed regardi she believed an elo SA when a resident DON stated that wa not reported to the believed since the r	p.m. the DON was ng elopements, and stated opement was reportable to the t left the "facility property." The as why the elopements were SA. The DON stated she receptionist saw R45 leave the or assistance and R45 was in					

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	DATE SURVEY COMPLETED	
		245387	B. WING			08/19/2013		
NAME OF I	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	RESIDENCE				2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	The DON confirme prior to her employ sidewalk around th pavement was une verified she had wa facility and R45 wo staff to touch the W was able to move f outside the facility. On 8/16/13, at 3:58 for Wanderguard p be "delegated" to N	not considered an elopement. In the elopements occurred ment to the facility; verified the e facility, the parking lot and even and unsafe. The DON alked with R45 outside the uld not always allow her or V/C. The DON verified R45 fast when wheeling the W/C B p.m. RN-A stated checking lacement and function could IA staff, but the nurse	F 3	323				
	documented the re remained unclear if was removed in Ju Wanderguard was 11/2012. On 8/19/13, at 10:0 therapist verified R "community involve stated the treatment with R45 while he w community. Occup not want staff to be was "confused" on R45. The occupation staff provided teach occupational therap R45 on the walks, R45 why staff was choose times and f "isolated" as he wat walks. The occupation	 Isults. RN-A stated she f or when the Wanderguard ily, but stated she thought the first applied to R45 on D5 a.m. the occupational 45 was in therapy for ement." Occupational therapist at was to develop approaches was out on walks in the ational therapist stated R45 did with him and the nursing staff behavioral approaches with onal therapist stated therapy hing on how to talk to R45. The pist stated she went out with timed them and explained to with him; encouraged R45 to for staff to not make R45 feel as being escorted on these tional therapist denied the 			*			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

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		E & MEDICAID SERVICES			OMB NO. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED C		
		245387	B. WING		1	_ 19/2013	
	PROVIDER OR SUPPLIEF	3	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 323	daily. The Elopement As dated as revised of policy was to asse potential risk factor identified, "All resi admission and an resident determined will be assessed of the completion of Assessment [Risk Review]." The poli appropriate interve bottom of the form "elopement preve The policy further an intervention. The [sic] working prop 9. Implement sign test Wanderguard tested and workin The undated Wan System manual di tester" within one bracelet, press an one time, the tested times if the bracel "good." The manu- test the Wandergu function. The manu-	ssessment policy and procedure on 5/15/13, identified the facility ess each resident to identify ors for elopement. The policy dents will be assessed on nually for elopement. That ed to be 'at risk' for elopement quarterly." The policy directed the "Elopement Risk of Elopement/Wandering icy further directed to apply entions from the "list" at the n, directed to complete an ntion/management care plan." directed, "8. If Wanderguard is est Wanderguard to ensure it erly before putting on resident. aling device testing calendar, I daily and sign daily that it is	F 323				

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245387		B. WING			C 08/19/2013		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
ST OLAF	RESIDENCE	e.			012 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	SK SL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From par crossbars of the W The immediate jeop was removed on 8/ corrected the defici replaced R45's Wa Wanderguard syste residents for function testers were ordered Wanderguard prote evaluated and char provided on these of established a monif audits and revised ongoing compliance R87's admission M R87 had no fall hist in the room indepen- supervision on off t 12/18/13, indicated present. R87's falls assessed as R87 of care was not impled interventions to min- the falls. The lack of record to minimize R87 at harm. The Of comprehensive ass or as possible control	ge 204 /C. bardy that began on 7/1/13, 16/13, when the facility ent practice as the facility had inderguard, tested all ems currently used on other on, three new Wanderguard ad and obtained, the ection at the front entrance was inged, and staff training was changes. The facility toring system which included the Wanderguard policy for e. DS dated 12/11/12, indicated ory. R87 was able to ambulate indently, however, R87 needed he unit. The Falls CAA dated R87 had fall risk factors were not comprehensively ontinued to fall and the plan of mented and/or revised with himize potential injuries from if evidence in the medical the injury due to falls placed CAA Falls lacked any ressments of the risk for falls ributing factors.		323			
	12/24/12, indicated medication, mobility impairment and bal plans. Additional int one to sit up in bed interdisciplinary tea redirect when unsa	see the ADL, psychotropic may vary d/t cognitive ance, and incontinence care terventions included assist of update MD/NP as needed, m (IDT) review as needed, fe with ambulation, lay down and provide five minutes					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387		이 이 것 같은 것	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		B. WING		08/19/2013			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 323	During observation was noted to have knuckles of the left to the right wrist and she fell down the s	on and Wanderguard. on 8/12/13, at 5:42 p.m. R87 dark purple bruising on the hand and dark purple bruising ea. When asked, R87 reported	F 3	23			
	and the right wrist a x 4 cm dark purple forearm. During observation was observed walk dining room with or NA-I assisted R87 and did not provide put shoes on R87's During observation was noted to wand exiting rooms. Whe room 214 (a third r stayed with R82. The Resident Incid 1/13 through 8/13, On 1/1/13, at 3:00 the floor in room 20 her room. The RN need 1:1 care whe resident rooms. Th was provided or the identified.	on 8/14/13, at 3:07 p.m. R87 er on the unit entering and en R87 observed R82 sitting in esident), R87 entered 214 and ent Reports reviewed from					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P		: 09/11/2013 APPROVED
		& MEDICAID SERVICES	1			1	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245387		B. WING			C 08/19/2013		
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	15/2015
ST OLAF RESIDENCE				L	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG	ı ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			323			

Facility ID: 00260

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/11/2013 APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	Construction of the second	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
245387		B. WING		C 08/19/2013			
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO			
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	REGULATORY OR LSC IDENTIFYING INFORMATION)			23			

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245387	B. WING				19/2013
NAME OF I	PROVIDER OR SUPPLIER	1		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 208	F	323			
	was seen lowering found to have a ski 4/29/13, a Nurse's bruises noted to the Reports were provi The Resident Incid orthostatic blood pr falls from 1/1/13 th orthostatic blood pr When interviewed director of nursing monthly orthostatic R87 related to psyc Review of the May TARs showed the H circled every day a A Physician's Telep indicated "Ok to d/d elbow protectors an stockings] d/t non of was not present in record was reviewed record lacked evide implemented and a alternate falls inter- minimize potential When interviewed LPN-D stated bruis Nurse's Notes.	on 8/14/13, at 1:10 p.m. the verified there also had been no blood pressure monitoring for chotropic medication use. 2013 through August 2013 hip and elbow protectors were nd noted as not available. whone Orders dated 8/14/13, c [discontinue] hip protectors, nd Ted hose [anti-embolism coverage." However, the order the medical record when the ed on 8/16/13. The medical ence of the care plan being any falls interventions and/or ventions being put into place to injury from falls. on 8/14/13, at 9:19 a.m. ses were monitored in the					
	Nurse's Notes. During an interview nurse consultant (C	on 8/16/13, at 11:11 a.m. the D)-D stated bruises are tracked When asked about the					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1921 Charles		ONSTRUCTION	СОМ	E SURVEY IPLETED C
		245387	B. WING				
	PROVIDER OR SUPPLIER			2912	EET ADDRESS, CITY, STATE, ZIP CODE PREMONT AVENUE NORTH NEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	implementation of t planning process o O-D made no com On 8/19/13, at 2:09 asked for documen and intervention for	he interventions and the care f the related falls with injuries	F	323			
	regarding Risperide Celexa (an anti-dep stated R87 had a lo depression includir and knew she was noted with the trial increased pacing, r falls. The NP stated restarted R87 had with her peers. The "paranoia" of going bed and she wante just sedated. Wher needed (PRN) Risp ordered after the se been discontinued, were just trying to NP stated R87 was had to "be careful was had to "be careful was had to a con policy was provided to the lack of a con the falls and lack o	ewed on 8/19/13, at 11:10 a.m. one (an antipsychotic) and pressant) use for R87. The NP ong standing history of ing tearfulness, anxiousness not with her daughter. The NP off Risperidone, R87 had not sleeping and increased d with the Risperidone no tears and interacted better a NP stated R87 had to bed and was afraid to be in d R87 to be comfortable not in asked if she knew the as peridone had not been used as cheduled Risperidone had the NP stated the nurses tolerate" R87's behaviors. The is a "big fall risk" and the NP what to use for her [R87]."					

DEPARTMENT OF HEALTH CENTERS FOR MEDICAR				FOR	D: 09/11/2013 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
	245387	B. WING	-	08	8/19/2013
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
 was wandering and rooms and was early admission Record have diagnoses to abuse, depressive osteoarthrosis and a history of wande which place him a way for the potent did not identify and R65 to decrease the During observation got up from the tal the dining room. The stated R65 would eating. A beeping stairwell area, LPN will stop when here staff remained in the wandered back to down and wandered on 8/12/13, at 6:4 a chair in room 21 sitting on the bed wroom. When the staff to man 21 sitting on the bed wroom. When the staff to man 214. On 8/13/13, at 12: p.m. R65 was obs On 8/13/13, at 2:0 wandering into room and redirected him into his room and On 8/13/13, at 2:2 	e dated 1/21/13, indicated R65 bund the halls and into patient sily redirected. Resident dated 1/22/13, noted R65 to include dementia, alcohol disorder, Alzheimer's disease, history of brain injury. R65 had ring into other resident rooms nd other resident(s) in harm's al of an altercation. The facility l/or implement interventions for ne behaviors. n on 8/12/13, at 6:15 p.m. R65 ble and wandered away from he nurse in the dining room come back shortly to finish noise was heard from the north I-A stated "that's just [R65]; it noves away from the door." All he dining room area. R65 the dining room, did not sit ed away again. 5 p.m. R65 was noted sitting in 4. The resident from 214 was when R65 was observed in the urveyor approached R65, he a fearful look on his face and 25 p.m. and again at 12:43 erved wandering in the hallway. 7 p.m. R65 was observed m 224. A NA approached R65 n to his room. R65 refused to go the NA walked away. 6 p.m. R65 wandered into room nd two NAs walked by R65 and		323		

Event ID: 6QVR11

Facility ID: 00260

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		HAND HUMAN SERVICES	1		FORM OMB NC): 09/11/2013 MAPPROVED). 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1	IPLE CONSTRUCTION		TE SURVEY MPLETED C
		245387	B. WING		08	/19/2013
NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP	and the second	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From p	age 211	F 32	23		
		bserved looking for R65. R65 214 and was redirected out of				
	the room.	3 p.m. R65 was observed				
	On 8/14/13, at 7:4	8 a.m. R65 was observed in bom with staff providing one on				
		5 p.m. R65 was observed				
	wandering into oth not observed to be whereabouts.	ier resident rooms; staff was e monitoring R65's				
	And Risk To Other indicated R65 "sw is mad and hits/str others and was no pose a threat to ot Assessment For F And Risk To Other	or Resident Vulnerability, Safety rs assessment dated 1/22/13, ears/yells, attempts to hit if he rikes out" as a potential risk to oted as "does not appear to ther residents." No other Resident Vulnerability, Safety rs assessment had been 165 started and continued with ns.				
	identified R65 as h physical and verba	s/Dementia CAA dated 1/29/13, naving had episodes of both al aggression, wandered on the d into other resident rooms.				
	risk for harm from dated 1/29/13, ind verbally abusive b changes in interve thought process c indicated R65 war directed to allow for	1/29/13, indicated R65 was at self or others. A care plan licated R65 had physically and ehavioral symptoms with no entions noted. The altered are plan dated 2/11/13, indered without purpose and or safe wandering in an inment and re-approach if				

Facility ID: 00260

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DEPARTMENT	OF HEA	ALTH AND	HUMAN	SERVICES
CENTERS FOR	R MEDIC	ARE & M	EDICAID	SERVICES

PRINTED:	09/11/2013
FORM	APPROVED
OMB NO	0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED C
		245387	B. WING			/19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2912 FREMONT AVENUE NOR MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 323	to offer bed if wand blanket over to enc of fifteen minute ch (during the survey) 8/15/13, when one the survey, R65 ha observations. On 8 fifteen minute chec directions to compl discontinue. The ca	nute checks and on 7/13/13, lering into rooms and place ourage rest. The intervention lecks was added on 8/14/13 and was discontinued on on one was initiated. Prior to d not been on one to one /16/13, the intervention of ks was restarted with ete for three days and then are plan lacked evidences what havior and how to protect R65	F 32	23		
	2/10/13, indicated I and began to wand admission and was was noted to have entering other resid their beds and floo noted: - On 2/8/13, R65 w other resident's foo upset and the resid - On 2/10/13, R65 w up food from anoth intervened, R65 to it on the other resid strike staff. The int at a table near othe the observations of continued to walk a to other resident ta re-direct R65 at the were no Nurse's N 4/24/13. R65 was a	te's Notes from 1/23/13 to R65 was admitted on 1/22/13, ler on the unit shortly after s combative with cares. R65 been pacing the hallways; dent's rooms and lying down on r mats. Also, the following was ras noted to be reaching for od and the other resident was lents had to be separated. was observed to have picked her resident's tray, when staff ok water off the tray and threw dent and then attempted to ervention was to not place R65 er residents. (However, during n all days of the survey R65 across the dining room and go bles. No staff was observed to e times it had occurred.) There otes included from 2/4/13 until again noted to have been and going into other resident's				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/11/2013 APPROVED). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	122 33	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING		08	C /19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		19/2013
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	another resident who other resident's menot indicate what in facility staff had tak behavior. - On 5/21/13, R65 who left hand and was menoted - On 6/1/13, R65 who resident in the face third resident's roor left leg and hip with were noted. - On 6/7/13, R65 hit arm when the other of his bed. - On 6/24/13, R65 who back stairwell pacin not alarm. - On 6/25/13, a new R65. - On 6/29/13, R65 who another resident's r was noted to have a attacked him. - On 6/27/13, R65 who wandering into other bed while remaining Throughout the mo noted to be pacing rooms. - On 7/25/13, R65 who centimeter cut on the centimeter cut on the centimeter cut on the con the comparison of the centimeter cut on the comparison of the comparison of the comparison of the comparison of the centimeter cut on the centimeter cut on the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the centimeter cut on the comparison of the comparison of of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the	ge 213 as noted to have pushed nile attempting to eat off of the al tray. The Nurse's Notes did terventions or actions the en to minimize R65's was noted to have blood on the eported to have opened an old as reported to have opened an old as reported to have hit another after being chased out of a m where R65 was hit on the a "reacher stick" no injuries t another resident on the right resident asked him to get out was found at the bottom of the ng in a circle, noted door did w Wanderguard was placed on was noted to have been in oom and the other resident a torn shirt and reported R65 was again noted to be er resident rooms and lying in g on every 30 minute checks. nth of July 2013, R65 was and going into other resident struck a trained medication was noted to have a one he left side of his head and the n was found detached from	F 3	23		

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a descende contractor		CONSTRUCTION	COM	E SURVEY PLETED C
		245387	B. WING				
	PROVIDER OR SUPPLIER			2912	EET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323		The second	F3	323			
	noted to be pacing resident rooms. - On 8/13/13, R65 v fist and growling ar observation. - On 8/15/13, R65 v being directed awa	gust 2013, R65 was again on the unit in and out of other was noted as agitated, shaking nd was started on direct was noted to hit staff when y from another resident who s given Ativan for increased					
	had severely impai decision making, h behavior one to thr A Social Services M dated 2/5/13, ident abusive and physic identified R65 as w purpose. A Social S Update dated 5/8/1 wander on the unit been stable during Services Meeting// 7/9/13, indicated w aggression were d monitoring, working interventions and a therapy for sensory	t Report dated 2/12/13,					
	another resident an R65, R65 then tipp did not identify or p to minimize R65's Report dated 5/14/	mpted to take food from nd the other resident struck bed the table over. The facility but into place any interventions behavior. A Resident Incident /13, indicated R65 was beek by another resident when					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 09/11/2013 // APPROVED). 0938-0391
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. WING		08	/19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 2912 FREMONT AVENUE NOF MINNEAPOLIS, MN 55411	, ZIP CODE RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A	DF CORRECTION CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 323	R65 attempted to e The intervention wa "stop sign" on the m re-direction had alm an intervention. A R 6/26/13, noted R65 several times when to get R65 out of hi into place 30 minut no other intervention safe. The Behavior/Intervention safe. The Behavior/Intervention safe. The Behavior/Intervention safe. The Behavior/Intervention safe. The Behavior/Intervention safe. The Behavior/Intervention safe. The Behavior/Intervention safe. The Behavior sfor Zypre agitation, wandering behaviors for Zypre agitation was docume the evening shift. The agitation was noted as behavior of wander on the day and even continuous. The ide shift was noted as a not being effective identified. The inter on the evening shift which was docume days documented. noted almost daily identified intervention as effective. The in added on 8/15/13, noted as being effective X physician's order discontinue Zyprex Tylenol (a mild ana	nter the other resident's room. as to re-direct R65 and use a esident's room. The eady put on the plan of care as Resident Incident Report dated struck another resident the other resident attempted s bed. The intervention put e checks for R65. There were ins put into place to keep R65 wention Monthly Flow Records included target behaviors of g in rooms and aggressive exa. The target behavior of mented as only occurring on the identified intervention for d as offer food and fluids and s effective. The target ring in rooms was documented ening shifts as being entified intervention on the day one on one and was noted as with no other interventions rvention noted for wandering it was redirect and one on one ented as being effective on all Aggressive behavior was on the evening shift with on of redirect which was noted tervention of one on one was during the survey and was	F 3	323		

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Facility ID: 00260

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1.000 C. 1000	TIPLE CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	C	OMPLETED
		245387	B. WING			8/19/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT		
ST OLAF	RESIDENCE			2912 FREMONT AVE MINNEAPOLIS, MI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	for anxiety/agitation Review of the Beha Records started on behaviors of wande	n every six hours as needed	F 3	23		
	family member (F)- R65 more which w weekends, staff are and are not watchin On 8/14/13, at 6:23 abuse policy were and DON. The faci the facility was goin determine intent, a resident to residen interventions were potential harm from administrator state corporate policy are corporate policy are corporate make an When interviewed stated the only indi were eating other r in other resident's RN-A offered no of behavior. R65 com aggression to othe of a comprehensiv	B p.m. the particulars with the reviewed with the administrator lity policy did not identify how ng identify, investigate, nd keep resident's safe from t altercations and what put in place to minimize n the altercation(s). The d the policy was an Ecumen nd they would need to have ny changes to the policy. on 8/19/13, at 9:56 a.m. RN-A tractions for use or Zyprexa resident's food, pacing, laying beds and resistive to cares. ther comments regarding R65's tinued to display physical rs and himself due to the lack e assessment for the physical to fimplementation and /or				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 09/11/2013 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2.5.2.5.5.7	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. WING		0.8	/19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	and the second se	10/2010
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 323	indicated R8 had di disorder with depre muscle spasm, infa hemiplegia (loss or the body), contractic control), and narciss anti-social traits. The extreme verbal and removed from the f resident to the Hen (HCMC) crisis inter supervision to imple management plan for R8 to prevent re abuse to staff and R8 was observed of resident requested stating his name w resident that said h sitting at a dining ro with his puzzle boo On 8/12/13, at 8:00 have a verbal outb slandering him, and forward repeatedly peer, staff interven the resident who co R8 was again at a watching a movie w On 8/14/13, at 6:00 have a verbal outb third floor, during th not able to redirect intervene to calm F	iagnoses of adjustment assion, anxiety, convulsions, antile palsy, stroke with decreased use of one side of ure, dystonia (lack of muscle asistic personality disorder with he resident had a plan for a physical abuse to be facility by a call to 911 to send nepin County Medical Center vention unit. The facility lacked ement R8's behavior and/or behavioral programing epeated verbal and physical peers. on 8/12/13, at 1:00 p.m. the an interview with surveyor, as being slandered by a he had abused her. R8 was boom table watching a movie, iks and mail on the table. 0 p.m. R8 was observed to urst at the peer he said was d became agitated, leaning in his wheelchair, towards the ed and attempted to redirect ontinued his verbal outburst. third floor dining room table with his puzzle book nearby. 0 p.m. R8 was observed to urst in the dining room on the ne dinner meal. The staff was c R8 and the DON had to R8. The observation of the third oted the room to be out of	F3	323		
	R8's care plan initia	ated 9/29/08, indicated R8 was				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387		(X1) PROVIDER/SUPPLIER/CLIA	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING			C 08/19/2013		
NAME OF F	PROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
ST OLAF	RESIDENCE			1220.02210	REMONT AVENUE NORTH EAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	a vulnerable adult a others, inappropriat state related to nurs with staff, verbally a cares, disruptive be swearing and yellin arguing with staff a impulsive and easil verbally abusive an received anti-psych anti-anxiety medica the tendency to per concerns, his eye g listed were to offer calling was not app re-direction, and re competencies. Stat room to calm down leave him to cool o aggressive and che speak softer. "Call (intervention unit w space between tab fellowship hall, disc to concerns, expres a gentleman, re-en Discuss his role as life; discuss how ot his life. (Wife who p kindness approach needed. Encourage resident's sister of vulnerability assess post abuse reportin Hennepin Counties trained on abuse re-	at risk for harm to self or te behavior and altered mood sing home placement, anger abusive/name calling, refusing abusive/name calling, refusing abuse to Hennepin County.		323			
	The significant cha	nge MDS dated 6/7/13,					

Event ID:6QVR11

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
245387		B. WING _		08/19/2013	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2010
ST OLAF	RESIDENCE	*		2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	moderate cognitive delirium - psychom and goes. R8 requi two person physica transfers. Extensive dressing, personal locomotion off the u locomotion on the u directed towards of physical behaviors dated 6/7/13, trigge that was not addres summary. The incident report 8/27/12, going forw noted: - On 8/27/12, during television (TV) in th struck R78 on the f (cm) by 1.5 cm bru watching a TV prog came into the dinin TV, I told him I was and would change started yelling at m room, but he hit me to his room and at nurse that R8 had s SA on 8/28/12 (one responded to yellin NA prevent R8 from investigative report R8 stated "I got so report indicated R8 aggressive behavior	age 219 core of 11/15, which indicated impairment and evidence of otor retardation that comes red extensive assistance and assist with bed mobility and e assistance of one person for hygiene, toileting, and unit, was independent in unit. R8 had verbal behaviors hers one to three days and one to three days. The CAA's ered behavioral symptoms, but seed in the CAA's narrative s for R8 were reviewed from rard and the following was g an altercation over the he third floor dining room, R8 hand leaving a 3.0 centimeter ise. R78 stated he "was gram at 7:00 p.m. and R8 g room and wanted to watch a lready watching a program it at commercial time, he e so I tried to go back to my e on my hand!." R78 returned 10:30 p.m. reported to the floor struck him. The report to the a day late), indicated a RN g in the dining room and saw a in charging R78. The was submitted 8/30/12, and mad that I just hit him!" The had a history of physical or towards staff and other irsing home. R8 had both in t on an as needed basis and a		-	

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Facility ID: 00260

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391	
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5 C C			(X3) DATI COM	E SURVEY PLETED	
		245387	B. WING			C 08/19/2013		
NAME OF I	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	RESIDENCE			1.000	12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	Continued From pa	age 220	E :	323				
	psychiatrist in the c care plan; they are themselves, move	community. Stafffollowed the to protect residents and other resident's away from R8 11 to send R8 to HCMC crisis				*		
	spoken with MD regin the community the	directable. SSD-A had also garding alternative placement nat would better suit R8's will make a referral for		and a state of the second			2.47	
		for a more appropriate						
	- On 9/9/12, (untim staff that R599 atte pick something off asked R599 to mov did not move fast e	ed) incident R599 reported to empted to help another resident the floor on ground level. R8 ve out of his way. When R599 enough, R8 became mad and						
	him out of the way. State agency on 9/ investigative report care plan interventi	the arm and attempted to push That was reported to the 10/12 (one day late). The submitted 9/13/12, indicated ions were followed for both behaviors and physical						
	behaviors. Residen separated and R8 R8 had other incide protocol is in place contact 911 and se	nts were immediately was asked to lower his voice. ents at the facility. "(A) 911 for R8, staff was aware to and R8 to HCMC crisis unit if						
	process of request relocation services appropriate for grou	anageable." SSD-A was in the ing Hennepin County to assess to see if R8 was up home setting. R8 was also sychologist on 9/10/12, for						
	- On 12/3/12, at 4:2 with R54 who had r channel in the grou was near R8 who v	20 p.m. R8 had an altercation requested to change the TV and floor Fellowship Hall. R54 vas acting out. R8 scratched oulder and threatened to break						
	R54's laptop. Staff	immediately intervened and dents. R54 was sent to his						

Facility ID: 00260

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

PRINTED:	09/11/2013
FORM /	APPROVED
OMB NO	0038-0301

State weeks as	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON			E SURVEY
CTION	IDENTIFICATION NUMBER:	Contraction from a provider				PLETED
	045007				C	
				08/19/2013		
	κ.		2912 FF	REMONT AVENUE NORTH		
CH DEFICIENO	CY MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)	D BE	(X5) COMPLETION DATE
and R8 was evaluation the investi- 2, and indic- aluated by ations were in treturned in by in hou at three to s inge in care. It's behavio ntions. The y psychiatri 2/31/12, a M report at 8 with other re- channel sh ened R76, a esent in the need R76, a esident sen esident sen e psych [sic s so can be en by in hou in house p	sent out 911 to HCMC crisis and the keep the other illding safe. On 12/3/12, reports inepin County, the SA and the gative report was submitted ated R8 was admitted to HCMC the HCMC psychiatrist, evaluated and changed. The to the facility on 12/5/12. R8 will se psychiatrist every month for ix months, HCMC was notified SSD-A will continue to monitor r and follow care plan chart lacked documentation of st appointments. Minnesota Department of Health 00 p.m. stated "R8 did not esidents in the dining room that ould be changed and verbally nother resident on 3rd floor that e dining room. The two residents separated by staff and made to the nursing communication 8 to prevent recurrence. Deen initiated. On 1 /4/13, the ation indicated staff working that esidents R8 refused to go to his preted him to his room. If the un-manageable and unsafe for staff is aware to call 911 and t to HCMC for evaluation. See J, SSD-A attempting to get seen by in house psych [sic], use psychologist. SSD-A will sychologist on his next visit on	F 3	:23	DEFICIENCY)		
	CIENCIES CTION ROR SUPPLIEF ENCE SUMMARY ST CH DEFICIENC GULATORY OR ued From p and R8 was revaluation nts in the bu- nade to Her The investi 2, and indica aluated by in hour at returned f n by in hour at three to s nge in care. nt's behavio ntions. The y psychiatri 2/31/12, a N report at 8: with other re channel sh ened R76, a esent in the mediately was added o monitor R gation has I up investiga eparated re the RN esco s so can be en by in hour s so can be en by in hour s so can be en by in hour a sent so can p sych [sic] s so can be en by in hour a sent so can be an by in hour s so can be en by in hour a sent so can be an by in hour a sent so can be a so can be a so a so can be a so can be a so a so can be a so can be a so a so can be a so	CTION IDENTIFICATION NUMBER: 245387 R OR SUPPLIER	DENCIES CTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 245387 B. WING 2000 245387 SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG ued From page 221 F 3 ued R8 was sent out 911 to HCMC crisis evaluation and the keep the other ths in the building safe. On 12/3/12, reports nade to Hennepin County, the SA and the The investigative report was submitted 2, and indicated R8 was admitted to HCMC aluated by the HCMC psychiatrist, ations were evaluated and changed. The 1 nt returned to the facility on 12/5/12. R8 will 1 n by in house psychiatrist every month for 1 three to six months, HCMC was notified 1 ngt in care. SSD-A will continue to monitor 1 <td>DENCIES CTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CON A. BUILDING 245387 B. WING ENCE STREET 2912 FF MINNE SUMMARY STATEMENT OF DEFICIENCIES INCE DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES evaluation and the keep the other ths in the building safe. On 12/3/12, reports hade to Hennepin County, the SA and the The investigative report was submitted 2, and indicated R8 was admitted to HCMC aluated by the HCMC psychiatrist, ations were evaluated and changed. The th treturned to the facility on 12/5/12. R8 will n by in house psychiatrist every month for tt three to six months, HCMC was notified nge in care. SSD-A will continue to monitor nt's behavior and follow care plan ntions. The chart lacked documentation of y psychiatrist appointments. 2/31/12, a Minnesota Department of Health report at 8:00 p.m. stated "R8 did not with other residents on 3rd floor that esent in the dining room. The two residents nmediately separated by staff and made was added to the nursing communication o monitor R8 to prevent recurrence. gation has been initiated. On 1 /4/13, the up investigation indicated staff working that eparated reside</td> <td>SHENGES [X1] PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION 245387 B. WING 200R SUPPLIER B. WING ENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREEMONT AVENUE NORTH MINNEAPOLIS, MN 55411 SUMMARY STATEMENT OF DEFICIENCIES ID CHOP FORCEVOUST EE PROCEDED BY FULL PROVIDER'S PLAN OF CORRECTING CROSS-REFERENCED TO THE APPROP JULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Lead of Control of the CMC crisis readuation and the keep the other rish the building safe. On 12/3/12, reports F 323 add to Hennepin County, the SA and the F The investigative report was submitted F 2, and indicated R8 was admitted to HCMC aluated by the HCMC psychiatrist, ations were evaluated and changed. The rt th returned to the facility on 12/5/12. R8 will F rgs in care. SSD-A will continue to monitor rt ris behavior and follow care plan ntons. The chart lacked documentation of y psychiatrist appointments. grain frequent for resident in the dining room. The two residents 2/31/12, a Minnesota Department of Health report at 5:00 p.m. stated "R8 did not with other resid</td> <td>ZENDES (X1) PROVIDERSUPPLERCLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT CTION 245387 B. WING 08/ I OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/ SIMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ ULL TOWN OR IS CORNTY OR IS CORNTY OR IS CONTRUCTION INTERCEDED BY FULL PROVIDER PLAN OF CORRECTION 08/ ULL TOWN OR IS CORNTY OR IS CONTRUCTION OF DEFICIENCY MUST BE PROCEED BY FULL PROVIDER PLAN OF CORRECTION ADDRECTION 08/ UP ADDRESS DE ANTEMINT OF DEFICIENCY OR IS CONTRUCTION OF DEFICIENCY MUST BE PROCEED BY FULL F 323 08/ 08/ UP ADDRESS DEANTON ON UNABULE DESTINATION ON UNABULE DESTINAT</td>	DENCIES CTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CON A. BUILDING 245387 B. WING ENCE STREET 2912 FF MINNE SUMMARY STATEMENT OF DEFICIENCIES INCE DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES evaluation and the keep the other ths in the building safe. On 12/3/12, reports hade to Hennepin County, the SA and the The investigative report was submitted 2, and indicated R8 was admitted to HCMC aluated by the HCMC psychiatrist, ations were evaluated and changed. The th treturned to the facility on 12/5/12. R8 will n by in house psychiatrist every month for tt three to six months, HCMC was notified nge in care. SSD-A will continue to monitor nt's behavior and follow care plan ntions. The chart lacked documentation of y psychiatrist appointments. 2/31/12, a Minnesota Department of Health report at 8:00 p.m. stated "R8 did not with other residents on 3rd floor that esent in the dining room. The two residents nmediately separated by staff and made was added to the nursing communication o monitor R8 to prevent recurrence. gation has been initiated. On 1 /4/13, the up investigation indicated staff working that eparated reside	SHENGES [X1] PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION 245387 B. WING 200R SUPPLIER B. WING ENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREEMONT AVENUE NORTH MINNEAPOLIS, MN 55411 SUMMARY STATEMENT OF DEFICIENCIES ID CHOP FORCEVOUST EE PROCEDED BY FULL PROVIDER'S PLAN OF CORRECTING CROSS-REFERENCED TO THE APPROP JULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Lead of Control of the CMC crisis readuation and the keep the other rish the building safe. On 12/3/12, reports F 323 add to Hennepin County, the SA and the F The investigative report was submitted F 2, and indicated R8 was admitted to HCMC aluated by the HCMC psychiatrist, ations were evaluated and changed. The rt th returned to the facility on 12/5/12. R8 will F rgs in care. SSD-A will continue to monitor rt ris behavior and follow care plan ntons. The chart lacked documentation of y psychiatrist appointments. grain frequent for resident in the dining room. The two residents 2/31/12, a Minnesota Department of Health report at 5:00 p.m. stated "R8 did not with other resid	ZENDES (X1) PROVIDERSUPPLERCLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT CTION 245387 B. WING 08/ I OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/ SIMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PLAN OF CORRECTION 08/ ULL TOWN OR IS CORNTY OR IS CORNTY OR IS CONTRUCTION INTERCEDED BY FULL PROVIDER PLAN OF CORRECTION 08/ ULL TOWN OR IS CORNTY OR IS CONTRUCTION OF DEFICIENCY MUST BE PROCEED BY FULL PROVIDER PLAN OF CORRECTION ADDRECTION 08/ UP ADDRESS DE ANTEMINT OF DEFICIENCY OR IS CONTRUCTION OF DEFICIENCY MUST BE PROCEED BY FULL F 323 08/ 08/ UP ADDRESS DEANTON ON UNABULE DESTINATION ON UNABULE DESTINAT

Event ID: 6QVR11

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245387	B. WING			C 08/19/2013		
	PROVIDER OR SUPPLIER			291	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	R76 was near R8 v scratched R76 on t threatened to break immediately interver residents to de-esc R76 was interview from his perspective back to 1st floor to him from R8. R8 w for evaluation and t the building safe. (S incident by alleged was made and 911 to HCMC crisis unit evaluation was dor - On 1/5/13, reside pleasant and comp psychiatrist. Per NF by in house psychia three to six months and follow up care was submitted on verbally threatening personality disorde delayed. R8 can be disruptive with both behavior has a hist physically aggressi place which staff for to lower his voice, a He was escorted to call 911 and have F evaluation. Residen physiatrist; SSD-A all medical records resident can be set was also seen by in	age 222 d floor TV in fellowship hall. when he was acting out; R8 he left shoulder and c R76's laptop. Staff ened and separated the two valate the situation. Resident ed regarding what happened e and then immediately sent o where his room is to separate as sent 911 out of the building to keep the other residents in Stated no evidence of previous perpetrator. A police report were called to send resident t. R8 admitted to crisis unit and he. R8 returned to the hospital. Int was returned to facility plaint. Seen by outside P request resident will be seen atrist every month for the next s. Staff will continue to monitor plans. The investigative report 1/4/13, and indicated R8 was g other residents, and has a r and was developmentally e verbally aggressive and n residents and staff, this ory of escalating to being ve. (A) 911 intervention was in plowed when resident refused and refused to go to his room. b his room. Staff was aware to R8 sent to HCMC for nt presently sees an outside was in the process of getting from outside psychiatrist so en by in house psychiatrist. R8 n house psychologist, SSD-A ouse psychologist regarding a	F	323				

Facility ID: 00260

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245387	B. WING	·	and the second		C 19/2013
					REET ADDRESS, CITY, STATE, ZIP CODE	1	
STULAP	RESIDENCE			MII	NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	50.01	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	more specific behave - On 5/7/13, R8 had HCMC for pancreat aggressive behavior conditions see sign - On 6/17/13 R8 had HCMC for increasin and R8 was dischare 6/20/13, (discharge past year gained 90 month and then dro months period. was decreased intake, le On 8/16/13, at 8:43 interviewed and sta physician comment appropriate setting been attempting to day discharge. SSE a behavioral manage told to move the other because they are months SSD-A stated that F refused to watch then not aware that R8's physical aggression remove R8 from the that when R8 acts of him to his room, but facility and find R8 if the plan (written in the not been followed b R8's behaviors diss and June 2013. The other placement for	vior plan. I a medical admission to itis and urosepsis. R8's r decreased to health ificant change MDS above. d a medical admission to ng kidney failure and lethargy, rged back to the facility on summary showed weight over) pounds (lbs.) of weight in one opped 100 lbs. over a 4 in increasing kidney failure ethargy. a.m. the SSD-A was ted she was not aware of the that the facility was not the for R8, and stated she had get ammunition to get a 30 0-A stated she had requested gement plan for R8 and was her residents out of the dining residents refused to go, ot doing anything wrong. R8 was very territorial and had e TV in his room. SSD-A was n other than the call to 911 to e facility. SSD-A further stated out and SSD-A had restricted t she will come back into the in the dining room, because the communication book) had	Fι	323			

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Se se amine		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 F 325 SS=D	him here and partic but say "how can h The psychologist's remove others from refuse since they a was called, they do HCMC, if he refuse 483.25(i) MAINTAII UNLESS UNAVOID Based on a residen assessment, the fa resident - (1) Maintains accept status, such as boot unless the resident demonstrates that	cipates in care conferences, e get away with this behavior." recommendation was to in the environment, but they re not misbehaving. When 911 not always take him out to is they leave him here. N NUTRITION STATUS DABLE it's comprehensive cility must ensure that a btable parameters of nutritional dy weight and protein levels, 's clinical condition this is not possible; and apeutic diet when there is a	F 3				
	by: Based on observation interview, the facilit resident (R68), revire recommended diet recommended by the Findings include: R68 was admitted the had diagnosis that disease (Stage IV) He attended dialysit	NT is not met as evidenced tion, document review and y failed to provide 1 of 1 ewed for dialysis, with the and dietary supplement as he dialysis program. to the facility on 8/17/11, and included chronic kidney and diabetes mellitus Type II. s three times weekly.R68 was utritional risk and the staff did					

Facility ID: 00260

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED		
		245387	B. WING _	B. WING		C 08/19/2013	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2010	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 325	Nutritional supplement On 8/14/13, at 8:30 personal cares, five crackers, seven par ounce container of observed on R68's opened dresser dra ounces containers of of the soups was da dated 7/13/12 and the chocolate chip cool- bedside table. In the wheeled walker were container of Jell-O, three unopened eig 2 Cal (a protein diet acknowledged all the not confirm if they we dietary plan. R68 was served brea a.m. He was served piece of French toa 2% milk and coffee was a card, which in oranges, bananas, cantaloupe. He was salt. R68 was served brea a.m. by NA-M. He we egg, a piece of toas was also served a g	ved the prescribed diet or	F 32	 F325 Corrective Action: A) Resident #68 had nutritional supplement needs reassessed and care plan was update B) Resident #68 had including foods to av his fluid restriction reviewed and his care was revised. Dialysis updated and agreed. Corrective Action as applies to other resid A) All residents receidialysis have the potebe affected by the same deficient practice. B) The nutritional an nutritional supplement needs and fluid needs new dialysis patients assessed and care plaupdated appropriately. C) Nursing and Dietawere educated on importance of follow special diets and beim compliant. 3. Date of Completion: 10/3/13	nts his d. his diet oid and e plan team it ents: iving ential to me d at s of all will be ns // ry staff ing		

Facility ID: 00260

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 C	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245387	B. WING		1	/19/2013	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	13/2013	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 325	worked with the res she knew his needs resident was on no specific fluid restric way she knew if the diet was to look at t	ident several times and felt s fairly well. She indicated the special diet and had no tion. She reported the only e resident was on any special the diet card on the meal tray. and done so and felt she had	F 32	 4. Recurrence will be prevented by: A) Random audits will be completed weekly x4 then monthly x3 with results being presented to the QA Committee for follow up discussion/planning. 			
	had the potential fo to the need for a the disease with the new week, potential for appetite related to f depression, weight diuretic. The dietary maintain his weight established interven with the diet prescri	olished on 9/24/12, noted R68 r alteration in nutrition related erapeutic diet related to kidney ed for dialysis three times a weight loss and decreased ailure to thrive and fluctuation due to the use of a y goal was the resident would at 165# or above. The ntions were to provide R68 ibed by the physician, oplements as ordered by the	a		5. Completion will be monitored by: Director of Nursing or Designee		
	by the certified dieta 6/21/13, and docum no added salt and I milliliter (ml) fluid re with dietary plan "m assessment reporte	ament was last completed on ary manager (CDM) on mented R68 was a regular diet, ow protein diet with 2000 estriction and was compliant nost of the time." The ed R68 was consuming 2000 is considered at medium risk dration.					
	on 7/12/13, and ind decline in the reside hospitalized from 6 some improvement	essments (CAAs) completed icated the staff had noted a ent mobility and he had been /11/13 to 6/14/13. They noted is in some care areas but ident had declined overall and					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING			C 08/19/2013	
	NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	due to his potential need for assistance potential/expectatio variations in mobilit status was variable condition, dialysis, f increased weakness change assessmer nutritional CAA note alteration in nutritio therapeutic diet. A progress note, we dietician on 7/12/13 no added salt, low restriction diet. He most meals and sh for any dietary char A significant change was completed on resident had long a and was considered disorganized thinkin or behavioral issue was cooperative wi personal cares. He of one staff with be toilet use and perso was set up by staff, independently. R68 had a physicia 8/1/13, for a no ado potassium and 200 had an order for To two tablets twice a	for skin breakdown, continued with transfers and the on he would continue to have y. It was also documented his related to his medical fragile status and periods of as and as result a significant at was completed. The ed R68 had the potential for n related to the need for a ritten by the consultant 8, indicated R68 remained on potassium, 2000 ml fluid had good intakes of foods at e made no recommendations nges. e Minimum Data Set (MDS) 7/19/13. The MDS noted the nd short term memory issues d moderately impaired. R68 of being inattentive and ng. He had no mood concerns s. The MDS indicated R68 th staff efforts to provide him needed extensive assistance d mobility, transfers, dressing, onal hygiene. Once his meal	F	325			

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0938-039 E SURVEY PLETED
C 19/2013
(X5) COMPLETION DATE

Facility ID: 00260

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY MPLETED
		245387	B. WING	۱ <u> </u>			C / 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			7.5%	912 FREMONT AVENUE NORTH /INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL \$C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	Continued From pa	age 229	F3	325			
E	although, he could could have mashed baked potatoes wa restriction, it was a An interview on 8/1 Dialysis Dietician (I reported R68 was t which is to include potassium, low sod facility staff were to fluid intake. She ind resident was on a r sodium/potassium but felt that it was a the facility did not o if any contact was n facility. She reporte monthly basis and training with the fac appropriate dietary concerned that he high in potassium to offer. She indicated	es. She also indicated not have baked potatoes, he d potatoes. She indicated the s not part of the potassium personal preference. 4/13, at 1:33 p.m. with the DD) was completed. She to be on a renal (Dialysis) diet increased protein, low lium and low phosphorus and also monitor and restrict the dicted she was not aware the regular diet, low diet with 2000 cc fluid intake acceptable. She reported that contact her in consultation and made, she needed to call the ed she talked to the CDM on a had offered to do dietary cility staff regarding the plan for R68 as was was getting a diet that was too but the facility had declined the d R68 was to receive a diet that comatoes, bananas, oranges					
	(RDC) was comple She reported she co oversaw dietary set the resident's diet w attempt to have the dietary plan. She re resident was very r She reported she h educational materia	ted on 8/15/13, at 1:58 p.m. ame to the facility monthly and rvices for R68. She indicated vas liberalized in efforts to e resident more compliant with eported in the past, the non-compliant with dietary plan. ad provided the resident with als on foods that were high in lth consequences of					

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245387	B. WING				C 19/2013	
NAME OF I	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	ST OLAF RESIDENCE				EMONT AVENUE NORTH APOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2283 1. 224	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 325	consuming foods the she questioned the the educational ma with the dialysis die offers of additional A second interview on 8/16/13, at 1:15 dietician had offere facility staff but she felt the resident was dietary plan. Nutritional Supplem On 7/11/13, the dia the resident be prov Nepro nutritional su recommendation w 7/16/13 and a phys Three unopened co observed in the bas 8/14/13, at 8:30 a.m An interview with lic (LPN)-D was comp She reported she th receiving a nutrition expectation if the su resident, staff obse A review of the Med (MAR) was comple nurse (LPN)-A on 8 was unable to find of physician order or to the ordered nutrition	hat were high in potassium but resident's receptiveness to terials. She denied any contact tician or any knowledge of dietary training for the staff. with the CDM was completed p.m. She reported the dialysis d to do dietary training for the had declined this offer as she s doing well with the current hent lysis program recommended vided with eight ounces of upplement daily. The as noted by the facility on ician order was received. ontainers of Nepro were sket R68's rolling walker on n. censed practical nurse leted on 8/14/13, at 9:45 a.m. hought the resident was nal supplement and it was an upplement was given to the rves the resident drinking it. dication Administration Record ted with licensed practical /19/13, at 9:37 a.m. LPN-A evidence in the MAR of the hat the resident was receiving	F	325				
FORM CMS-25	567(02-99) Previous Versions		1	Facility ID:	00260 If continuati	on sheet Pa	ge 231 of 298	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245387	B. WING			C 08/19/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		19/2013	
				2912 FREMONT AVENUE NORTH			
ST OLAI	RESIDENCE			MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION EFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD FORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROFIDEFICIENCY)				(X5) COMPLETION DATE	
F 327	the MAR did not re nutritional supplem the resident was re also verified the nu administering the s	(13, at 9:40 a.m. She verified flect the physician order for the ent and there was no evidence ceiving the supplement. She rsing staff was responsible for	F 3 F 3	F327			
	sufficient fluid intak and health. This REQUIREME by: Based on observa- review, the facility fand provide with su proper hydration and (R68) in the sample services. Findings include: R68's Resident Ad listed the diagnosis (Stage IV). He atte weekly. R68 was id nutritional risk as w centimeters (cc) flu diuretic. R68 was a facility lacked evide fluid intake. On 8/14/13, at 8:30 personal cares, five	ovide each resident with the to maintain proper hydration NT is not met as evidenced tion, interview and document trailed to consistently monitor ufficient fluid intake to maintain and health for 1 of 1 resident te who received dialysis mission Record dated 8/17/11, as chronic kidney disease inded dialysis three times dentified to have a high vas on dialysis, had 2000 cubic uid restriction and was on a fat risk for dehydration and the ence they were monitoring his 0 a.m. during observation of the packages of grahams ackages of Oreo cookies, a 24		 A) Resident #68 had nutritional supplement needs reassessed and care plan was updated B) Resident #68 had l and his fluid diet revit and care plan was rev Dialysis team updated agreed. Corrective Action as it applies to other reside A) All residents receit dialysis have the potent be affected by the samt deficient practice. B) The nutritional and nutritional supplement needs and fluid needs new dialysis patients v assessed and care plant updated appropriately C) Nursing and Dietart were educated on importance of followint special diets and being 	ts his l. nis diet ewed ised. l and t nts: ving ntial to re of all vill be s y staff		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11 Facility ID: 00260

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	1	0. 0938-0391 TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:		3	COMPLETED	
		245387	B. WING	· · · · · · · · · · · · · · · · · · ·	08	C 8/19/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 327	Continued From pa ounce container of ounce of orange so dresser by his bed. were four unopene chicken noodle sou dated 1/7/13, a sec two of them were u cookie was lying or In the metal basket were a four ounce three bags of snac eight ounce contain protein dietary sup acknowledged all t not confirm if they dietary plan. R68's dining was o a.m. The resident's station, prepared b assistant (NA)-B se a slice of French to NA-B also served I orange juice and 1 prepared for him. T independently after tray was a diet caro oranges, bananas, cantaloupe. No sal at 9:15 a.m. R68 w even though she h reported she was t special instructions not do so prior to sa		F 32	DEFICIENCY)	/3/13 ented by: ompleted / x3 with e QA	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245387	B. WING				19/2013
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF RESIDENCE					12 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	10.0	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 327	that resident was of aware of the amou Assistant Care She diet, but did not ha Breakfast was sen NA-M. R68 was sen piece of toast and also served 240 cc of mil- interview with NA-H finished serving the reported she had w several times and well. She indicate special diet and ha She reported the of resident was on an the diet card on th had done so and f correct meal. The plan of care e indicated R68 did in fluid balance du hypertension and a risk for dehydrat to administer the for ordered by the phy effects and effecti signs and weights the physician orde symptoms of dehy turgor, dry mucus In addition, the resi fluid restriction. Th 5/9/13, and noted	n a fluid restriction but not nts. She reported the Nursing eet would tell her of any special	I F	327			

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DEPART		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY PLETED
		245387	B. WING	-		08/	19/2013
	RESIDENCE			291	REET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 327	Staff was directed the resident. A nutritional asses by the certified die 6/21/13, and docu no added salt and fluid restriction and plan "most of the t R68 was consumi considered at med hydration. The Care Area As on 7/12/13, and in decline in the resi hospitalized from some improveme determined the re due to his potentian need for assistant potential/expectant variations in mob status was variable condition, dialysis increased weakting change assessing a problem with bat ambulation but and stabilize himself of frequently inconting ambulation was defined increased period to use a wheelch periods where hit bad no falls. The	age 234 to explain risk versus benefit to sment was last completed on tary manager (CDM) on mented R68 was a regular diet, low protein diet with 2000 ml d was compliant with dietary time." The assessment reported ng 2000 ml or less. R68 was dium risk for nutrition and sessments (CAAs) completed adicated the staff had noted a dent mobility and he had been 6/11/13 to 6/14/13. They noted nts in some care areas but esident had declined overall and al for skin breakdown, continued ce with transfers and the tion he would continue to have ility. It was also documented his ble related to his medical s, fragile status and periods of ess and as result a significant ent was completed. They noted alance during transition and t other times, R68 was able to without staff assistance. He was inent of bowel and bladder. He he use of a wheeled walker but d an expectation the resident's expected to change due to ls of weakness and he may nee hair at times. Even though he had a balance was an issue, he had a nutritional CAA noted R68 had alteration in nutrition related to	d d	327		2	

Facility ID: 00260

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	MENT OF HEALTH	AND HUMAN SERVICES				APPROVE . 0938-039
TEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	CON	E SURVEY
		245387	B. WING		08	/19/2013
AME OF P	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP C 912 FREMONT AVENUE NORTH	ODE	
T OLAF	RESIDENCE		-	NINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 327	Continued From p	age 235	F 327			
	the need for a the	rapeutic diet. The CAA did not ent's risk for dehydration.				
	dietician was on 7 remained on a no 2000 ml fluid restr noted at most me	note, written by the consultant /12/13, and noted the resident added salt, low potassium, riction diet with good intakes als. She made no				
au -	A significant chan	s for any dietary changes. ge Minimum Data Set (MDS)				
	was completed or resident had long and was consider did exhibit periods disorganized think or behavioral issue was cooperative personal cares. H of one staff with the toilet use and per	n 7/19/13. The MDS noted the and short term memory issues red moderately impaired. R68 is of being inattentive and king. He had no mood concerns ues. The MDS indicated R68 with staff efforts to provide him the needed extensive assistance bed mobility, transfers, dressing, rsonal hygiene.				
	July 31, 2013. Ele documentation w of fluids ranged f documentation w	uid Intake Record for July 1 to even days during that time, the ras incomplete. The daily intakes rom 240 cc to 1780 cc. No ras found of the resident's fluid mes, other than meals.	i -			
÷	August 1 to Augu of the days were noon meal the re absence). The day 780 cc to 1480 c	uid Intake Record for R68 for ist 14, 2013 were reviewed. Six incomplete and indicated for the sident was on a LOA (leave of aily intakes of fluids ranged from c per day. No documentation resident's fluid intake at other				-

		AND HUMAN SERVICES			FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Accessed a rest of the second	TIPLE CONSTRUCTION	CON	E SURVEY
		245387	B. WING			C /19/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	DESIDENCE			2912 FREMONT AVENUE NORTH		
STOLAP	RESIDENCE		a.	MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 327	torsemide 20 millig day for diuretic ther The Medication Ad August, 2013 was found of the fluids no documentation resident drank. The amounts the reside An interview was c 8/14/13, at 9:20 a.r no added salt, low fluid restrictions. So resident was coope and restriction. She responsible for mo resident. She also developed specifyi could give R68 and give the resident. So resident fluid intake prescribed amount lacked any evidend amount of fluids th of the food/beverage resident's room on the CDM, who reponursing assistants nurse, but unsure she was not aware food/beverages in An interview with li (LPN)-D on 8/14/1 She reported that a document on the M	ction and an order for rams (mg), two tablets twice a rapy. ministration Record (MAR) for reviewed. Documentation was R68 consumed at meals, but was found on other liquids the ere were also no totals of daily ent consumed. ompleted with the CDM on m. She reported R68 was on a potassium diet with 2000 cc of he indicated that generally the erative with the dietary plan e reported nursing staff are nitoring the fluid intake of the reported that no plan had been mg how much fluid nursing staff d how much fluid dietary can She also reported felt the e did not go over the to the review of the record ce of dietary tabulating the e resident consumed. A review ge items observed in the 8/14/13, was reviewed with orted she would expect the to report this to the charge if this happened. She reported e of the resident "hoarding"	F3	27		

Facility ID: 00260

If continuation sheet Page 237 of 298

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION	CON	TE SURVEY MPLETED	
		245387	B. WING		Contraction of the local division of the loc	/19/2013
a inte de l	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 327	reported they did n resident drank duri or throughout the d The facility's policy review date of 8/13 monitoring of fluid both the food/fluids fluids consumed du	ot monitor how much fluid the ng medication administration lay. Dialysis (Program Guidelines) /13, did not address the intake, which would include s served by the dietary staff and uring medication pass and at	F 32	27		
F 329 SS=E	station. 483.25(I) DRUG R UNNECESSARY I Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its u adverse conseque should be reduced combinations of th Based on a compr resident, the facility who have not used given these drugs therapy is necessa as diagnosed and record; and reside drugs receive grad behavioral interver	ag regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F 32	1. Corrective Acti A) Resident medication a completed a behaviors ar for use of D been revised psychotropi (Prozac and also reviewe indications	#45 had a review nd his target nd indications epakote have d. His other c medications Remeron) were ed related to for use and riors. His care	

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED
STATEMEN	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT COM	0938-0391 E SURVEY IPLETED
	245387		B. WING			C 08/19/2013	
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ST OLA	FRESIDENCE				2 FREMONT AVENUE NORTH INEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	This REQUIREMEI by: Based on observa review, the facility f	NT is not met as evidenced tion, interview and document ailed to ensure 6 of 8 residents 37, R65, R49) were free of	F3	329	 B) Resident #35 had a medication review completed and his target behaviors and indications for use of Trazadone, Pax and Wellbutrin SR were reviewed and revised. Currently being reviewed by psychiatrist for possib reduction. 	äl	
	also used as a moo without adequate in medication. In addi establish appropria and care planning in The Resident Adm was admitted to the diagnoses to includ persistent mental of disorder. The annu dated 9/25/12, indi Mental Status (BIN cognition) score co identified R45 had impairments; R45 with all Activities of Area Assessment dated 9/25/13, ider and that R45 was in making skills, that disorganized thinkin others and rejectio R45 had "a difficult and identified spect risk and referral to	akote (a seizure medication, od stabilizing medication) indications for the use of the tion, the facility did not ite target behavior monitoring for the use of the medication. ission Record indicated R45 e facility on 9/19/12, with de vascular dementia, lisorder, and depressive ital Minimum Data Set (MDS) cated R45's a Brief Interview of IS - a tool used to measure build not be completed and short and long-term memory required physical assistance Daily Living (ADLs). The Care (CAA)Cognitive Loss/Dementia ntified R45's cognitive losses not independent with decision R45 was inattentive, had ing, physical behaviors towards n of cares. The CAA identified t time adjusting to the move" cific physical behaviors, suicidal the psychiatrist. The CAA for Medication Use dated 10/2/12,			 C) Resident #68 medication has been reviewed and reduced per recommendation. D) Resident #87 had a medication review completed and her fall ris have been reassessed. He target behaviors and indications for use of Celexa and Risperidone were reviewed and revised Her care plan has been reviewed and revised. Th MAR/TAR reflects the ne to monitor orthostatic bloc pressures monthly and the nursing staff was educated on the need to complete this. The physician and pharmacist have reviewed her psychotropic medications. 	er d. ne ed od e	

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED
		245387	B. WING _		08	C //19/2013
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODI		10/2010
				2912 FREMONT AVENUE NORTH		
ST OLAF	RESIDENCE			MINNEAPOLIS, MN 55411		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLÉTION DATE
F 329	Continued From pa	ae 239	F 32	29 E) Resident #65 had the use	of	
1 020	Continued From page 239 indicated R45 received the antidepressant Prozac		(1) (1) (2)	Seroquel and Ativan		
	for depression.			reviewed (Zyprexa		
				discontinued on 8/14/13)		
	A care plan dated 10/9/12, identified R45 was at			The target behaviors and		
		from psychotropic drug use		indications for use were		
		received "antidepressant med		reviewed and revised and		
	use of Depakote.	care plan did not include the		the care plan was updated	1.	
	use of Deparote.			PRN Ativan is being		
	Doctor's Order She	ets indicated the following:		monitored for effectivene	SS	
		kote 125 milligrams (mg) by		after administration.		
	mouth (PO) twice daily (BID) was started for the			Orthostatic blood pressur	res	
	diagnosis of anxiet			are being monitored		
		epakote was increased to 250 diagnosis of anxiety.		monthly on the MAR/TA		
	The PO BID for the	diagnosis of anxiety.		F) Resident #49 had the use	of	
				Seroquel, Ativan and		
	Review of the June	e, July and August 2013		Zolpidem reviewed and	he	
	-	on Monthly Flow Records		indications for use and		
	indicated the follow			target behaviors were		
		identified target behavior for		revised. The care plan w	as	
		or the Prozac and Remeron		updated.		
		as to be completed. Although ns of the sheets were blank,				
		ad documented no mood				
		and night shift documentation				
	was blank.	Ū				
		lentified the target mood				
		ac was increased sadness				
		ne target mood monitoring for				
		eased isolation. The clinical et behavior mood monitoring				
	for the use of Depa					
		d included monitoring for				2
		eased isolation, increased				
		busive; target behavior				
		neron was "depression;" the				
		mood monitoring for Prozac ness and increased				
	was increased sad	LESS AUG INCLEASED				

	OF DEFICIENCIES OF CORRECTION	성하는 것이 있는 것이 있어서 있는 것은 방법을 받았다. 이 것은 것이 있는 것이 있 같이 것이 같이 있는 것이 있 같이 같이 것이 같이 있는 것이 있다. 것이 있는 것이 없이 있는 것이 있는 것이 있는 것이 있는 것이 없는 것이 없는 것이 있는 것이 없는 것이 없는 것이 있는 것이 있는 것이 있는 것이 있는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없는 것이 있는 것이 없는 것이 있는 것이 없는 것이 있는 것이 없는 것이 없 것이 것이 것이 없는 것이 없 것이 않이 않이 않이 않이 않는 것이 않는 것이 않는 것이 않는 것이 않이		CON	DATE SURVEY COMPLETED C	
		245387	B. WING			/19/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	tearfulness. The moresident specific tar to determine indica medications. On 8/15/13, at 1:31 manager (RN)-A st Depakote was "any behaviors needed to resident specific. R indication for the us "agitation" was more target behaviors be same as for Rement On 8/16/13, at 9:30 behavior monitoring mood problems and the social service of involvement has be she completed the of the care plan and not address R45's behavior monitoring SSD-A stated it was behaviors, but ther no behavior progration implemented. I need information and the On 8/19/13, at app director of nursing findings and confir- not an indication for of the Depakote sh	 p.m. the registered nurse ated the diagnosis for the use of the p.m. the registered nurse ated the diagnosis for the use of the p.m. the registered nurse ated the diagnosis for the use of the p.m. the registered nurse ated the diagnosis for the use of the to be monitored for were not N-A was unclear on the se of Depakote. RN-A stated intored for and explained the eing monitored for were the ron/Prozac. D a.m. when asked about g, reporting of behavior or d target behavior monitoring designee (SSD)-A stated, "My seen limited." SSD-A verified mood and behavior sections d confirmed the care plan did resident specific target g for the use of Depakote. s a team effort to address in stated, "[We] currently have un here. It's being ed help on how to gather the 	F 32	 2. Corrective Actions at it a to other residents: A) All residents on psych medications have the pott to be affected by the sam deficient practice. B) The target behaviors/indications for and care plans of all resid receiving psychotropic medications were review revised as necessary. C) Drug regimen review recommendations have be sent to the physicians for response. D) Orthostatic BP's have added to the MAR/TAR fresidents who require this monitoring C) Nursing staff has been educated on the protocol Medication Review Polic Psychotropic Medication Behavior Monitoring Polineed to check orthostatic pressures as ordered, and medications appropriately target behaviors. 3. Date of Completion: 10/3 	totropic ential e use lents ed and een been for the for y, Policy, tcy, the blood using / for	

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		AND HUMAN SERVICES			FORM	D: 09/11/2013 APPROVED 0. 0938-0391	
IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245387 B				08	C 08/19/2013	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORT MINNEAPOLIS, MN 55411	ſĦ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	·		1	 DEFICIENCY) 4. Recurrence will be prevented by: Random weekly audits x4 then monthly x3 with findings being presented to the QA committee for follow up/planning. 5. Completion will be monitored by: Director of Nursing or Designee 			
	identified R35 rece medication." The C "Trazadone, Paxil & The CAA indicated [medication] side e effectiveness. His n CAA identified R35 and indicated, "No time." The quarterly MDS	erns. The CAA for Medication use dated 2/27/13, ived an "antidepressant AA indicated R35 received Wellbutrin for depression." , "He is monitored for med ffects & observed for med mood has been stable." The 's psychiatrist and psychologis referrals are needed at this dated 5/14/13, indicated R35 of 13 (mild impairment). The					
	MDS indicated R38 and was now zero behavior concerns The Physician's Or offer:	5's PHQ-9 score had improved and indicated R35 had not					
ORM CMS-25	- Paxil one 40 mg 1	ablet by PO daily for the s Obsolete Event ID: 6QVF	۲11	Facility ID: 00260	If continuation sheet I	Page 242 of 29	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY
) PLAN C	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING		0111-0241	C
		245387	B. WING			19/2013
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	and the second se	
T OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
F 329	on 12/20/12. - Trazodone half of daily at bedtime for The Trazodone wa - Wellbutrin SR on	ession." The Paxil was started f a 50 mg tablet (25 mg) PO r diagnosis of "Depression." is started on 12/20/12. e 200 mg tablet PO BID for ession." The Wellbutrin was	F 329			
	at risk for side effe use, such as hypor movement disorde non ambulatory) ar related to his diagr plan identified the Wellbutrin for "dep Insomnia." The car has been stable." / update directed, "S monthly flow recor- care plan identified outcomes resulting medications" and " hours/night." The car hours/night." The car impairment, such a for constipation, up orthostatic blood p observe for insomn provide a quiet, car care plan identified not identify resider	ed 3/15/10, indicated R35 was cts from psychotropic drug tension (low blood pressure), rr, gait disturbance (R35 was nd cognitive/behavior changes nosis of "depression." The care use of Paxil, Trazodone and ression & Trazadone [sic] for re plan identified, "His mood An undated hand written See Behavior/intervention d for S/E [side effects]." The d goals of "no negative g from psychotropic 'he will sleep at least 6 care plan directed: observe for and monitor for side effects; elated cognitive/behavioral as delirium symptoms; observe odate the physician as needed, ressures per facility protocol, nia and difficulty sleeping; Im environment. Although the d the above, the care plan did nt specific target mood to the use of Paxil and ed-Release (SR).				
		ing Assistant Assignment Sheet "Demanding - verbally abusive				

		AND HUMAN SERVICES			OMB NO	APPROVED . 0938-0391	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245387	B. WING _		C 08/19/2013		
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH			
STOLAF	RESIDENCE			MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 329	when care not prov The sheet indicated cares to nurse." The Behavior/Inter- for June, July, and following: - The record for Ju monitor for "depress intervention of "Rei designee]" for the of June documentation second monitoring blank for behaviors were documented shift and twice on the record lacked evide monitoring for the of - The record for Ju monitor for "Deprest" "Refer to S.W." for July documentation monitoring records SR were included both blank. The cli R35 was monitored - The record for Au "Document # [num Trazodone. The do the partial month of hours R35 slept was monitoring records and symptoms of] documentation wa of August. The Bel Flow Records lack	vided when he wants it done." d, "Report non-compliance with vention Monthly Flow Records August 2013 indicated the ne directed licensed staff to ssion symptoms" with fer to S.W. [social service use of Paxil. The month of on was all "0's." Although a record for Trazodone was is to be monitored for, "0's" 13 times during the evening the night shift. The clinical ence of behavior/mood use of Wellbutrin SR. ly directed licensed staff to ssion" with intervention of the use of Paxil. The month of n was all "0's." Two more for Trazodone and Wellbutrin with the monitoring, but were nical record lacked evidence d for sleep in July. ugust directed licensed staff to, iber of] hrs [hours of] sleep" for boumentation was of "0's" for of August and the number of as not documented. Two is for Wellbutrin SR and Paxil staff to monitor for "S/S [signs	F 32	29			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ð	co	MPLETED
		245387	B. WING		08	C 8/19/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	care. The records i consistently monito for sleep. In additio evidence R35 was determine monitorin two antidepressant and Paxil) which we diagnosis of depress On 8/15/13, at 1:31 the target behavior were not resident s the indication for th Paxil. RN-A verified consistent and the lacking. On 8/16/13, at 9:30 behavior monitoring	ndicated R35 was not ored for efficacy of Trazodone in, the clinical record lacked comprehensively assessed to ing for the concurrent use of medications (Wellbutrin SR ere both prescribed for the ssion. I p.m. the RN-A stated verified s needed to be monitored for specific. RN-A was unclear on the use of Wellbutrin SR and d sleep monitoring was not number of hours of sleep was 0 a.m. when asked about g, reporting of behavior or	F 329			87
	the SSD-A stated, ' limited." SSD-A ver and behavior section confirmed the care resident specific ta the use of Paxil, W SSD-A stated it was behaviors, but ther no behavior progration implemented. I need information and the On 8/19/13, at app verified resident sp have been monitor antidepressant me R68's Resident Ad indicated R68 had	ed help on how to gather the en run with it." roximately 1:30 p.m. the DON becific target behaviors should red for the use of the			4	

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • • • • • • • • • • • • • • • • • • •	LE CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	240007		STREET ADDRESS, CITY, STATE, ZIP CODE	00/	19/2013
	FRESIDENCE		2	2912 FREMONT AVENUE NORTH WINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	failure to thrive. R6 bedtime for depress evidence was found had considered a d medication. A significant change 7/19/13. The MDS and short term mer considered modera periods of being ina thinking. He had no issues. The MDS in with staff efforts to Quarterly MDS's we 6/21/13, and both a resident had no pro The CAA complete resident declined to process. She indica disorganized thoug CAA also noted R6 was seen by the fa During the monthly the consulting phar for a dose reductio pharmacist also no 5/28/13, of the anti- decreased. A note, written by th 5/2/13, requesting resident's depressi Staff was instructed	 8 was on Effexor 75 mg at sion since 5/17/12. No d of the resident's physician lose reduction of the e MDS was completed on noted the resident had long mory issues and was ately impaired. R68 did exhibit attentive and disorganized o mood concerns or behavioral ndicated R68 was cooperative provide him personal cares. ere completed on 3/22/13 and assessments noted the oblems with depression. d on 7/12/13, noted the need oblems with depression. d on review on 4/22/13, macist questioned the need on of the Effexor. The oblems are depressed to be oblems. d to review the medication with ician during his next visit but 	F 329			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF A CONTRACTOR O			TE SURVEY
		245387	B. WING		08	C /19/2013
	ROVIDER OR SUPPLIER		2	BTREET ADDRESS, CITY, STATE, ZIP COD 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 329	R68 was seen by h 8/9/13, and evidence physician reviewing appropriateness or An interview with th p.m. was complete	is physician on 6/6/13 and ce was not found of the g the medication for considering a dose reduction. ne DON on 8/19/13, at 12:16 d. She verified that physician yed the recommendations	F 329	25		
	Review (Monthly R pharmacist was to of each resident at directed staff to en- acted upon and do and/or the prescrib R87's Resident Adu included diagnoses anxiety, hypertensi facility did not estal	mission Record dated 12/5/12, s of dementia, insomnia, on and paranoid state. The blish appropriate target nitoring and care planning for				
	was noted to wand exiting rooms. Whe	on 8/14/13, at 3:07 p.m. R87 er on the unit entering and en R87 observed R82 sitting in esident's room), R87 entered h R82.				
	staff to invite R87 t manicures, escort	e plan dated 12/13/12, directed o special events, give to room, give hand massages, me and wander guard.				
	to be seen by in-ho	dated 12/14/12, directed okay buse psychologist/ psychiatrist. cord did not reveal any				

		AND HUMAN SERVICES				FORM): 09/11/2013 1APPROVED): 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURV COMPLETED	
		245387	B. WING	s_		C 08/19/2013	
	NAME OF PROVIDER OR SUPPLIER ST OLAF RESIDENCE				STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	0.1	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	The admission MD R87 had both shor problems, moderat daily decision make staff identification of depression). The q indicated R87 had skills for daily decis wander daily, have and staff identified The psychotropic r 12/24/12, indicated as insomnia, depre and identified hypo as possible side ef R87 had a fall on 1 Resident Incident I did not identify Tra- the fall. The only m contributing factor Resident Incident I orthostatic blood p falls R87 had from two of the 12 falls I pressures recorder A physician's order discontinue Trazad A Mood Interview v 3/8/13, and indicat depression were n A nurse practitione 4/22/13, indicated no delusions and F	 S dated 12/18/12, indicated t and long term memory tely impaired cognitive skills for ing and a score of three for of mood indicators (minimal juarterly MDS dated 6/7/13, severely impaired cognitive sion making. R87 was noted to no delusions or hallucinations no mood indicators. medication care plan dated d diagnoses for medication use ession, anxiety and dementia otension and gait disturbance fects. 1/1/13, according to the Report dated 1/1/13. The report zadone as a potential cause of nedication noted as a possible was Lasix (a diuretic). The Report included a place for ressure, however, of the twelve 1/1/13 through 7/11/13, only had an orthostatic blood d. r dated 1/11/13, directed to done due to fall after first dose. was completed for R87 on ed no signs or symptoms of 	F	32	9		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11

Facility ID: 00260

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		AND HUMAN SERVICES				RINTED FORM MB NO	APPRC	OVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I present resources		PLE CONSTRUCTION	(X3) DAT COM	E SURVE	Y
		245387	B. WING				C 19/201	3
				- 3	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH	1 00,	10/201	•
STULA	RESIDENCE				MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5 COMPLE DAT	ETION
F 329	physician's order da discontinue Risperi Risperidone 0.25 m days for paranoia, i the nurse's notes a Review of the April revealed R87 did n Risperidone from 4 following was noted psychotropic medic Celexa: The April 2013 Beh Flow Record revea antidepressant med The target mood id occurring daily with and one on one wh The May 2013 Beh Flow Record revea pacing and in and o mood identified we	ated 4/22/13, directed to done scheduled and give ng daily as needed times thirty if needed please document in nd update the physician. 2013 and May 2013 MAR ot receive any as needed /22/13 through 5/6/13. The d for the scheduled cation: navior/Intervention Monthly led target mood for Celexa (an dication) resistive to cares. entified was noted as noted interventions of redirect ich were noted as effective. avior/Intervention Monthly led target mood for Celexa as put of other rooms. The target re noted as occurring daily with of redirect and one on one	F	329	β			
	Flow Record revea Risperidone was pa resident rooms whi daily. The intervent redirect and one or being effective. The May 2013 Beh	avior/Intervention Monthly led the behavior monitored for acing in and out of other ch were noted as occurring ions noted as used were n one which were noted as avior/Intervention Monthly led the behavior monitored for						

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	And the states		PLE CONSTRUCTION	COM	E SURVEY PLETED
		245387	B. WING	;			C 19/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	noted as occurring as used were redire noted as being effe A physician's order Risperidone 0.25 m needed daily. Nurse's Notes were forward and the foll - On 5/12/13, R87 ' what she does bes - On 5/12/13, R87 ' what she does bes - On 5/13/13, noted until talked into goin more before going - On 5/14/13, was r 6/2/13, indicated R - On 6/5/13, indicated and - On 6/7/13, R87 w until 11:45 p.m. A Pharmacy Servic 5/28/13, indicated t dose reduction (GE the Celexa GDR wa provided. A mood interview c 6/7/13, noted no inter A Social Service M dated 6/12/13, indic but is easily re-dire had no signs or syr A NP progress note trial dose reduction	daily. The interventions noted ect and one on one which were active. dated 5/6/13, included ng every bedtime and as e reviewed from 5/12/13 going lowing was noted: 'woke up once to pace as it's t." d R87 paced until 12:00 a.m. ng to bed and was up twice	FS	329			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6QVR11

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		AND HUMAN SERVICES				FORM	: 09/11/201 APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ALC: NUMBER			CON	E SURVEY MPLETED
		245387	B. WING				/19/2013
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				12 FREMONT AVENUE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 250	F 3	329			
	The NP note indicatives calmer and ha Risperidone was re "sitting more as here	and decreased sleep at night. ted staff had reported R87 d decreased pacing since started and indicated R87 was friend who paces no longer P note indicated no reports of ve symptoms.					
	2013, indicated Ris paranoia/delusions for major depression	Il Care Plan dated August peridone was being given for and Celexa was being given on. Review of the medical 87 was not being monitored ons or depression.					
	DON verified there	on 8/14/13, at 1:10 p.m. the had been no monthly ressure monitoring for R87.					
	verified R87 had no and symptoms of d indications for the F	on 8/19/13, at 9:56 a.m. RN-A ot been monitored for signs epression and the only Risperidone use were pacing, resident rooms and resistive to					
	regarding Risperide The NP stated R87 depression includin and knew she was noted with the trial increased pacing, r falls. The NP stated restarted R87 had with her peers. The	ewed on 8/19/13, at 11:10 a.m. one and Celexa use for R87. had a long standing history of g tearfulness, anxiousness not with her daughter. The NP off Risperidone, R87 had not sleeping and increased d with the Risperidone no tears and interacted better NP stated R87 had to bed and was afraid to be in	5				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		245387	B. WING			C 08/19/2013		
	RESIDENCE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329	Risperidone had no the scheduled Risp discontinued, the N trying to "tolerate" F	be been used as ordered after beridone had been IP stated the nurses were just R87's behaviors. The NP big fall risk" and the NP had to	F 3	329				
	indicated R65 had dementia, alcohol a Alzheimer's diseas brain injury. The far appropriate target l	mission Record dated 1/22/13, diagnoses to include abuse, depressive disorder, e, osteoarthrosis and history of cility did not establish behavior monitoring and care e of the medication.						
	indicated for R65 " medication outweig neuroleptics in pati directed to avoid lo paradoxical agitatic also indicated R65 seizures as it was	al problems and even			-			
	had severe demen a urinary tract infect indicated R65 rece in the late afternoo downing agitation, with little effect, wa	lated 1/20/13, indicated R65 tia, potential delirium related to ction. The psychiatry note also ived Zyprexa (anti-psychotic) n related to a history of sun received as needed Zyprexa is noted to have been pacing d did not appear to be in						
		s/Dementia CAA dated 1/29/13, aving had episodes of both						

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	B. Warner		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245387	B. WING	·		– C 08/19/2013		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAF	RESIDENCE			1.1.1.265	912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411			
040.15	SUMMARY STA	TEMENT OF DEFICIENCIES	10	IV	PROVIDER'S PLAN OF CORRECTION		000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	Continued From pa	ge 252	F 3	329				
		aggression, wandered on the into other resident rooms.						
	The admission MD	S dated 2/4/13, indicated R65			34			
	had severely impair	red cognitive skills for daily						
		ad physical/verbal and other ee days and wandered daily.						
	2/11/13, identified F	t process care plan dated R65 wandered without purpose w for safe wandering in an						
		ment and re-approach if						
	dated 4/22/13, reco Zyprexa dose for R Zyprexa is used for to dementia- the re dose is 7.5 mg/day signed the Consulta Review on 5/7/13 a if the recommendat Review of the Medi R65 did not include							
-	administered Zypre above the recommended the 5 mg as needed	2013, MAR revealed R65 was exa 10 mg per day (2.5 mg ended amount) and received d (PRN) dose on 4/23/13 and on with no results noted.						
24	administered Zypre above the recomme	2013, MAR revealed R65 was exa 10 mg per day (2.5 mg ended amount) and received e on 5/6/13 for agitation with						

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Sec. Statements		E CONSTRUCTION	Сом	E SURVEY PLETED
		245387	B. WING				C 19/2013
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
ST OLAF	RESIDENCE			1.23	912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	no results recorded Review of the June administered Zypre above the recomment the 5 mg PRN dose agitation, no outcor Review of the July received Zyprexa 1 p.m. for a diagnosis doses of PRN Zypr and 12:00 a.m. for identified on the Ju Monthly Flow Reco wandering in rooms The identified target as not occurring on needed Zyprexa wa identified as used w food and fluids and had been administe amount of Zyprexa The facility staff did above the recomment physician's attentio	 2013, MAR revealed R65 was exa 10 mg per day (2.5 mg ended amount) and received e on 6/27/13 and 6/28/13 for me noted for the medication. 2013, MAR revealed R65 0 milligrams (mg) daily at 3:00 s of dementia and received six exa 5 mg between 10:30 p.m. agitation. The target behaviors ly 2013, Behavior/Intervention rd included agitation, s and laying in others beds. It behaviors were documented the night shift when the as as used. The interventions were redirect, one on one, give were noted as effective. R65 ered above the recommended since admission of 1/22/13. I not bring the Zyprexa 2.5 mg ended amount to the 	F 3	29	DEFICIENCY)		
	for 8/1 to 8/14/13, in agitation, wandering behaviors for Zypre agitation was document the evening shift. T agitation was noted was documented a behavior of wander on the day and even continuous. The ide	ncluded target behaviors of g in rooms and aggressive exa. The target behavior of mented as only occurring on he identified intervention for I as offer food and fluids and s effective. The target ing in rooms was documented ning shifts as being entified intervention on the day one on one and was noted as					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245387	B. WING	;			C 19/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	identified as used. wandering on the e one on one which w effective on all days behavior was noted shift with identified was noted as effect one was added on was noted as being A physician's order discontinue Zyprex analgesic) twice a d antipsychotic medic Ativan every six ho anxiety/agitation. Review of the Beha Records started on behaviors of wande and physical aggres for Ativan. A Nurse's Notes da was directed away was yelling and stru- Ativan for increased indication if R65 wa after striking out at noted to have been room, noted as agif When interviewed of director of nursing monthly orthostatic R65.	with no other interventions The intervention noted for evening shift was redirect and was documented as being s documented. Aggressive d almost daily on the evening intervention of redirect which tive. The intervention of one on 8/15/13, during the survey and g effective. dated 8/14/13, directed to a, start Tylenol (a mild day, and start Seroquel (an cation) twice a day and start urs as needed for avior/Intervention Monthly Flow 8/15/13, included target ering and agitation for Seroquel ssion and physical outbursts ated 8/15/13, indicated R65 from another resident who uck out at staff. R65 was given d agitation; there was no as agitated either before or staff. On 8/17/13, R65 was n wandering from room to tated and was given Ativan. on 8/14/13, at 1:10 p.m. the verified there had been no blood pressure monitoring for	F	329			
	When interviewed of	on 8/19/13, at 9:56 a.m.					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 St. 19		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY
		245387	B. WING	÷			C / 19/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	registered nurse (F indications for use resident's food, pad beds and resistive A Pharmacy Recor Sheets Directions I dated 4/4/12, direct off with either a yes nurses notes and p recommendation w nurse's notes revea documentation or f regarding the lack physician. R49's resident Adm noted R49 had diag anxiety, persistent R49's received psy adequate indication medication. In addi establish appropria and care planning f On 8/19/13, at 9:56 her wheelchair, we and a sock on her stuffed animal hors police, call the polic On 8/19/13, at 10:0 the stuffed horse b and was scooted fo side. Nursing assis get her repositione horse in her hands "AHHHHHH, GET HOUSE, I AIN'T GO	RN)-A stated the only or Zyprexa were eating other cing, laying in other resident's to cares. mmendation/Communication For Nurse Managers protocol ted once the physician signed s or no, to document in the but a note on the copy that the vas complete. Review of the aled there was no ollow-up with the physician of response from the hission Record dated 6/12/12, gnoses of schizophrenia, mental disorder, and insomnia. rehotropic medications without hs for the use of the ition, the facility did not tet target behavior monitoring for the use of the medication. B a.m. R49 was observed in aring a shoe on the left foot right foot. She was carrying a se. Calling out quietly "call the	F	329	9		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 09/11/2013 APPROVED). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S. 150		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245387	B. WING	·		08	C /19/2013
NAME OF F	PROVIDER OR SUPPLIER	r:			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
ST OLAF	RESIDENCE				2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	herself into a dining "her baby" (the stuff R49 then moved he the fan (floor fan), p	VEY." 4 a.m. R49 observed bumping room chair, and trying to get fed horse) settled in her lap. erself to the wall, and touched picked up her right foot and	F	329	9		
	grabbed the toes of my shoes, give me comfort her. - At 10:23 a.m. R49 but had calmed dow - At 10:32 a.m. R49 dining room, approx	her right foot "crying give me my shoes." NA-J attempted to had moved herself in a circle,					
	lack of comprehense elopement risk off confusion, vision los	d 6/25/12, indicated R49 had a sion at times and was an of unit related to cognitive loss, ss, and hallucinations. R49 sychotic medications and					
	unable to complete status, required ext mobility and extens	4/13, indicated R49 was the brief interview for mental ensive assist of two for bed ive assist of one for toileting, ssing, personal hygiene, off unit and bathing.					
	and indicated R49 r 50 mg po at bedtim 25 mg three times a Ativan 1 mg po for a	ers were reviewed on 8/19/13, received quetiapine (Seroquel) e for psychosis and quetiapine a day for psychosis PRN, anxiety and agitation, and bien) at bedtime for insomnia					
	The treatment reco	rd for August 2013 noted R49					

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		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. March March		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING				C 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH /IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	had behavioral mor and delusions. The were to redirect and monitoring treatment documentation, and or delusions looked On 8/19/13, at 11:3 were interviewed re- sheets (delusions s- that did not match the both are up to date delusions are recor- stated that the targe be revamped, the p- address what beha- observed and the fa- address the medica- target behavior mor- with the psychiatrist for the behavior she worked with pharms what medications a sheets. The DON v sheets list anxiety a define what constitue On 8/19/13, at 4:00 pharmacist verified sheets were not ind behaviors, and a sy needed to be define the resident display verified duplicate ta- needed and having the same stated tar- delusions) was con-	nitoring for anxiety, agitation, interventions for all three d use 1:1. The behavioral nt record was void of any d did not define what agitation l like for R49. 0 a.m. the DON and RN-A egarding the target behavior sheet with Seroquel labeled the delusion sheet for Ativan, to today, but the number of rded differently. The DON et behavior system needed to osychiatrist was being asked to viors the psychiatrist wanted acility was only going to ations that actually require nitoring. The SSD was working t to develop a better system eets. The DON had also acy to develop a list that states inctually require target behavior fled the target behavior flow as a target behavior for R49. p.m. the consultant the target behavior for R49. p.m. the consultant the target behavior of delusion ed for the individual behaviors red. The consultant pharmacist arget behavior sheets were not different documentation for rget behavior (agitation or fusing.		329			
F 387	483.40(c)(1)-(2) FR	EQUENCY & TIMELINESS	F3	887			

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		AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	ILTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		245387	B. WING	G 08/19/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF	RESIDENCE		-	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
F 387 SS=D		To start the second se second second sec	F	387 F387
	The resident must l once every 30 days admission, and at le thereafter. A physician visit is o	be seen by a physician at least for the first 90 days after east once every 60 days considered timely if it occurs bys after the date the visit was		 Corrective Action: A) Resident #65 was seen on 8/6/2013 by his physician. Since survey resident has been discharged from facility.
	by: Based on interview facility failed to ens reviewed for unnec by the physician on 90 days after admis 60 days thereafter Findings include: R65's medical was R65 was only seen 5/3/13 and 8/6/13. Referral Forms dat R65's next appoint physician did not m the physician did not m the physician did not recommendations medication. A psychiatry note d had severe demen a urinary tract infec indicated R65 rece afternoon related to	NT is not met as evidenced y and document review, the ure 1 of 8 residents (R65) essary medications was seen ce every 30 days for the first asion, and at least once every as required. reviewed and it was noted by the physician on 1/28/13, The physician included on the ed 1/28/13 and 8/6/13, to have ment in six months. The take face to face contact and ot address the pharmacist of the use of the psychotropic ated 1/20/13, indicated R65 tia, potential delirium related to ction. The psychiatry note also ived Zyprexa in the late of a history of sun downing as needed Zyprexa with little		 2. Corrective Action as it applies to other residents: A) All residents have the potential to be affected by the same deficient practice. B) The medical records of the current residents were reviewed for regulatory compliance with physician visits and any resident in need of a physician visit has either been seen in house or an appointment has been made for an out of facility face to face with their physician. C) Nursing and Medical Records staff have been educated on the physician visit requirement which reads: "The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter".

Facility ID: 00260

STATEMENT OF DEFICIENCIES [X1] PROVIDERSUPPLIENCIAN (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLY 245387 245387 INVIDE INVIDENCIANT (X3) DATE SUPPLY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE 2312 FREMONT AVENUE NORTH (X5) DATE SUPPLY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE 2312 FREMONT AVENUE NORTH (X5) DATE SUPPLY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE 2312 FREMONT AVENUE NORTH (X5) DATE SUPPLY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE 2312 FREMONT AVENUE NORTH (X5) DATE SUPPLY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE 2312 FREMONT AVENUE NORTH (X5) DATE SUPPLY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE (X5) DATE SUPPLY (X5) DATE SUPPLY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE (X5) DATE SUPPLY (X5) DATE SUPPLY STATEMENT OR LSC DENTIFY WINT INFORMENT OF DEFICIENCIES PERTY, TAG (X6) DATE SUPPLY (X6) DATE SUPPLY STATEMENT OR LSC DENTIFY WINT INFORMENT OR DEFICIENCY PERTY, TAG (X6) DATE SUPPLY (X6) DATE SUPPLY STATE ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRES	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245387 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 387 Continued From page 259 effect, was noted to have been pacing around the unit and did not appear to be in distress. The Resident Admission Record indicated R65 dated 1/22/13, noted R65 to have diagnoses of dementia, alcohol abuse, depressive disorder, Altrbeimer's disease, and bietory of brain injuny F 387 S. Completion Date: 10/3/13	NTED: 09/11/2013 FORM APPROVED B NO. 0938-0391
245387 B. WING 08/19/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 212 FREMONT AVENUE NORTH MINNEAPOLIS, NN 55411 Street ADDRESS, CITY, STATE, ZIP CODE 212 FREMONT AVENUE NORTH MINNEAPOLIS, NN 55411 PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PRETX PRETX PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (CONSERVENCE TO THE APROPRIATE DEFICIENCY Comptetion Date: 10/3/13 Comptetion Date: 10/3/13 F 387 Continued From page 259 effect, was noted to have been pacing around the unit and did not appear to be in distress. The Resident Admission Record indicated R65 dated 1/22/13, ndc R65 to have diagnoses of dementia, alcohol abuse, depressive disorder, Alzheimer's disease, and history of brain injury. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 1/29/13, identified R65 as having had episodes of both physical and verbal aggression, wandered on the unit which included into other resident rooms. S. Completion to be monitored by: Director of Nursing or Designee. S. Completion to be monitored by: Director of Nursing or Designee. A Consultant Pharmacist's Medication Review dated 4/22/13, recommended review of the Zyprexa tose for R65 and nighted Withou to dementa-the recommended max Zyprexa dose is 7.5 mg/day [milligrams]. The physician signed the Consultant Pharmacist's Medication Review on 57/13, and did not include a response if the recommendation was accepted or rejected. S. State Stat	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE F 387 Continued From page 259 F 387 Completion Date: 10/3/13 effect, was noted to have been pacing around the unit and did not appear to be in distress. F 387 S. Completion Date: 10/3/13 The Resident Admission Record indicated R65 dated 1/22/13, noted R65 to have diagnoses of dementia, alcohol abuse, depressive disorder, Alzbeimer's disease, and bitcher of brain injury F 387 S. Completed weekly x4 then monthly x3 with the	COMPLETED
ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 V010 PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECEDED BY FULL TAG D PRETX TAG D PRETX CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CONTRUCT A CONSTRUCT A C	ST OLAF RESIDENCE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 (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) F 387 Continued From page 259 effect, was noted to have been pacing around the unit and did not appear to be in distress. The Resident Admission Record indicated R65 dated 1/22/13, noted R65 to have diagnoses of dementia, alcohol abuse, depressive disorder, Alzbeimen's disease and bistory of brain injuny F 387 Completed weekly x4 then monthly x3 with the	
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 as having had episodes of both physical and verbal aggression, wandered on the unit which included into other resident rooms. The admission Minimum Data Set (MDS) dated 2/4/13, indicated R65 had severely impaired cognitive skills for daily decision making, had physical/verbal and other behavior one to three days and wandered daily. The altered thought process care plan dated 2/11/13, identified R65 wandered without purpose and directed to allow for safe wandering in an uncluttered environment and re-approach if resistive. A Consultant Pharmacist's Medication Review dated 4/22/13, recommended review of the Zyprexa is used for behavioral management due to dementia-the recommended max Zyprexa dose is 7.5 mg/day [milligrams]." The physician signed the Consultant Pharmacist's Medication Review on 5/7/13, and did not include a response if the recommendation was accepted or rejected. 	The Cognitive Loss/Dementia Care Area The QA committee for	
R65 did not include any follow-up from the pharmacist regarding the lack of response from	 as having had episodes of both physical and verbal aggression, wandered on the unit which included into other resident rooms. The admission Minimum Data Set (MDS) dated 2/4/13, indicated R65 had severely impaired cognitive skills for daily decision making, had physical/verbal and other behavior one to three days and wandered daily. The altered thought process care plan dated 2/11/13, identified R65 wandered without purpose and directed to allow for safe wandering in an uncluttered environment and re-approach if resistive. A Consultant Pharmacist's Medication Review dated 4/22/13, recommended review of the Zyprexa dose for R65 and indicated "when Zyprexa is used for behavioral management due to dementia-the recommended max Zyprexa dose is 7.5 mg/day [milligrams]." The physician signed the Consultant Pharmacist's Medication Review of 5/7/13, and did not include a response if the recommendation was accepted or rejected. Review of the Medication Regimen Review for R65 did not include any follow-up from the 	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Star Star and	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245387	B. WING		08/19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 387	received Zyprexa 1 diagnosis of demen as needed Zyprexa 12:00 a.m. for agita	ding the Zyprexa ritten on 4/22/13. 2013, MAR revealed R65 0 mg daily at 3:00 p.m. for a tia and received six doses of 5 mg between 10:30 p.m. and tion.	F 3	87	
	social service desig been difficult to hav physician as require insurance plan, R65 the facility physician that the facility's me regarding R65's phy A policy and proced physician's visits an 483.55(a) ROUTINI SERVICES IN SNF The facility must as routine and 24-hour A facility must provi resource, in accord part, routine and en meet the needs of en Medicare resident a routine and emergen necessary, assist th appointments; and to and from the dem	lure was requested for id none was provided. E/EMERGENCY DENTAL	F 4	F 411 1. Corrective Action A) Resident #82 h had dental service provided.	as

TATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	<u>). 0938-0391</u> TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	C	
		245387	B. WING		08	8/19/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)E	
ST OLAI	F RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 411	This REQUIREMEN by: Based on observat review, the facility fa	ge 261 NT is not met as evidenced ion, interview and document ailed to ensure dental services of 2 residents (R82) reviewed	F 4	 Corrective Action a applies to other residents: A) All residents hav the potential to be affected by the same deficient practice. B) The facility has 	e	
· ·	Admission record d diagnoses to includ diabetes mellitus, h During observation was noted to have left upper side of he black in color. The significant chan Set (MDS) dated 7/ natural teeth or too extensive assist of was assessed to ha cognitive skills for o The Care Area Ass Care dated 7/5/13, with a history of ref and noted no referr The Alteration in De 7/11/13, noted R82 and a history of ref	on 8/16/12, and Resident ated 8/16/12, noted the e but were not limited to ypertension and dementia. on 8/12/13, at 5:45 p.m. R82 multiple broken teeth on the er mouth and teeth that were nge in status Minimum Data 5/13, identified R82 had no th fragment(s), required one for personal hygiene and ave severely impaired laily decision making. essment (CAA) for Dental noted R82 had poor dentition using dental exams in the past als were needed. entition Care Plan dated had some missing teeth noted using dental exams. ed, schedule dental exams as allow- respect her right to		 contracted with a new mobile dental compa C) Dental services w be offered routinely a on a PRN or emerger basis in accordance v regulatory guidelines 3. Date of Completion: 10/3/13 4. Recurrence will be monitored by: Random audits will be conducted weekly x2 then monthly x3 with findings being presented to the QA committee for follow up discussion/planning. 	ny. ill and ney vith	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
NAME OF	PROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE			INNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 411	Review of the Socia Meeting/Assessme 11/28/12, 2/20/13, 5 include information Review of the medi evidence R82 was dental exam. The S Meeting/Assessme indicted R82 was u	al Services nt Updates of 9/5/12, 5/22/13, and 6/28/13, did not regarding dental services. cal record lacked any other offered or was scheduled for a	F 411	 Completion will be monitored by: Director of Nursing Designee 	or	
	would help make all record lacked evide involved in decision care. When interviewed of member (F)-A repo- slow her down a bit Upon interview on 8 director of nursing (information for R82 stated there had be transportation and s care and R82 was s 8/23/13. A policy and proced requested and was 483.60(a),(b) PHAF ACCURATE PROC The facility must pro- drugs and biological them under an agre §483.75(h) of this p unlicensed personn	I decisions. The medical ence R82's daughter was making regarding dental on 8/12/13, at 3:41 p.m. family rted R82's teeth problems 3/16/13, at 1:03 p.m. the (DON) stated no dental visit was available. The DON een issues with consent, scheduling for R82's dental scheduled for a dental visit on lure regarding dental care was not provided. RMACEUTICAL SVC -	F 425			

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED
		& MEDICAID SERVICES	()(0)	TID: -		1	. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY
		245387	B. WING				C (19/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OLAF	RESIDENCE				012 FREMONT AVENUE NORTH		
07.0 15	STIMMADY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	2.2	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	Continued From pa	age 263	F 4	125	F 425		
	supervision of a lice	-					
	2.5. 19. 2.5. 2.5. 2.5. 2.				1. Corrective Action:		
		ide pharmaceutical services			A) Resident #81 is		
	acquiring, receiving	es that assure the accurate			receiving her		
		drugs and biologicals) to meet			medications as		
	the needs of each i				ordered and the		
					physician was notified that the		
		nploy or obtain the services of			medications were		
		cist who provides consultation			missed on said		
	services in the facil	e provision of pharmacy			dates. Her		-
	Services in the raci	ity.			MAR/TAR and care		
					plan was reviewed		
					and revised as		
					appropriate.		
	[1] 및 방송성관 - 이가 가 제도 이 김 명치가 (17 5km) 이 단	NT is not met as evidenced					
	by: Based on interview	v and document review, the			2. Corrective Actions		
		sure medications were	5		at it applies to		
		(R81) residents reviewed for			others:		
	unnecessary medic	cations.			A) All residents		
					have the potential to		
	Findings include:				be affected by the		
	R81's psychotropic	medication care plan			same deficient		
		psychotropic drug use as R81			practice.		
	received a hypnotic	c and an anti-anxiety			B) Nursing staff has been educated on		
		edications were not available			the need to contact		
	for the staff to adm	ninister to R81.			the pharmacy		
	Review of R81's H	ennepin County Medical			immediately if there		
		clinic visit progress notes dated			is a medication		
		under assessment: "2.			ordered but not		
	Insomnia. Patient r	reports her sleep is disrupted			available to		
		n going to go ahead and try			administer and that		
		ng at bedtime. 4. Severe			they must contact		
		Ativan she is getting at least day], which she needs to					
	Li.u. [unee unes a	uay], which she needs to					1

Facility ID: 00260

If continuation sheet Page 264 of 298

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR	RUCTION	(X3) DAT COM	E SURVEY PLETED
		245387	B. WING			A Markade	C 19/2013
	RESIDENCE			2912 FREM	DRESS, CITY, STATE, ZIP CODE MONT AVENUE NORTH POLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	control anxiety." R81's Physician Or zolpidem (Ambien- bedtime. Another p directed lorazepam three times daily ar	age 264 ders dated 6/17/13, directed sleep aid) by mouth at rescription dated 6/19/13, a (anti-anxiety) 1 milligram (mg) and another prescription himum Data Set (MDS) dated	F 4		 the physician if the pharmacy is not able to provide a prescribed medication. Completion Date: 10/3/13 		
	7/8/13, indicated R delusions, manic d disorder (other than indicated R81 was antianxiety, antidep During review of M Records (MAR) da noted R81 had mis from 6/17/13 throug doses of Ambien a During review of N through 8/5/13, at n notified of medicati resident. On 8/5/13 indicated resident v tremors, sweating, breakfast, no lunch pharmacy had bee writer wrote had sp medication had be On 8/15/13, at 10:2 nursing (O)-D verif been administered circled with notes to "Ativan 1 mg not an stated she was goi	81 had anxiety disorder, epression and psychotic in schizophrenia). MDS also taking antipsychotic, pressant and hypnotic. edication Administration ted 8/2/13 through 8/5/13, used nine doses of Ativan and gh 6/26/13, had missed 10 lso. urse's Notes dated 6/17/13, no point was the physician ions not being available for 8, at 1:40 p.m. Nurse's Note was noted to have increased droopy, had ate very little at h, had bad breath and the n called regarding Ativan and poken with someone that			Recurrence will be prevented by: A) Random audits will be completed weekly x4 then monthly x3 with the findings being presented to the QA committee for follow up discussion/planning Completion will be monitored by: Director of Nursing or Designee		

Event ID: 6QVR11 Facility ID: 00260

If continuation sheet Page 265 of 298

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
		245387	B. WING			C
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		/19/2013
	RESIDENCE			2912 FREMONT AVENUE NORT MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE
F 425	Continued From pa available.	ge 265	F4	25		
	(RN)-A stated the p delivering medication facility. Licensed pro- standing at the desi	3 a.m. registered nurse harmacy had issues with ons in a timely manner to the actical nurse (LPN)-A who was k added that the pharmacy ng changed to twice daily with olve the problem.				
	surveyor and stated that medication was script from the prov O-D prescription sc that resident had br	p.m. O-D approached this d that the pharmacy reported s not filled as there was no rider. Surveyor showed the ript in the chart dated 6/17/13, rought to facility from ad been noted on the same				
	called back to the p that the prescription until 6/26/13, and m 6/27/13. O-D and L medications in the f (automated medica 8/15/13, on the list agreed that staff sh from the machine a the pharmacy had s LPN-A also stated t the machine and th 8/13/13. O-D stated R81 had missed he	p.m. O-D stated she had harmacy and had been told a script had not been received hedication was dispensed on PN-A provided a list of facility Pyxis machine tion dispensing system) dated was Ativan and Ambien. Both ould have gotten medications and given it to the resident until supplied the medications. hat Ativan was not stocked in at it had been stocked on at that she was not aware that er medications and reported lity medication error for both				
		a.m. RN-A stated her e trained medication aide's				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S	CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
NAME OF	PROVIDER OR SUPPLIER	2	STF	REET ADDRESS, CITY, STATE, ZIP C		10/2010
ST OLAI	RESIDENCE			2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 425	medications from pharmacy to "STA She also stated if should let her know RN-A added, that issues surrounding and had given the together. The phan if there were issue script to contact th On 8/16/13, at 12: expectation was th nurses know wher and each resident medications as or a problem with get the pharmacy, sta know of the issue. On 8/19/13, at 4:0 pharmacist supervise consultant pharma medications were [R81], nursing sho the pharmacy rega supply of medicati manner, the facilit medication was su should not have by resident's medicati and in the case fo for an extended popotential to cause	e nurse immediately to get the Pyxis machine then call the T" medication out to the facility. the problem continued staff w immediately to follow up. the facility had discussed the g supplying medications timely pharmacy thirty days to get it rmacy had also been instructed as with requiring or obtaining a ne primary doctor immediately. 45 p.m. the O-D stated her the TMA's needed to let the in the medications were missing needed to be given their dered. She added, if there was tting resident medications from ff should let administration	F 425			

(EACH DEFICIENCY	245387	B. WING			С
RESIDENCE SUMMARY STA (EACH DEFICIENCY					8/19/2013
SUMMARY STA (EACH DEFICIENCY			STREET ADDRESS, CITY, STATE, ZIP		19/2013
SUMMARY STA (EACH DEFICIENCY			2912 FREMONT AVENUE NORTH		
(EACH DEFICIENCY			MINNEAPOLIS, MN 55411		
	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
Continued From pa	ae 267	F 4	25		
pharmacist supervision medication were av	sor confirmed these ailable in the Pyxis during the				
oharmacist stated, ' always been in the l nurse to obtain if no	Ativan and Ambien have Pyxis machine for the facility supply and for controlled				
pharmacy to get a v here should not hav nissed medications	vaiver to get the medications, ve been reason resident had s as ordered and he was not				
Abrupt discontinua Abrupt discontinua nedication is strong eductions should n every month unless special circumstance eductions."	8/7/97, identified that an, tion of any psychotropic gly discouraged and dosage ot occur more than once the attending physician feels ses warrant quicker				
		F 4:	28		
he attending physic	cian, and the director of				
	nedication were av hissed medication bove. On 8/19/13, at 4:38 harmacist stated, ' lways been in the urse to obtain if no hedications the nur harmacy to get a w here should not ha hissed medications ware of resident m harmacy." The Psychotropic D rocedure revised 3 Abrupt discontinua hedication is strong eductions should n very month unless pecial circumstance eductions." 83.60(c) DRUG RI RREGULAR, ACT The drug regimen of eviewed at least or harmacist.	nedication were available in the Pyxis during the hissed medication administration dates listed bove. On 8/19/13, at 4:38 p.m. the facility consultant harmacist stated, "Ativan and Ambien have lways been in the Pyxis machine for the facility urse to obtain if no supply and for controlled nedications the nurse only needed to call the harmacy to get a waiver to get the medications, here should not have been reason resident had hissed medications as ordered and he was not ware of resident medication supply issues by harmacy." The Psychotropic Drug Monitoring policy and rocedure revised 3/7/97, identified that an, Abrupt discontinuation of any psychotropic nedication is strongly discouraged and dosage eductions should not occur more than once every month unless the attending physician feels pecial circumstances warrant quicker eductions." 83.60(c) DRUG REGIMEN REVIEW, REPORT RREGULAR, ACT ON	 nedication were available in the Pyxis during the hissed medication administration dates listed bove. On 8/19/13, at 4:38 p.m. the facility consultant harmacist stated, "Ativan and Ambien have laways been in the Pyxis machine for the facility urse to obtain if no supply and for controlled nedications the nurse only needed to call the harmacy to get a waiver to get the medications, here should not have been reason resident had hissed medications as ordered and he was not ware of resident medication supply issues by harmacy." The Psychotropic Drug Monitoring policy and rocedure revised 3/7/97, identified that an, Abrupt discontinuation of any psychotropic nedication is strongly discouraged and dosage eductions should not occur more than once very month unless the attending physician feels pecial circumstances warrant quicker eductions." 83.60(c) DRUG REGIMEN REVIEW, REPORT F 4: RREGULAR, ACT ON The drug regimen of each resident must be eviewed at least once a month by a licensed harmacist. 	nedication were available in the Pyxis during the hissed medication administration dates listed bove. Dn 8/19/13, at 4:38 p.m. the facility consultant harmacist stated, "Ativan and Ambien have lways been in the Pyxis machine for the facility urse to obtain if no supply and for controlled nedications the nurse only needed to call the harmacy to get a waiver to get the medications, here should not have been reason resident had hissed medications as ordered and he was not ware of resident medication supply issues by harmacy." The Psychotropic Drug Monitoring policy and rocedure revised 3/7/97, identified that an, Abrupt discontinuation of any psychotropic nedication is strongly discouraged and dosage eductions should not occur more than once very month unless the attending physician feels pecial circumstances warrant quicker eductions." 83.60(c) DRUG REGIMEN REVIEW, REPORT REGULAR, ACT ON The drug regimen of each resident must be eviewed at least once a month by a licensed harmacist. The pharmacist must report any irregularities to he attending physician, and the director of	nedication were available in the Pyxis during the hissed medication administration dates listed bove. On 8/19/13, at 4:38 p.m. the facility consultant harmacist stated, "Ativan and Ambien have lways been in the Pyxis machine for the facility urse to obtain if no supply and for controlled nedications the nurse only needed to call the harmacy to get a waiver to get the medications, here should not have been reason resident had hissed medications as ordered and he was not ware of resident medication supply issues by harmacy." The Psychotropic Drug Monitoring policy and rocedure revised 3/7/97, identified that an, Abrupt discontinuation of any psychotropic nedications should not occur more than once very month unless the attending physician feels pecial circumstances warrant quicker eductions." 83.60(c) DRUG REGIMEN REVIEW, REPORT REGULAR, ACT ON The drug regimen of each resident must be eviewed at least once a month by a licensed harmacist. The pharmacist must report any irregularities to the attending physician, and the director of

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/11/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	1 00	19/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	by: Based on observat review, the facility fa	ge 268 NT is not met as evidenced tion, interview and document ailed to ensure 3 of 8 residents essary medications (R45, R35,	F 4	 28 F 428 1. Corrective Action: A) Residents #45, 35 and 68 have had their medications reviewed by the consultant pharmacist and any recommendations were sent to the physician for review 		
	also used as a moc without adequate in and the consultant appropriate target b planning for the use A care plan dated 1 risk for side effects and identified R45 r [medication]." The o use of Depakote. Doctor's Order She - On 7/19/13, Depa mouth (PO) twice d diagnosis of anxiety - On 7/30/13, the D mg PO BID for the Review of the June Behavior/Interventio indicated the follow - The June record in monitoring for Proz (antidepressants) w the behavior section the evening shift ha	0/9/12, identified R45 was at from psychotropic drug use received "antidepressant med care plan did not include the ets indicated the following: kote 125 milligrams (mg) by aily (BID) was started for the /; epakote was increased to 250 diagnosis of anxiety. , July and August 2013 on Monthly Flow Records ing: dentified target mood/behavior		 and response. B) Psychotropic Medications were reviewed and target behaviors and the indication for use of the medications were reviewed and revised. Updates were made to the care plan of Resident #45. C) Psychotropic Medications were reviewed and target behaviors and the indications for use of the medications were reviewed and revised. Updates were made to the care plan of Resident #35. D) Psychotropic Medications were reviewed and target behaviors and the indications for use of the medications were reviewed and revised. Updates were made to the care plan of Resident #35. D) Psychotropic Medications for use of the medications for use of the medications were reviewed and target behaviors and the indications were reviewed and revised. Updates were made to the care plan of Resident #68. 		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
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F 428	 The July record id monitoring for Proz- and tearfulness. Th Remeron was incre- record lacked targe use of Depakote. The August record Depakote was incre- agitation/verbally at monitoring for Rem target behavior mon- increased sadness The monitoring did target mood/behavi- indications for the u The Monthly Medic- indicated R45's me reviewed on 7/30/1 Remeron was incre- side note indicated, On 8/19/13, at 3:35 pharmacist supervi- would not be a stro Depakote. The con- monitoring for effica- be resident specific use such and targe would be identified the facility had a sy facility wide and spe- irregularities may n 	entified the target mood ac was increased sadness e target mood monitoring for ased isolation. The clinical t behavior monitoring for tased isolation, increased busive; target behavior eron was "depression;" the nitoring for Prozac was and increased tearfulness. not include resident specific or monitoring to determine use of the medications. ation Regimen Reviews dication regimen was last 3. The review identified tased to 15 mg. An undated "Depakote 125 Anx." p.m. the consultant sor (CPS) stated anxiety alone ng indication for the use of sultant pharmacist stated acy of the medication should the cPS verified indications for t behavior mood monitoring he pharmacy review and as an irregularity. CPS stated stem problem which was ecific resident medication ot have been identified bigger system problem."	F	428	 Corrective Action as it applies to other residents: A) All residents on psychotropic medications have the potential to be affected by this deficient practice. B) All residents with orders for psychotropic medications have had their medications reviewed by the pharmacist and recommendations were sent to the physicians for review and response. C) All residents who receive psychotropic medications have had their target behaviors and indications for use reviewed and revised. The changes are reflected on their care plans D) Nursing staff has been educated on the importance of monitoring target behaviors and proper use of psychotropic medications. Completion Date: 10/3/13 Recurrence will be prevented by: A) Random audits will be conducted weekly x4 then monthly x3 with findings 		
1		nitoring to determine the					

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A Children Co			(X3) DAT CON	. 0938-0391 E SURVEY IPLETED
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F 428	efficacy of Paxil, Tra (all antidepressant r mechanisms) and th not identify the cond R35's Physician's C to offer: - Paxil one 40 mg ta diagnosis of "Depre	azodone and Wellbutrin SR medications with different he consultant pharmacist did	F 4	128	 presented to the QA committee for follow up discussion/planning. 5. Completion to be monitored by: Director of Nursing or Designee 	1	
	on 12/20/12. - Trazodone half of daily at bedtime for The Trazodone was - Wellbutrin SR one diagnosis of "Depre started on 5/23/12. The care plan dated at risk for side effect use, such as hypote movement disorder non ambulatory) an related to his diagno plan identified the u Wellbutrin for "depre Insomnia." The care has been stable." A update directed, "Se monthly flow record care plan identified outcomes resulting medications" and "h hours/night." The care observe for drug rel impairment, such as for constipation, upo	a 50 mg tablet (25 mg) PO diagnosis of "Depression." s started on 12/20/12. 200 mg tablet PO BID for ssion." The Wellbutrin was d 3/15/10, indicated R35 was the from psychotropic drug ension (low blood pressure), gait disturbance (R35 was d cognitive/behavior changes basis of "depression." The care se of Paxil, Trazodone and ession & Trazodone [sic] for e plan identified, "His mood n undated hand written ee Behavior/intervention for S/E [side effects]." The goals of "no negative					

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	care plan identified not identify resident indicators related to Wellbutrin slow relev The Behavior/Interv for June, July, and A following: - The record for Jur monitor for "depress intervention of "Refit the use of Paxil. Th documentation was monitoring record fo behaviors to be mo documented 13 tim and twice on the nig lacked evidence of the use of Wellbutri - The record for Jul monitor for "Depress "Refer to S.W." for July documentation monitoring records SR were included w both blank. The clin R35 was monitored - The record for Aug "Document # [numb Trazodone. The doc the partial month of hours R35 slept wa monitoring records directed licensed st and symptoms of] D	m environment. Although the above, the care plan specific target mood of the use of Paxil and ease (SR). vention Monthly Flow Reco August 2013 indicated the ne directed licensed staff sion symptoms" with er to S.W. [social worker] e month of June all "0's." Although a seco or Trazodone was blank for nitored for, "0's" were es during the evening shi ght shift. The clinical reco behavior/mood monitoring in SR. y directed licensed staff to sion" with intervention of the use of Paxil. The mon was all "0's." Two more for Trazodone and Wellbuvith the monitoring, but we ical record lacked eviden for sleep in July. gust directed licensed staf cumentation was of "0's" August and the number of s not documented. Two for Wellbutrin SR and Pa aff to monitor for "S/S [sig	the did ords to to " for or ft rd g for of th of utrin ere ce ff to, p" for for of xil gns	428			
	of August. The Behavior/Interv 67(02-99) Previous Versions	vention Monthly Flow Rec	ords :6QVR11	Facility II	0.00260		ge 272 of 298

		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and and sugar		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 428	symptoms, such as mood or refusal/rej indicated R35 was efficacy of Trazodo clinical record lacke comprehensively as monitoring for the of antidepressant mea Paxil) which were b diagnosis of depress The Monthly Medic indicated R35's dru on 7/30/13, and the - On 10/18/12, "No traz [Trazodone]" - On 1/18/13, Trazo signed out." - A Consultant Pha form dated 1/18/13 antidepressant ord irregularity, "Patien medications for 'de need for a potentia "antidepressants." communicated, " one agent is being The physician resp no dosage reductio refer R35 to psychi Irregularities in mon identified. - On 2/18/13, "traz" down and, "Wellbu traz 25 HS [hour of "address antidep [a [discontinue] traz."	or resident specific depression s but not limited to irritable ection of care. The records not consistently monitored for ne for sleep. In addition, the ed evidence R35 was ssessed to determine concurrent use of two dications (Wellbutrin SR and ooth prescribed for the ssion. ation Regimen Reviews ug regimen was last reviewed e following: GDR [gradual dose reduction] odone was identified as "not rmacist's Medication Review 6, identified the three ered and identified the t continued to take above spression'." and identified a I dosage reduction of The note further particularly when more than utilized to treat depression." ionse dated 1/28/13, identified ons were recommended and to	F 4	428			

Event ID: 6QVR11

Facility ID: 00260

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		AND HUMAN SERVICES			FORM	D: 09/11/2013 APPROVED). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a ser a ser a ser a ser a	TIPLE CONSTRUCTION		TE SURVEY MPLETED C
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ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	Н	
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F 428	antidepressant orde irregularity, "Patient medications for 'dep need for a potential "antidepressants." communicated, "p one agent is being The physician respo	, identified the three ered and identified the t continued to take above pression'." and identified a dosage reduction of The note further particularly when more than utilized to treat depression." onse dated 2/21/13, identified	F 4	28		
	refer R35 to psychia Irregularities in mor identified. - On 7/30/13, "Repe [recommendation] s - A Consultant Phar form dated 7/30/13, Trazodone and, "Th current dose of Trat appropriate to atten months. Please cor Trazodone to a PRI physician's response	hitoring for efficacy were not eat 4/13 Traz recom: since 12/2012." rmacist's Medication Review , identified R35's use of his patient has been on his zodone since 12/20/12. It is npt a dose reduction every 3 hsider changing this patient's N [as needed]." The se dated 8/1/13, directed to arities in monitoring for				
	would be for a diag to monitor for "Depr appropriate. CPS s resident specific mo the PHQ-9 and MD use such and targe would be a part of t been identified as a facility had a system wide. CPS explaine medication irregula	p.m. the CPS stated the Paxil nosis of depression, but stated ression" alone would not be tated he would expect to ood monitoring as outlined in S. CPS verified indications for it behavior/mood monitoring the review and should have an irregularity. CPS stated the n problem which was facility ad he believed specific resident rities may not have been it was a "bigger system		·		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	X3) DATE SURVEY COMPLETED
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		245387	B. WING		08/19/2013
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F 428	problem." R68 was on Effexo depression since 5 regimen irregularity the consulting phar been acted upon. A significant chang	age 274 r 75 mg at bedtime for /17/12. R68's medication r, which had been identified by macist on 4/22/13, had not e Minimum Data Set (MDS) 7/19/13. The MDS noted the	F 428		
	and was considere did exhibit periods disorganized thinki or behavioral issue was cooperative wi personal cares.	nd short term memory issues d moderately impaired. R68 of being inattentive and ng. He had no mood concerns s. The MDS indicated R68 th staff efforts to provide him			
	6/21/13, and both a	ere completed on 3/22/13 and assessments noted the oblems with depression.			
	7/12/13, noted the in the assessment resident did have d				
	the consulting phar for a dose reductio (Effexor). The phar pharmacy note of 5 not being decrease bring the informatic	medication review on 4/22/13, macist questioned the need n of the antidepressant macist also noted on his 5/28/13, of the antidepressant ed. The pharmacist did not on forward again to the director or the months June or July			*

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER		29	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411	
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F 428	A note, written by th 5/2/13, requesting to resident's depression Staff was instructed the resident's physion no later than two models R68 was seen by the 8/9/13, and evidence	he facility nurse practitioner on the physician evaluate the on and trial dose reduction. d to review the medication with ician during his next visit but ionths. is physician on 6/6/13 and ce was not found of the	F 428		
F 431 SS=D	An interview with th p.m. was complete should have review made by the pharm An interview with a done on 8/19/13, at physician should ha recommendation. The undated facility Review (Monthly R pharmacist was to of each resident at directed staff to ens acted upon and do and/or the prescrib 483.60(b), (d), (e) II LABEL/STORE DR The facility must en a licensed pharmacion of records of receip controlled drugs in accurate reconcilia records are in orde	considering a dose reduction. The DON on 8/19/13, at 12:16 d. She verified that physician red the recommendations macist. consultant pharmacist was t 3:35 p.m. He reported the ave reviewed the reviewed the review the medication Regimen least monthly. The policy sure recommendations are cumented by the facility staff er.	F 431		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 8 - S	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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	Continued From page 276 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			 31 F431 1. Corrective Action: 	C.
				A) The expired bottle of Tuberculin solution has been discarded.2. Corrective actions as it	S
	facility must store a locked compartment controls, and permit have access to the The facility must pr permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit ibution systems in which the ninimal and a missing dose can		 applies to other residents: A) All future residents and future staff members have the potential to be affected by the same deficient practice. B) Nursing staff was educated on the need to date Tuberculin solution when opened and to discard after 30 days. 3. Completion date: 10/3/13 	5
	by: Based on observa review, the facility f Tubersol, used for was not dated whe potential to affect F	NT is not met as evidenced tion, interview, and document failed to ensure 1 of 1 vial of tuberculin skin testing (TST), n opened. This had the R99, R29, the director of d future resident admissions is.		 4. Recurrence will be prevented by: A) Random audits will be conducted weekly x then monthly x3 with findings presented to the QA committee for follow up/discussion. 	

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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F 431	On 8/14/13, at 11:4 (TMA)-F referenced medication cart whi passing medication medication was to b medication cart after On 8/14/13, at appr	5 a.m. trained medication aide d a list taped to the top of the ch provided direction to staff s, as to when a particular be removed from the	F 43′	5. Completion will be monitored by: Director of Nursing or Designee		
	not dated when oper Tubersol vial was w nurse (LPN)-I. A review of immuni and R29 received C on 5/1/13; and two DON received a do assistant (NA)-Z re The February 2013 Tubersol noted the when opened and the not use after expirat 483.70(h) SAFE/FUNCTION/ E ENVIRON The facility must pr sanitary, and comfor residents, staff and This REQUIREME by: Based on observa- review, the facility for	AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 46	5 F 465 1. Corrective Action: A) The inside and outside of the dishwasher has been cleaned and a cleaning schedule is in place.		

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				APPROVED 0. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 465	potentially contamin the potential to affect in the facility; the fac dining area on 1 of which had the poten residents (R33, R56 R38, R37, R53, R8	ge 278 from debris which could nate clean dishes. This had ct 62 of 66 residents that ate cility failed to provide a clean 3 dining areas in the facility ntial to affect 15 of 17 6, R82, R87, R26, R49, R65, 1, R32, R40, R70, R72) who om; and the facility failed to	F 4	B) The dining r tables on each f were cleaned immediately an being cleaned routinely after e meal to assure sanitary eating conditions for th residents at St.	floor d are each		
	in a clean and funct residents (R45, R1, Findings include: Findings include: Dishwasher: On 8/12/13, at 12:1 sanitation kitchen to (O)-F surveyor obse whitish colored sub- edges of both the m sections of the dish appeared to be thic away easily with a f plate screwed to the inside side of dish w brownish substance greenish and whitis seams and edges of Additionally, the bro the plate was rust w inside side of the di On 8/12/13, at 12:1	3 p.m. during the initial bur with the director of dietary erved yellowish, greenish and stance along the seams and hid-top and inside side washer. The substance k, porous and loose; it flaked ingernail. Also observed a e wall on the right side of the washer covered with thick e. O-F verified the yellowish, h colored substance on the of dishwasher was lime. ownish buildup substance on which was all buildup on the		Olaf's. C) The quad cane and w/c of residen #45 were cleaned immediately and staff are monitorin routinely for the need to clean the devices when soiled. D) The electric w. of resident #1 was cleaned immediately and staff are monitoring routinely for the need to clean it when it appears soiled. E) Resident #35 has received a new mattress.	ng /c ng		

		AND HUMAN SERVICES				FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	State Summer		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245387	B. WING	i			19/2013
	PROVIDER OR SUPPLIER			29	TREET ADDRESS, CITY, STATE, ZIP CODE 912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	clean the outside or staff was not able to facility had no outsi routine professional to make sure the di working in regards operation of the dis could potentially co The facility Cleaning through 8/31/13, di inside of the dishwa direction to address surfaces, seams, et the clean side of the The Kitchen Repor listing provided by I distributor of janitor and equipment) on performed as, "Tes good. Test ran dish The undated Equip Control & Sanitation staff shall maintain Department throug comprehensive clean the facility by the D procedure directed EQUIPMENT. Free Wipe exterior of ma Dry and polish with Clean dishmachine solution." Although directed a pertinen lacked direction to and who was respon	f the dishwasher if the dietary o clean it. O-F verified the de contractor who performed il cleaning except for checking ishwasher was properly to water temperatures and shwasher. O-F stated the lime intaminate the cleaned dishes. g Schedule dated 4/6/13 rected staff to de-lime the asher weekly but lacked s de-liming the outside edges and adjacent areas of	F	465	 Corrective Action as is applies to other residents: A) All residents who eat their meals at St. Olaf's have the potential to be affected by this deficient practice. B) The housekeeping staff was educated on the need to wash tables after meals. The nursing staff was educated on the need to wash the dining room tables in the absence of housekeeping staff. C) A dishwasher cleaning/de-liming schedule has been put into place to assure that both the interior and exterior of the dishwasher are clean. 		

Event ID: 6QVR11

Facility ID: 00260

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	IPLE CONSTRUCTION		TE SURVEY
		245387	B. WING _		08	C /19/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 465	observed to be soil on 8/12/13, and on On 8/12/13, at appr quad cane was obs debris on the base observed to have m	nd wheelchair (W/C) were ed with food spills and spatters	F 46	55 Director, Dietary Manager or their Designee's See Addendum Comple		/3/2013
	through 8/14/13, the -On 8/14/13, at app observed to be whe to go to the elevato have oily food spatt frame. On 8/15/13, at appr registered nurse ma coffee cup, the W/C (as indicated above equipment should h stated she did not k cup and confirmed need to clean the it usually cleaned on when R45's W/C w 8/16/13, at 2:57 p.n tour the O-C confirm had food splatters of stated the W/Cs are	n. during the environmental med the W/C was dirty and on the wheels and frame. O-C e cleaned once monthly on		Attached		
	stated the W/Cs are Tuesdays according cleaned twice a mo the maintenance de	e cleaned once monthly on g to floors, but could be nth if it had been reported to				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY PLETED
		245387	B. WING			1.00.000	19/2013
	PROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 12 FREMONT AVENUE NORTH INNEAPOLIS, MN 55411	••••••	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	spills on the W/C fr p.m. through 8/16/1 when the administr service director (O) and spatters. On 8/16/13, at 3:05 environmental tour were only deep clea facility and nursing the W/C every ever with food debris. The W/C cleaning frequested but was The W/C cleaning directed "To provide sanitary wheelchair checked and clean department will be cleaning of wheelch The W/C cleaning requested but was R35's mattress was right side of the ma was not reported for On 8/14/13, at 7:53 transferred from th cover of R35's matt ripped the entire le mattress. The foan At 9:27 a.m. R35 w The bed was made nursing assistant (fi	ame from 8/13/13, at 1:48 3, at 3:02 p.m. ator and the environmental -C verified it was food spills p.m. during facility the O-C stated electric W/Cs aned once a month by the was responsible to wipe down- ning if staff noted it was soiled og and schedule was not provided. policy revised 12/1/11, e residents with safe and rs. All wheelchairs are to be ed on a monthly basis. Nursing responsible for daily spot nairs." og and schedule was not provided.	F	465			

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		AND HUMAN SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245387	B. WING	·		14 m (r)	C 19/2013
	ROVIDER OR SUPPLIER			291	REET ADDRESS, CITY, STATE, ZIP CODE 2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	and NA-A verified to stated the rip was " the mattress had be stated the mattress stated items in nee in a book at the nur During review of the Requisitions Comm Housekeeping and report/request writh ripped. On 8/14/13, at10:00 he overheard the si mattress and he wa book to see if it was confirmed R35's rip in the log book. The mattress would nee administrator verifie "deteriorated" and to replaced. The adm way maintenance si requests and need The facility's Enviro Cleanliness policy a indicated, "St Olaf I responsible to oper so as to provide the comfortable, safe a suitable for the pro- the longevity of the equipment." The po- practice if cleaning visual observations and inspection for a	he mattress was ripped and not new." Both NA staff stated een ripped for a "month" and thad been reported. NA-H d of repair were documented rsing station. e Environmental Services nunication Log Maintenance, Laundry book there was no en that R35's mattress was 6 a.m. the administrator stated urveyor asking about the as going to check the same s reported. The administrator oped mattress was not logged e administrator stated the ed to be special ordered. The ed R35's mattress cover had the mattress would need to be inistrator stated book was the staff was notified of repair s.	F	465			

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		AND HUMAN SERVICES				FORM): 09/11/2013 APPROVED
STATEMEN	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		245387	B. WING			08	C /19/2013
	PROVIDER OR SUPPLIER			2912 F	T ADDRESS, CITY, STATE, ZIP CODE FREMONT AVENUE NORTH EAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 465	was maintained in a debris which could dishes. Dining room tables: The second floor di	a clean manner free from potentially contaminate clean ning room tables were clean 8/12/13, 8/13/13,	F 4	165			
	main second floor of observed to have b substance on the e beween the table to pedestals itself of a were mid afternoon 8/13/13 through 8/1 evening. During that week ho observed on severa area after meals wh however, staff never browishish food spa	8/16/13, the four tables in the dining room area were rowish, spatters and sticky dges, metal area space ops and the pedestal and the II the tables. The observations to evening on 8/12/13, on 6/13, mid morning and early busekeeping staff were al occurances cleaning the nich included wiping the tables, er cleaned off the sticky, atters on the tables and			-		
	environmental serv administrator verifie clean as the browis and food spatters re attached areas. O-(were not on a routin expected the tables	p.m. during facility tour the ice director (O)-C and the ed the four tables were not h, sticky substance was dust emained on all the tables and C further stated the tables ne cleaning schedule but he to be cleaned on a daily basis taff as they do regular routine ain a clean area.					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: 6QVR1	1	Facility II	D' 00260 If continuet	ion sheet P	age 281 of 298

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	- 19 - 19 - 19 - 19 - 19 - 19 - 19 - 19		CONSTRUCTION	(X3) DAT	. 0938-039' E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			APLETED	
		245387	B. WING				C 08/19/2013	
NAME OF I	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010	
ST OLAF	RESIDENCE				2 FREMONT AVENUE NORTH NNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	responsibility." and repair and/or replace needed."	sidence clean is everyone's "4. Building and equipment cement shall be completed as	F۷	165	7.			
F 492 SS=D	FEDERAL/STATE/L	OCAL LAWS/PROF STD	F۷	192				
	compliance with all local laws, regulation accepted profession	erate and provide services in applicable Federal, State, and ons, and codes, and with nal standards and principles sionals providing services in						
	by: Based on observat review, the facility fa modify the toilet roo	NT is not met as evidenced ion, interview and document ailed to obtain a waiver to om in a resident room (R7) g board for transfers.						
	unenclosed toilet an	was observed to have an nd sink that resident was d water closet was void of a						
	NEW CONSTRUCT and final working dr proposed construction commissioner of he Preliminary plans m preparation of final undertaken. Final w	5 APPROVAL OF PLANS; TION noted "Preliminary plans awings and specifications for ion must be submitted to the ealth for review and approval. nust be approved before the working drawings is rorking drawings and be approved before						

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/11/2013 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second of the second second	TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING			C 19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 492	Continued From pa construction is begu	The second s	F 49	92 F492		
	R7's diagnoses incl amputation and mo Data Set (MDS) dat same MDS identifie physical assistance	uded left above the knee rbid obesity per Minimum ted 5/21/13. Additionally, the d R7 required extensive of two for transferring d one physical extensive		Corrective Action: A waiver has been requested toilet in the room of Reside the Commissioner of Healt notified of the re-construct change of resident room.	ent # 7 and h has been ion upon	
	toilet in resident slee entering room with s on the opposite left stated that the facili and had sure helper continent and indep showed surveyor a he transferred to the On 8/16/13, at 2:15 with the administrat director (O)-C, the a and room modificati March 2013 and con and was not sure of work was completed modifications "the p the sink and toilet pi on the ceiling piping further stated the ho toilet had been mov administrator and O waiver per regulatio	p.m. surveyor observed the eping area to the right when sink next to it, and bed located side of the room. Resident ty had made the modifications d him to continue being endent with toileting. He binder with instructions of how e toilet using a sliding board. p.m. during the facility tour or and environmental service administrator stated "the toilet on work had been started in mpleted end of April 2013", the specific dates when the d. O-C stated that during the lumber came in and relocated ipes and did the connection on the floor below." O-C ole in the bathroom where the ed from was sealed. Both the -C stated the facility had no ns for room modification and lent sleeping area nor was the		Corrective Action as it appresidents: Waivers will be applied for Commissioner of Health wi of any future construction of resident's rooms. Therapy has screened to ass toileting options. Date of Completion: 10/3/1 Recurrence will be prevente Random room audits will be monthly with new findings the QA committee for follow discussion/planning. Completion will be monitor Administrator	and the ill be notified or revision to sess other 13 ed by: e conducted reported to w up	
F 497	comissioner of healt re-construction. 483.75(e)(8) NURS		F 49	97		

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 09/11/2013 APPROVED . 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY
		245387	B. WING			08	C / 19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	15/2015
ST OLAF	RESIDENCE				912 FREMONT AVENUE NORTH IINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa		F 4	197	F 497	1	
55=F	REVIEW-12 HR/YR	R INSERVICE			1. Corrective Action:		
	of every nurse aide months, and must p education based on	at least once every 12 provide regular in-service the outcome of these			A) The Performance Evaluatio of all Nursing Assistants have been completed and the	ns	
	sufficient to ensure nurse aides, but mu	vice training must be the continuing competence of ist be no less than 12 hours reas of weakness as			Performance Evaluations of all other facility staff are also bein completed.	g	
	determined in nurse and may address th as determined by th	e aides' performance reviews le special needs of residents le facility staff; and for nurse vices to individuals with			B) On-going education is being provided to NAR's to meet the 12 hour annual requirement.	S	
		nts, also address the care of			2. Corrective Action as it applies to others:A) All staff has the potential to		
	by: Based on interview	IT is not met as evidenced and document review, the			be affected by the deficient practice. B) Department Heads and Nurs	e	
	completed annually	are performance reviews were for all of the employees in the ability to affect all 66 lity.			Managers have been educated of the need to complete annual performance evaluations on the staff.		
	Findings include:	÷			C) Regularly scheduled in- service education will be		
	last performance ev	IA)-A was hired 8/6/01, the valuation was 10/28/09. 6/2000, the last performance			provided in accordance with regulatory requirements.		
	evaluation was 4/20 NA-C was hried 6/12	/09. 2/2000, the last performance			3. Date of completion: 10/3/13		
	evaluation was 9/8/0 NA-D was hired 8/1/ evaluation was 11/1	/94, the last performance			4. Recurrence will be prevented by:A) Random audits will be		
	NA-E was hired 8/23 evaluation was 11/1	3/93, the last performance			completed weekly x4 then		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/11/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Contraction of the second second		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245387	B. WING				C 19/2013
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 497 F 514 SS=F	performance evalua NA-T was hired on performance evalua NA-U was hired 4/8 performance evalua NA-V was hired 12/ performance evalua An interview with hu 11:30 a.m. verified performance evalua NA-D, NA-E, NA-S the employee's file. 483.75(I)(1) RES RECORDS-COMP LE The facility must m resident in accorda standards and prace accurately docume systematically orga The clinical record information to ident resident's assessm services provided;	ations since 6/9/10. 7/1/08, and has had no ations in the employee file. 8/12, and had no current ations in the employee file. (1/11, and had no current ations in the employee file. (1/11, and had no current ations in the employee file. uman resources on 8/15/13, at there was no evidence of ations for NA-A, NA-B, NA-C, , NA-T, NA-V were located in LETE/ACCURATE/ACCESSIB aintain clinical records on each nce with accepted professional ctices that are complete; nted; readily accessible; and nized. must contain sufficient tify the resident; a record of the ients; the plan of care and the results of any ening conducted by the State;	F		 monthly x3 with findings presented to the QA committee for follow up discussion and planning. 5. Completion will be monitor by: Administrator and/or Director of Nursing or their Designee 	ed	
	by: Based on observa review, the facility of were complete and residents (R15, R4	NT is not met as evidenced tion, interview and document did not ensure medical records accurately orderly for 11 of 20 2, R601, R41, R35, R68, R1, 8). This practice had the					

Facility ID: 00260

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	********	TIPLE CONSTRUC	TION	(X3) DAT CON	. 0938-0391 TE SURVEY MPLETED
		245387	B. WING			1	C (19/2013
	PROVIDER OR SUPPLIER			2912 FREMON	ESS, CITY, STATE, ZIP CODE IT AVENUE NORTH IS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH	OVIDER'S PLAN OF CORRECT H CORRECTIVE ACTION SHOU -REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514	potential to affect a the facility. Findings include: R84's medical reco 4:47 p.m. In the me	ge 288 Il 66 of 66 residents residing in rd was reviewed on 8/12/13, at dical record for R84 were for R15, R42, and R601.	99 - P.S.	to othe A) The resider chart o B) Me in the approp	rective Action as it appler residents: e Medical Records of al nts are being reviewed forder and accuracy. edical Records will be fi proper charts and under priate chart tabs. e Medical Records char	l òr led the	
	documents, RN-C s be filed in the corre- misfiled documents RN-C further stated done by the health that the nurses do h R41's medical reco- filed in R35's medical On 8/19/13, at 10:5 medical record wer consultant RN was R41's Consultant P form dated 8/12/13 The consultant RN filed incorrectly in R consultant RN verified in R41's medical R68's medical reco- 3:50 p.m. A Physici in the medical reco- medical record wer The licensed practi- and orders and for- medical record. R23's Physician Or	2 a.m. after copies of R35's e flagged and requested, the observed to provide a copy of harmacist Medication Review , from R35's medical record. verified the R41's review was (35's medical record. The ied the form should have been		order f the flo double in the d 3. Con 4. Rec by: A) Ran comple month presen for fol discus 5. Con by:	has been disseminated of pors. Staff are also to e check proper placement correct Medical Record mpletion Date: 10/3/13 currence will be prevent indom audits will be leted weekly x4 then ally x3 with findings bein ated to the QA committee llow up ssion/planning. mpletion will be monitor tor of Nursing or Design	nt s. ted ng ee red	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/11/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245387	B. WING	_		1000	C 19/2013
	RESIDENCE				STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	and R48's signed P were both filed betw 2013 Physician Ord On 8/19/13, at 10:0 copies from R23's p R12's and R48's sig 2013 were provided nursing (O)-D. At th	hysician Orders for July 2013 veen R23's May and June	F 5	51	4		
	Orders and copies wrong chart R23's. On 8/19/13, at 10:1 RN-A standing by a records staff or hea responsible with filin filed various forms i On 8/19/13, at 5:34 director of nursing (regarding quality iss survey. The DON c record issues of do charts and orders th implemented. The undated Medic directed "1. Upon a will be created for e record number will using	provided were filed in the 5 a.m. interviewed O-D and t the time stated the medical lth unit coordinator were ng but added at times nurses in the charts. p.m. the administrator and DON) were interviewed sues identified during the onfirmed there were medical cuments filed in the wrong hat had not been al Records Filing Procedure dmission, a medical record file each resident. The medical					

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ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT CON	0938-0391 E SURVEY IPLETED
		245387	B. WING				C 19/2013
				2912 F	T ADDRESS, CITY, STATE, ZIP CODE		
				MINN	EAPOLIS, MN 55411		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	0.6	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Continued From pa		F 5	514			
F 500	records were kept a	accurate.		200	5520		
	483.75(0)(1) QAA COMMITTEE-MEM	IBERS/MEET	FC	520	F520		
55-1	QUARTERLY/PLAI				1. Corrective Action:		
			2 		A) Elopements and the Wander	r	
	A facility must main	tain a quality assessment and		-	Guard system review will be a		
		ee consisting of the director of			part of the QA meetings until		
	nursing services; a	physician designated by the			further notice.	1	
		3 other members of the			B) Medical Records policy and procedures will be reviewed at		
	facility's staff.				QA meetings until further notion		
	The quality assess	ment and assurance			C) Medication Delivery and		
		at least quarterly to identify			Medication Administration wil	11	
		t to which quality assessment			be reviewed at QA meetings un		
		ivities are necessary; and			further notice.		
		ements appropriate plans of entified quality deficiencies.			D) The Medical Director and Board of Administrators have		
		retary may not require		- il .	been notified of the IJ situation	n in	
		cords of such committee			the facility.	11	
		such disclosure is related to the n committee with the			E) Incidents and Accidents will be a routine part of the QA		
	requirements of thi				meeting.		
					F) All areas identified on the		
		s by the committee to identify deficiencies will not be used as			2567 will be monitored throug	gh	
	a basis for sanction				the QA process until further notice.		
	이 같은 것이 없는 것이 가지 않는 것이 가지 않는 것이 것 같아. 아이는 것 같아? 아이는 것 같아?	NT is not met as evidenced					
	by: Based on observa	tion, interview and document					
	review, the facility	failed to ensure the Quality					
		ssurance committee (QAA)					
		essed quality concerns related					
		t/review/revision of the facility's and failed to ensure the					

Facility ID: 00260

If continuation sheet Page 291 of 298

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
						c
		245387	B. WING			/19/2013
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
ST OLAI	FRESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	Wanderguard (depa functional to prever residents (R45). In development/review and procedures reg	arture alert system) was at elopement for 1 of 6 addition, the facility did not v/revision the facility's policies garding medical records and had the ability to affect all 66	F 5	 20 2. Corrective Actions as it applies to other residents: A) Elopements and the Wa Guard system review will b part of the QA meetings un further notice. B) Medical Records policy procedures will be reviewe QA meetings until further notice. 	e a til and d at	
	times in the month 7/11/13, 7/29/13, ar clinical record. The evidence R45's Wa monitored for place staff did not know w placed on his whee the equipment to ch function. Although s scheduled walks ou 10:00 a.m. and 2:30 leave the facility, th Wanderguard syste elopements from th R45's signed Patier (Physician's Orders 7/31/13, all directed placement & functio order dated 7/2/13, for Wanderguard." R45's care plan dat "Resident at risk foo [related to]: 1. Dx [c of CVA [cerebral va	Ily eloped from the facility five of July on 7/1/13, 7/2/13, and again on 7/31/13 per the clinical record lacked anderguard was consistently ment and function; the nursing where R45's Wanderguard was lichair (w/c); the facility lacked neck R45's Wanderguard for staff accompanied R45 on utside the facility twice daily at 0 p.m. to reduce attempts to e facility lacked a functional em to potentially prevent R45's he facility the Medical Care Plan b) dated 11/15/12, through d, "Wanderguard check on every shift." A Telephone at 8:00 a.m. indicated, "OK ted 9/27/13, identified, r harm from self or others R/T diagnosis] of depression 2. Dx scular accident, stroke] 3. Dx I disorder AEB [as		 C) Medication Delivery and Medication Administration be reviewed at QA meeting further notice. D) The Medical Director an Board of Administrators had been notified of the IJ situal the facility. E) Incidents and Accidents be a routine part of the QA meeting. F) All areas identified on the 2567 will be monitored through the QA process until furthen notice. G) The Quality Assurance I has been reviewed and staff members were educated on process. 3. Completion Date: 10/3/14 4. Recurrence will be preven by: 5. Completion will be monitory by: Administrator or Designee 	will s until d ve tion in will e pugh r Policy the 3 nted	

		AND HUMAN SERVICES			FORM): 09/11/2013 1 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		245387	B. WING			C /19/2013
NAME OF I	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STAT		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NO MINNEAPOLIS, MN 5541		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 520	evidenced by]: 1. R making suicidal sta plan dated 10/9/12, Communication r/t persistent mental d self understood & u A hand written care identified R45 had p and left hemiplegia The care plan date prefers activities that i.e. [in example] wa R45 would "have st 2:30 PM. If he is co times resdient [sic] Resdient [sic] to sig agreeing to above." directed, "OT [occur resdient [sic] (modi with behavior mod update dated 7/13 i applied [crossed ou placement/function photograph of resic Allow safe mobility Encourage movem 5. Redirect & reorie calm reassurance, Cont [continue] wal day weather permit identified R45 could abusive; he resister statements, and he choke self with han identified R45 had a did not identify R45 from the facility or a of the facility, such	esdient [sic] has a history of tements/actions." The care identified R45 had, "Impaired impaired cognition, dementia - /o [disorder]ability to make inderstand others is impaired." plan for falls dated 10/21/12, potential for fall r/t weakness (paralysis on the left side). d 7/31/13, indicated, "Resident at identify with prior lifestyle ilking program" and identified taff walk him at 10 AM and ompliant with sticking to these will get a treat of his choosing. gn a walking program contract ' The interventions further pational therapy] to work with fied community integration [modification])." A hand written indicated, "1. Wanderguard		520		
FORM CMS-2	567(02-99) Previous Versions		11	Facility ID: 00260	If continuation sheet P	age 293 of 298

If continuation sheet Page 293 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 09/11/2013 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000000		(X3) DA	TE SURVEY MPLETED
		245387	B. WING		- 08	C /19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE MINNEAPOLIS, MN 554		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 520	elopement, such as Wanderguard, R45 remove the Wande Wanderguard, nurs elopement attempts identified a "walking plan did not identify with a cane or to be wheelchair. The can consideration relate safety assessment allow the wheelchai the walking program On 8/16/13, at 1:45 interviewed regardi she believed an elo State agency when property." The DON elopements were n agency. The DON sreceptionist saw R4 for assistance and not considered an elope employment to the around the facility, was uneven and un had walked with R4 would not always a wheelchair. The DO move fast when wh the facility. On 8/16/13, at 3:58 stated checking for function could be "o	s placement of the 's history of attempts to rguard, reasons for the ing interventions to address s. Although the care plan g program" for R45, the care if R45 was supposed to walk e escorted while R45 used a re plan lacked safety ed to elopements, such as schedules or R45 refusing to ir to be touched while out on	F 5	DEFI		
ORM CMS-2		mained unclear if or when the	11	Facility ID: 00260	If continuation sheet P	age 294 of 298

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 09/11/2013 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	M. Manuration	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245387	B. WING		08	C /19/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	Wanderguard was stated she thought applied to R45 on 1 On 8/19/13, at 10:0 therapist verified R4 "community involve stated the treatment with R45 while he w community. Occupation not want staff to be was "confused" on R45. The occupation staff provided teach occupational therap R45 on the walks, t R45 why staff was choose times and f "isolated" as he was walks. The occupation therapy was to "pre- and stated the therap compliance with the daily. On 8/19/13, at 5:34 elopements came u review (not as an io administrator verifie concerns such as o not a part of QA, bu	removed in July 2013, but the Wanderguard was first	F 5			
	policy was to asses potential risk factor identified, "All resid admission and ann	a 5/15/13, identified the facility is each resident to identify s for elopement. The policy ents will be assessed on ually for elopement. That d to be 'at risk' for elopement				

Facility ID: 00260

If continuation sheet Page 295 of 298

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- S	IPLE CONSTRUCTION		E SURVEY
		245387	B. WING			C 19/2013
AME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CC		10/2010
T OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	will be assessed qu the completion of th Assessment [Risk of Review]." The polic appropriate interver bottom of the form, "elopement prevent The policy further d an intervention. Tess [sic] working proper 9. Implement signal test Wanderguard of	arterly." The policy directed ne "Elopement Risk of Elopement/Wandering y further directed to apply ntions from the "list" at the directed to complete an tion/management care plan." irected, "8. If Wanderguard is it Wanderguard to ensure it ly before putting on resident. ling device testing calendar, daily and sign daily that it is	F 52	20		n _ 1
	System manual dire tester" within one for bracelet, press and one time, the tester times if the bracelet "good." The manua test the Wanderguar function. The manu Wanderguard away on a resident, or aw to a wheelchair. The the Wanderguard o and not against the metal may "interfere function. R45's War metal crossbars of Medical records and On 8/19/13, at 5:34	erguard Departure Alert ected to use a "Universal bot of the Wanderguard release the bracelet button light will blink green four t was active and has tested as I also included directions to and at the door to determine al further directed to keep the from metal jewelry if applied vay from metal when affixing it e manual directed to mount n the back of the wheelchair metal frame and indicated the e" with the Wanderguard inderguard was placed at the the wheelchair.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 C C C C C C C C C C C C C C C C C C	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245387	B. WING		08	C 8/19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	Quality (QA) meetin facility identified cor audits were then re- the QA meeting. Th "mock survey" to id- be "fixed or address The DON confirmed issues of document orders that had not and medications not	in the facility. He stated the neerns through audits. The ported and discussed through e facility had completed a entify pieces which needed to	F 5	520		
	governing board. The ducated the gover with compliance fro was unclear if the g the immediate jeop expected the medic DON notified the cli director's (MD's) cli the information. The to see quality data,	formation was provided to the ne administrator stated he had ning board on the time factors m the quality team reports. It overning board was notified of ardy (IJ), but stated he cal director to be notified. The nical director of the medical nic, and she would pass on the DON stated the MD, wanted and did review the trending in the past, and analysis of t, location.				
	The administrator s working on grievand satisfaction survey, customer complain were the mock surv that, tightening up t sure orders are follo	tated the facility was currently ce responses, and data from and doing root cause with ts. Ongoing quality projects rey, and continuing to improve he admission process, making owed up on, ensuring plans eamlining policy and				

		AND HUMAN SERVICES			FORM	09/11/2013 APPROVED	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a second contraction	TIPLE CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED	
		245387	B. WING		24	C 08/19/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE	
F 520	Minimum Data Set Assessments (CAA plans. Pull the med streamline that piec new communicatio implemented. The encourage the hea resource. A nursing	(MDS) using the Care Area As) to develop better care lical record job descriptions to ce, especially with orders. A	F 5	20			
	had been impleme implement a new w pharmacy, such as improving new slee orthostatic blood pi psychotropic medic The administrator	nted. The facility planned to yay to do admissions with getting consents right away, ep study forms, adding ressure checks for cations. stated since the DON had been efined better, and incidents					
÷					×		
ORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:6QVR	11	Facility ID: 00260	continuation sheet P	age 298 of 298	

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

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

		245387	B. WING	·	C 08/19/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	the second se
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	on one particularly to the topped	ULD BE COMPLETION
F 465	debris which could dishes. Dining room tables: The second floor di observed to not be 8/14/13, 8/15/13 an On 8/12/13 through main second floor of observed to have b substance on the en beween the table to pedestals itself of a were mid afternoon 8/13/13 through 8/1 evening. During that week ho observed on severa area after meals wh however, staff neve browishish food spa attached surfaces. On 8/16/13, at 2:43 environmental servi administrator verifie clean as the browis and food spatters re attached areas. O-0 were not on a routir expected the tables	a clean manner free from potentially contaminate clean hing room tables were clean 8/12/13, 8/13/13, d 8/16/13. 8/16/13, the four tables in the ining room area were rowish, spatters and sticky dges, metal area space ps and the pedestal and the If the tables. The observations to evening on 8/12/13, on 6/13, mid morning and early busekeeping staff were al occurances cleaning the hich included wiping the tables, r cleaned off the sticky, atters on the tables and p.m. during facility tour the ce director (O)-C and the d the four tables were not h, sticky substance was dust emained on all the tables and C further stated the tables the cleaned on a daily basis aff as they do regular routine	F 4	 D) All Resident mattresses were checked for rips and deterioration and replaced as necessary. E) A w/c and assistive device cleaning schedule was put into place. The cleaning of the w/c's and assistive devices will be logged routinely. Completion date: 10/3/13 Recurrence will be prevented by: A) Random weekly audits will be completed weekly x4 then monthly x3 with findings being presented to the QA committee for follow up discussion/planning . Completion will be monitored by: Director of Nursing, Maintenance 	

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

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

Event ID 6QVR11

Facility ID: 00260

If continuation sheet Page 281 of 298

PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

C

	MENT OF HEALTH							RINTED: 09/ FORMAPPI MB NO. 093	ROVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA	1			RUCTION	(X3) DATE SUR COMPLETE	
		24	5387	B. WING				C 08/19/20	013
NAME OF F	PROVIDER OR SUPPLIER				STRE	ETAD	DRESS, CITY, STATE, ZIP CODE		
STOL AD	RESIDENCE				2912	FREM	MONT AVENUE NORTH		
STULAP	RESIDENCE				MIN	NEAF	POLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY'STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFI TAG			PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION-SHOULD OSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	(X5) IPLETION DATE
F 309	Continued From paraware of the reside and after dialysis. Sobtained would be of record. The Physician Order staff to measure Re after dialysis. A revire revealed in June, 20 as ordered on two of not taken as ordered of 7/20/13 & 7/30/13) of the time. During resident's blood pre four times (8/3/13, 8 no taken as ordered of 8/14/13, at 2:25 p.m aware that the reside being taken before by the physician. Sh pressures taken wo record. An interview on 8/14 dialysis program re- reported the staff aft contacted the facilit 6/22/13, the resider critically high and as local emergency root the medical record physician ordered s suspension (a medi potassium levels) 1 Since that order wa	Arrow being with the also report documented in ers, signed on 88's blood pres ew of the med 013-blood pres days (6/1/13 ar d 53% of the ti- lent's blood pre- days (6/1/13 ar d 53% of the ti- lent's blood pre- and after days (7/ but not taken a August 1-13, 2 essure was tak 8/8/13, 8/10/13 d 25% of the ti- propleted with and after dialy build be charted and after dialy build be charted after dialy be and after dialy be and aft	ed all weight a the medical 8/1/13, directed ssure before and lical record ssure was taken and 6/6/13) and time. During essure was 6/13, 7/16/13, as ordered 50% 2013- the ten as ordered 3 & 8/13/13) and me. LPN-D on d she was not essure was not essure was not sis as ordered blood d in the medical a.m. with the (DPRN). He rogram d them on level was is seen at a ion. A review of (13, the facility ther Kionex o treat elevated outh every day.	F3	309	4.	 The facility has contracted with a new mobile Dental service to meet the needs of residents who cannot go our dental appointments. Date of Completion: 10/3/1 Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and the monthly X3 with results being presented to the QA commit for follow up discussion/planning. The Correction will be monitored by: The Director of Nursing or Designee 	f t to 13 ed hen ng	
FORM CMS-25	67(02-99) Previous Versions		Event ID:6QVR1	1	Facility	ID 002	260 If continuation	sheet Page 13	30 of 298

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FC387022

PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	17	701000	OWR NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A: BUILDING 01 -	ONSTRUCTION MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245387	B. WING		08/13/2013
	PROVIDER OR SUPPLIER		2912	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT AVENUE NORTH NEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
K 000	INITIAL COMMEN	rs	K 000	Dacok	
	FIRE SAFETY			PUC 1	
6-28-13	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE.	A	Pocok 11-12-13	
in in	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.	j.		
1913	Minnesota Departn time of this survey, not in substantial correquirements for pa Medicare/Medicaid (b), Life Safety from National Fire Prote	articipation in at 42 CFR, Subpart 482.41 n Fire, and the 2000 edition of ction Association (NFPA) a Life Safety Code" (LSC),		RECEIN NOV 1 2 201	B B
j.	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	R THE FIRE SAFETY		CRAUSE CRAU	SAFETY DIVISION
EXIT	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145			
	By email to:	ILAA 11	NATURE		(X8) DATE
LABORATOR	Y DIRECTOR'S OR PROVID	EUSH FLIER RUPPESENTATIVE'S SIG	E	Kecutive Director	9/25/13

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

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

Event ID: 6QVR21

Facility ID 00260

		AND HUMAN SERVICES				PRINTED: 0 FORM AF OMB NO: 0	PROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE S COMPL	URVEY ETED
		245387	B. WING	Marganetic Constant		08/13	/2013
NAME OF P	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE		0
ST OLAF	RESIDENCE	2		2912 FREMONT A MINNEAPOLIS,	MN 55411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Préf Tag	IX (EACH CO	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	LD BE ((X5) COMPLETION DATE
К 000	DEFICIENCY MUS FOLLOWING INFO	@state.mn.us and state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, don		000			
	3. The name and/c responsible for cor prevent a reoccurr St Olaf Residence basement. The ori in 1964, is separat fire rated barrier at Type I (332) const sprinkler protected system with smoke corridor system, in open to the corridor automatic fire dept	roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. is a 4-story building with a ginal building was constructed red from a church with a 2 hours and was determined to be of ruction. The facility is fully first the facility has a fire alarm a detection throughout the common areas and areas or system and is monitored for artment notification.	e				Y
K 027 SS=F	census of 66 at the The requirement a is NOT MET as ev NFPA 101 LIFE S/ Door openings in a 20-minute fire prof 1%-inch thick solid	capacity of 80 beds and had a e time of the survey. at 42 CFR, Subpart 482.41 (b) videnced by: AFETY CODE STANDARD smoke barriers have at least a tection rating or are at least d bonded wood core. Non-rate hat do not exceed 48 inches	K	027			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:6Q	VR21	Facility ID: 00260	If con	tinuation sheet	Page 2 of

		& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245387	B WING		08/13/2013
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ST OLAF	RESIDENCE			2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
K 027	Continued From pa	200 2	K 027		
	Horizontal sliding d Doors are self-clos accordance with 19 not required to swith	the door are permitted. loors comply with 7.2.1.14. sing or automatic closing in 9.2.2.2.6. Swinging doors are ng with egress and positive lired. 19.3.7.5, 19.3.7.6,	K 027	K 027 Corrective Action: 1) The door sequences replaced for the this smoke barrier by R Door Company. 2) Completion date 8	rd floor oy C
	Based on observa	is not met as evidenced by: tions and interview, the facility ain smoke/fire barrier doors in SC 19.3.7.5. This deficient ct all residents.		3) The Maintenance D will assure continue compliance by testi door closers monthl assure proper function	ng all y to
	On facility tour betw 12:30 PM on 08/13 that the door seque barrier doors failed This deficient pract	ween between 10:00 AM and 3/2013, observation revealed encer for the third floor smoke to properly function.			
K 029 SS=F		e time of the inspection. FETY CODE STANDARD	K 029		
	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sn doors. Doors are s field-applied protect	I construction (with ¼ hour an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are 2.1			

DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				E SURVEY PLETED
	245387	B. WING			08/	13/2013
			2912 FREMONT A	VENUE NORTH		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVID (EACH CC	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOL	JLD BE	(X5) COMPLETIO DATE
Continued From p	age 3	K 02	9		a.	
Based on observa hazardous areas a accordance with N 19.3.2.1. This def	ation and interview, the are not maintained in IFPA 101-2000, Section			Latching hardware installed on the set double doors and t door separating the	of he single)
Findings include: During facility tour PM on 08/13/2013 kitchen and dining separated from the kitchen serving wit shutter and the do	, observation revealed that the room are not properly e adjoining corridor. The ndow does not have a fire ors separating the dining area			Completion date 1 The Maintenance I will assure continu compliance by test door closers month	Director ed ing all aly to	
This deficient prac administrator at th	tice was verified by the e time of the inspection.					
					N	
	DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RESIDENCE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa Continued From pa Based on observa hazardous areas a accordance with N 19.3.2.1. This def patients. Findings include: During facility tour PM on 08/13/2013 kitchen and dining separated from the kitchen serving wit shutter and the do are not fire rated a This deficient prace	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245387 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect all patients.	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTH A BUILDING 245387 B. WING	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILD 245387 B. WING REVIDER OR SUPPLIER RESIDENCE STREET ADDRESS, 2912 FREMONT A' MINNEAPOLIS, 2912 FREMONT A' MINNEAPOLIS, 2913 FREMONT A' MINNEAPOLIS, 2914 FREMONT A' MINNEAPOLIS, 2915 FREMONT A' MINNEAPOLIS, 2916 FREMONT A' MINNEAPOLIS, 2917 FREMONT A' MINNEAPOLIS, 2918 FREMONT A' MINNEAPOLIS, 2919 FREF/X 2910 FREF/X 291	DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIE/RCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B. WING RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER/SPLAN OF CORRECTIVE ACTION SHOU (EACH DEFICIENCY) Continued From page 3 K 029 Construction and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect all patients. area and copridor. During facility tour between 10:00 AM and 12:30 PM on 08/13/2013, observation revealed that the kitchen serving window does not have a fire shutter and the doors separating the dining area are not fire rated assemblies. The Kitchen serving window does not have a fire shutter and the doors separating the	DF DEFICIENCIES CORRECTION (M1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 A BUILDING 01 - MAIN BUILDING 01 B WING (X3) ATE COMM 08/1 ROVIDER OR SUPPLIER 245387 B WING 08/1 RESIDENCE STREET ADDRESS, CITY, STATE, ZIP CODE 2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411 08/1 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 3 K 029 Corrective Action: 1) Latching hardware has been installed on the set of double doors and the single door separating the dining area and copfdor. 10 During facility tour between 10:00 AM and 12:30 PM on 08/13/2013, observation revealed that the kitchen and dining room are not properly separated from the adjoining corridor. The kitchen serving window does not have a fire shutter and the doors separating the dining area are not fire rated assemblies. 20 Completion date 10/8/2013 This deficient practice was verified by the