# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 7EFL
Facility ID: 27752

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245619**
2. STATE VENDOR OR MEDICAID NO. (L2) **753490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT THERESE AT OXBOW LAKE**
(L4) **5200 OAK GROVE PARKWAY**
(L5) **BROOKLYN PARK, MN** (L6) **55443**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **1/19/2016** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/13**

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

12.Total Facility Beds **64** (L18)
13.Total Certified Beds **64** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 64 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 1/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**07/16/2013**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

*Protecting, maintaining and improving the health of all Minnesotans*

CMS Certification Number (CCN): 245619

January 22, 2016

Ms. Brandi Barthel, Administrator
Saint Therese At Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, MN 55443

Dear Ms. Barthel:

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 January 13, 2016 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

*Protecting, maintaining and improving the health of all Minnesotans*

Electronically delivered
January 22, 2016

Ms. Brandi Barthel, Administrator
Saint Therese At Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, MN 55443

RE: Project Number S5619003

Dear Ms. Barthel:

On December 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2015, effective January 13, 2016 and therefore remedies outlined in our letter to you dated December 21, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

*Kamala Fiske-Downing*

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 245619 | A. Building<br>B. Wing | 1/19/2016 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT THERESE AT OXBOW LAKE | 5200 OAK GROVE PARKWAY<br>BROOKLYN PARK, MN 55443 |

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

| ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) |
|---|---|---|---|---|---|
| ID Prefix F0312<br>Reg. # 483.25(a)(3)<br>LSC | Correction Completed<br>01/13/2016 | ID Prefix F0323<br>Reg. # 483.25(h)<br>LSC | Correction Completed<br>01/13/2016 | ID Prefix F0329<br>Reg. # 483.25(l)<br>LSC | Correction Completed<br>01/13/2016 |
| ID Prefix F0356<br>Reg. # 483.30(e)<br>LSC | Correction Completed<br>01/13/2016 | ID Prefix F0428<br>Reg. # 483.60(c)<br>LSC | Correction Completed<br>01/13/2016 | ID Prefix F0431<br>Reg. # 483.60(b), (d), (e)<br>LSC | Correction Completed<br>01/13/2016 |
| ID Prefix F0465<br>Reg. # 483.70(h)<br>LSC | Correction Completed<br>01/13/2016 | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) GD/kfd | DATE 1/22/2016 | SIGNATURE OF SURVEYOR 18623 | DATE 1/19/2016 |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 12/4/2015 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
| --- | --- | --- |
| 245619 | A. Building 01 - MAIN BLDG<br>B. Wing | 1/4/2016 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| SAINT THERESE AT OXBOW LAKE | 5200 OAK GROVE PARKWAY<br>BROOKLYN PARK, MN 55443 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
| --- | --- | --- | --- | --- | --- |
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0029 | Correction Completed 12/06/2015 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0050 | Correction Completed 12/21/2015 | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
| --- | --- | --- | --- | --- |
| | TL/kfd | 1/22/2016 | 19251 | 01/04/2016 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |
| | | | | |

| FOLLOWUP TO SURVEY COMPLETED ON | |
| --- | --- |
| 12/2/2015 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

ID: 7EFL
Facility ID: 27752

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245619**
2. STATE VENDOR OR MEDICAID NO. (L2) **753490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT THERESE AT OXBOW LAKE**
(L4) **5200 OAK GROVE PARKWAY**
(L5) **BROOKLYN PARK, MN** (L6) **55443**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **12/04/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited; 1 TJC; 2 AOA; 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital; 02 SNF/NF/Dual; 03 SNF/NF/Distinct; 04 SNF; 05 HHA; 06 PRTF; 07 X-Ray; 08 OPT/SP; 09 ESRD; 10 NF; 11 ICF/IID; 12 RHC; 13 PTIP; 14 CORF; 15 ASC; 16 HOSPICE; 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/13**

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

12.Total Facility Beds **64** (L18)
13.Total Certified Beds **64** (L17)

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 64 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
Rebecca Wong, HFE NE II — 01/04/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 01/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/16/2013** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
December 21, 2015

Ms. Brandi Barthel, Administrator
Saint Therese At Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

RE: Project Number S5619003

Dear Ms. Barthel:

On December 4, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

**DEPARTMENT CONTACT**

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

**Gloria Derfus, Unit Supervisor**
**Metro C Survey Team**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**85 East Seventh Place, Suite #220**
**P.O. Box 64900**
**Saint Paul, Minnesota 55164-0900**
**Email: Gloria.derfus@state.mn.us**
**Phone: (651) 201-3792 Fax: (651) 215-9697**

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 13, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

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

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

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

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

**Original deficiencies not corrected**

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

**Original deficiencies not corrected and new deficiencies found during the revisit**

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition
of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

**Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by March 4, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if

deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245619 | A. BUILDING ______ B. WING ______ | 12/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT THERESE AT OXBOW LAKE | 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and document review, the facility failed to provide grooming for 1 of 3 residents (R4) who was dependent for activities of daily living (ADL) reviewed for ADL.<br><br>Findings include:<br><br>On 11/30/15, at 4:43 p.m. R4 was observed seated on the wheelchair in her room eyes closed. When approached R4 was observed to have multiple white facial hairs approximately quarter inch long (1/4) on her lower chin and on | F 312 | R4 was given grooming assistance for facial hair on 12/3/15.<br><br>Facility wide audit on grooming was completed. Care plans were updated per individualized preferences.<br><br>The policy and procedure on Resident Care Grooming was reviewed.<br><br>Staff will be re-educated on the policy by 1/13/16. | 1/13/16 |

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

Electronically Signed — 12/30/2015

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

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| | 245619 | A. BUILDING ______ B. WING ______ | 12/04/2015 |

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| F 312 | Continued From page 1<br>her cheeks.<br><br>On 12/1/15, at 8:17 a.m. when asked if the facial hairs bothered her R4 stated "Yes. I would like them removed the barber used to take them off for me" as she felt the hairs on her left cheek. When asked if the staff help me to remove them on her bath day R4 stated, "They have not told me they would."<br><br>On 12/2/15, at 7:13 a.m. R4 was observed to be up and dressed. When approached and asked how she had slept R4 indicated "good." R4 stated the community life specialist (CLS)-A was really good to her. R4 was still observed still with multiple facial hairs around her mouth and cheeks. CLS-A cued R4 to brush her teeth after CLS-A wheeled R4 close to the sink R4 was observed brush the teeth and applied her dentures as CLS-A was straightening the bed. At 7:17 a.m. CLS-A was observed wet a wash towel then handed it to R4 to wash the face. At 7:18 a.m. CLS-A was observed comb R4's hair as she turned around and looked at R4's face never offered to remove the facial hair. At 7:19 a.m. CLS-A wheeled R4 out of the bathroom into the room by the bed, got R4 eye glasses from the dresser handed them to R4 to put them on and a Kleenex. At 7:21 a.m. CLS-A wheeled R4 out of the room to the dining room (DR) table. At 7:23 a.m. CLS-A brought R4 into the dining room and offered coffee still never offered to remove the facial hair. At 7:25 a.m. the household coordinator approached R4 said "good morning" looked at R4's face never offered to remove the visible facial hairs. At 7:47 a.m. another staff approach R4 provided condiments and spoke briefly to R4 never offered to remove the facial hairs which were visible. At 8:31 a.m. R4 wheeled out of the | F 312 | Audits will be completed on 10% of residents weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring.<br><br>Clinical Director and/or designee will be responsible for ongoing compliance. | |

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| F 312 | Continued From page 2<br>DR into the hallway. At 8:33 a.m. the household coordinator and another staff both approached R4 and offered to ride back to room. Both staff went into R4's room were observed and heard converse with R4 about her life/family door wide open at this time never offered to remove the facial hairs. At 9:20 a.m. to 9:25 a.m. registered nurse (RN)-C was observed completed wound care for R4 never offered to remove the facial hairs.<br><br>On 12/2/15, at 1:57 p.m. RN-C stated he would at least expect the CLS's who worked with him to provide residents with assistance for all cares required which included grooming, personal hygiene, dressing and eating as some residents need extensive assist with cares.<br><br>On 12/3/15, at 7:57 a.m. when approached R4 was still observed with multiple facial hairs on her lips and cheeks.<br><br>On 12/3/15, at 8:29 a.m. RN-A verified R4 had facial hairs. RN-A was overheard asked R4 if the hairs bothered here and R4 stated "Yes they do because I touch them." R4 asked RN-A to remove them for her and RN-A indicated she was going to get a razor to remove them. At 8:32 a.m. when asked what the expectation was to remove the chin hair, RN-A stated on bath days. RN-A provided the bath schedule which indicated R4's bath day was Thursday evening and when asked if the staff documented if facial hair had been removed RN-A stated "no they don't" as she indicated she was going to take care of it.<br><br>R4's diagnoses included glaucoma and abnormal posture obtained from Admission Record dated 12/3/15. | F 312 | | |

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| F 312 | Continued From page 3<br><br>R4's ADL Care Area Assessment (CAA) dated 2/10/15, indicated resident required extensive assist with most ADL functions at this time.<br><br>R4's quarterly Minimum Data Set (MDS) 10/8/15, indicated R4 had intact cognition and required extensive assist with personal hygiene including shaving. Grooming care plan dated 10/9/15, indicated resident required extensive assist with grooming/hygiene related to debility and glaucoma. Goal "I want to participate as I am able in personal hygiene and remain neatly groomed." The care plan directed staff to provide extensive assist of one staff member for grooming tasks, hygiene and oral care.<br><br>On 12/3/15, at 9:44 a.m. the director of clinical services (DNS) stated she expected staff to provide grooming as directed by the care plan and the care guide sheets.<br><br>The Resident Care Grooming policy dated July 2014, indicated nursing staff was to provide assistance with grooming AM and PM according to resident needs. | F 312 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | | 1/13/16 |

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| F 323 | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure necessary supervision for meals was provided for 4 of 5 residents (R71, R52, R25, R60) who were assessed to need supervision for meals. In addition, the facility failed to ensure bedside rails were safely secured to the bed frame to minimize the risk of injury for 3 of 3 residents (R71, R44, R52) reviewed for accidents.<br><br>Findings include:<br><br>R71, R44, R52, and R60 were left unsupervised in the dining room during continuous observation of the Rhode house dining room on 12/3/15, from 7:17 a.m. to 8:37 a.m. No nursing staff was observed in the dining room during that time frame.<br><br>R71:<br>On 12/3/15, R71 was observed and the following was noted:<br>- At 7:17 a.m. one resident in dining room was eating peaches, coffee and orange juice on table.<br>- At 7:27 a.m. R71 and three other residents were in the dining room eating breakfast.<br>- At 7:28 a.m. R71 drank thickened coffee and then coughed twice. The thickened water and juice were placed in front of R71.<br>- At 7:31 a.m. R71 coughed twice.<br>- At 7:32 a.m. household coordinator (HC)-E stopped by and spoke to R71 then left.<br>- At 7:43 a.m. a staff member brought a resident to the dining room and gave the resident juice and coffee and then left immediately. Five residents remained in the dining room eating breakfast. | F 323 | Orders received on R71, R60 for re-evaluation of swallowing and need for supervision. Care plan will be reviewed and will be updated with final recommendations per SLP.<br><br>Hospice referral made for R52 to review swallowing and meal supervisory needs. Care plan will be reviewed and updated with final recommendations.<br><br>R25 chart review completed, resident passed away 12/18/15 on hospice care.<br><br>Residents with altered diets/consistencies will be reviewed for the need of supervision with meals. Care plan will be updated as needed.<br><br>Dining times were adjusted to ensure proper supervision of the dining room during meals by nurse/designee.<br><br>Resident Dining Policy has been reviewed and updated to ensure supervision for resident safety that require an altered diet and feeding assistance.<br><br>Education will be completed by 1/13/16.<br><br>Random audits will be completed weekly on varying meals for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring. Clinical Director and/or designee will be | |

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- At 7:57 a.m. staff brought three residents to the dining room and left immediately. Eight residents were in the dining room with beverages and or food in front of them.
- At 7:59 a.m. R71 was eating oatmeal and started coughing hard. R71 had two coughing bouts at that time.
- At 8:05 a.m. licensed practical nurse (LPN)-B moved the medication cart outside the dining room,
- At 8:14 a.m. LPN-B left the dining area HC-E entered the dining room. No nursing staff remained in dining room. Eight residents were in the dining room eating breakfast or drinking. HC-A sat down next to a resident.
- At 8:28 a.m. director of clinical services (DCS) was overheard speaking to HC-E. DCS asked about the reason there were no nursing assistants, HC-E stated "[LPN-B] asked me to watch the dining room."
- At 8:30 a.m. HC-E had left the dining room and then no nursing staff was present in the dining room.
- At 8:37 a.m. R71 coughed after drinking thickened juice.

R71's annual Minimum Data Set (MDS) dated 8/28/15, indicated R71 was severely cognitively impaired, requiring assistance with all activities of daily living (ADLs) including supervision with eating. R71's diagnoses included chronic obstructive pulmonary disease (COPD) Heart failure, diabetes, anxiety, dementia and dysphagia (difficulty swallowing).

Nutrition Care Area Assessment (CAA) dated 8/28/15, indicated R71 was receiving a No Concentrated Sweet diet NDD2 diet (a mechanically altered dysphagia diet) with nectar

**Provider's Plan of Correction (F 323):**

responsible for ongoing compliance.

R52, R71, and R44(R48 is not in the resident sample) side rails were inspected by the bed manufacturing company s technician on 12/8/15. Repairs that were needed were completed. New side rails were ordered for R52, R71, and R44 and will be replaced upon arrival.

A preventative maintenance procedure/checklist for the electric beds including side rails has been added and will be completed on all beds.

The Positioning Device: Positioning Rails/Bed Transfer Bars/Sheppard Hooks policy was reviewed.

Staff will be educated on functionality of the side rails and when to report safety concerns by 1/13/16. Maintenance staff will be educated on preventative maintenance procedure and functionality of the side rails by 1/13/16.

Audits will be completed on 10% of beds weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring. Plant Operations Director and/or designee will be responsible for ongoing compliance.

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thickened liquids because of dysphagia.

The Speech Therapy Evaluation and Plan of Treatment dated 1/13/15, indicated R71 was at high risk of choking and aspiration pneumonia.

During interview on 12/3/15, at 1:26 p.m. nurse practitioner (NP) stated R71 would be at risk for choking because of dementia. The NP confirmed it was expected R71 would be supervised when eating in the dining room.

During interview on 12/3/15, at 2:00 p.m. family member (F)-A stated R71 was in the hospital in January 2015 with influenza, urinary tract infection (UTI) and pneumonia (viral). "I would expect him to be supervised in the dining room. They should encourage him to slow down [to eat]."

R52:
On 12/3/15, from 7:17 a.m. to 8:37 a.m. R52 was observed and the following was noted:
- At 7:17 a.m. one resident in dining room eating peaches, coffee and orange juice on table.
- At 7:27 a.m. four residents eating breakfast.
- At 7:36 a.m. HC-E walked through the dining room.
- At 7:43 a.m. R52 was brought to dining room and given juice and coffee. Five residents were eating breakfast and no nursing staff were in the dining room.
- At 8:00 a.m. dietary staff brought R52 breakfast including scrambled eggs and toast.
- At 8:14 a.m. HC-E entered the dining room. Eight residents were eating breakfast.
- At 8:28 a.m. the director of clinical services (DCS) was overheard speaking to HC-E DCS

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asked about the reason there were no nursing assistants, HC-E stated "[LPN-B] asked me to watch the dining room."
- At 8:30 a.m. HC-E left the dining room and R52 coughed four times after drinking coffee. There were no nursing staff in the dining room.
- At 8:31 a.m. R52 coughed three more times after drinking coffee. No nursing staff in dining room.

R52's admission MDS dated 9/12/15, indicated R52 was cognitively intact and required assistance with ADLs. R52's diagnoses on admission MDS include Parkinson's and arthritis.

R52's Nutritional CAA dated 9/16/15, noted R52 needed assist with eating at times related to Parkinson's.

R52's care card dated 11/7/15, indicated R52 required assistance with eating.

R25:
On 11/30/15, at 5:52 p.m. HC-E was observed feeding R25 three bites of turkey. No coughing observed.

On 12/2/15, continuous observation from 8:12 a.m. to 8:23 a.m. noted the following:
- At 8:12 a.m. registered nurse (RN)-A encouraged R25 to use a spoon, not a fork for oatmeal.
- At 8:15 a.m. RN-A sat down and fed R25.
- At 8:16 a.m. R25 coughed after eating oatmeal. RN-A asked "are you having trouble swallowing today?
- At 8:17 a.m. R25 ate a spoonful of oatmeal and then coughed.

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- At 8:19 a.m. R25 coughed twice after drinking thin water.
- At 8:19 a.m. RN-A went out to kitchen
- At 8:20 a.m. RN-A offered sip of nectar thickened apple juice, no coughing heard.
At 8:23 a.m. R25 ate a bite of oatmeal and then coughed. RN-A heard to say to LPN-B "I want a temp taken and listen to lungs, update hospice."

On 12/3/15, R25 was in the Rhode House dining room and was continuously observed from 7:17 a.m. to 8:37 a.m.
- At 7:17 a.m. one resident in dining room eating peaches, coffee and orange juice on table.
- At 8:33 a.m. the clinical life specialist (CLS)-E brought R25 to the dining room brought R25 thickened water and juice, then left.

R25 quarterly MDS dated 9/25/15, indicated R25 was severely cognitively impaired and required assistance with ADLs including eating. The quarterly MDS indicated R25 experienced coughing or choking during meals or medications.

During an interview on 12/3/15, at 8:52 a.m. RN-A stated we are fully staffed. When asked if residents normally ate in the dining room without nursing staff being present, RN-A replied, "No." If the staff are unavailable the nurse was supposed to monitor the dining room. There may be a short time that the might be unattended, five minutes. RN-A said that there was no risk if the residents are on a regular diet and able to feed themselves. Someone should have been in the dining room with R71 and R25 should be supervised. RN-A said, "My expectation is that there should be someone in there if there is a feeder in the dining room. There should be staff in there."

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| F 323 | Continued From page 9<br>During interview on 12/3/15, at 11:59 a.m. dietary aide-A said, "If I hear someone coughing I ask if they are ok. I will give them some water to try to rinse it down. I will go get the nurse if it is bad or if it sounds like choking. I heard [R71] coughing today. I did not check on him, I was pretty busy trying to get everyone food."<br><br>During interview on 12/3/15, at 12:50 p.m. when asked how do you know a resident's choking risk, HC-A replied, "I think you should be able to make that decision based on their diets; NDD2 and NDD3 is at risk. I read the cards, no one needs to tell me no one has told me." When asked what he would to do if heard a resident coughing, HC-A replied, "Make sure they are ok, get the nurse as soon as possible or get [RN-A]. While I was in there I did not hear any one coughing. I cannot remember hearing [R52] coughing. I do remember [R71] coughing this morning I turned around and did an assessment. I supervise the dining room for breakfast most days, I pass through the dining room at lunch 80 % of time and supper sometime. I have not had any training on dining rooms or feeding since starting here."<br><br>During interview on 12/3/15, at 10:09 a.m. DCS said all of the dietary staff are trained to do the Heimlich maneuver. Dietary staff do monitor only, if anyone required eating assistance nursing staff would help them. "I would expect a CLS or other nursing staff member to be in the dining room." Dietary staff are not trained to observe for other risks involved with eating.<br><br>During interview on 12/3/15, at 10:45 a.m. the administrator said we should have a minimum of one staff in dining room during meals. | F 323 | | |

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On 12/3/15, at 1:16 p.m. CLS-E said, "When we bring residents to the dining room we give them liquids and tell kitchen they are here. We do not stay in the dining room until all the residents are up. I brought (R25) to the dining room this morning I gave thickened liquids and let the kitchen know."

R60 was observed on 12/2/15, at 7:40 a.m. to 7:59 a.m. during breakfast, several residents were observed in the dining room. The dietary aide was observed serve out beverages, bananas and breakfast plate. During that time noted staff come in and out of the dining room and residents were alone in the dining room except when dietary aide brought the food from the kitchenette and would retrieve back briefly leaving the residents who were eating unsupervised.
-At 7:59 a.m. R60 was observed resident coughing after taking the last bite of eggs, then sneezed three times, then was able to cough some more and spit the eggs out of mouth into a napkin and some fell on the clothing protector. Resident then continued to take a bite of the toast. No facility staff were in the dining room at the time of the observation.
-At 8:02 a.m. dietary aide came out of the kitchenette and stood at the far table.

R60's care plan for nutrition dated 7/3/15, indicated resident history of dysphagia, but tolerate a regular texture diet currently. The care plan directed staff "Assist me with eating." R60's annual MDS dated 9/25/15, indicated resident required supervision with eating after set up.

R60's Nutritional Assessment dated 9/26/15, indicated resident was on a regular diet, had no

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| SAINT THERESE AT OXBOW LAKE | 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 |

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| F 323 | Continued From page 11 chewing/swallowing concerns, had history of dysphagia, but tolerated a regular textured diet. The assessment also indicated factors that affected nutrition/hydration status included history of dysphagia and indicated "Needs assist with eating."<br><br>On 12/3/15, at 12:28 p.m. RN-A stated "The care plan should read she is variable from day to day and if she was tired staff will provide assistance." When asked if a staff person was supposed to be in the dining room when residents were being served breakfast and were eating RN-A stated "There should be someone around the dining room when residents are eating." When asked if R60 was safe to eat by herself in the dining room RN-A stated "I say if she is awake and fine she is able to do it fine. There has not been any issues." -At 12:37 p.m. RN-A reviewed R60's chart indicated R60 did not have dysphagia as one of the listed active diagnoses in the physician most recent progress note dated 11/1/15. RN-A verified the speech therapy evaluation and treatment plan dated 12/2/14, had indicated R60 was at high risk for aspiration pneumonia and/or chocking and required close supervision with oral intakes. When asked what her expectation was of her staff during meals RN-A stated resident was supposed to be supervised during meals if R60 had dysphagia. RN-A did not agree however that R60 had a diagnoses of dysphagia in spite it being listed even on the current physician orders.<br><br>On 12/3/15, at 1:27 p.m. via telephone the NP stated staff was supposed to be in the dining room during meal time to supervise residents and all other residents she thought. NP indicated she would have deferred to the recommendations speech therapy had indicated to provide | F 323 | | |

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supervision with meals as resident was at risk for aspiration pneumonia and choking Even though the family had declined to follow with diet consistency recommendation. NP further verified R60 had a diagnosis of dysphagia however had not been notified of any concerns with coughing.

Resident Dining policy dated November 2012, directed staff:
"I. The nurse is responsible to designate at least 1 nursing staff member to be physically present in the dining room until the meal had been completed.
A. Nurse monitors for adequate assistance, safety issues, and infection control practices, dignity of residents, proper positioning, adequate food intake, and resident behaviors needing attention. The nurse assists with feeding residents as needed..."

R52, R71 and R48's siderails were not securely fastened to the bed frame.

R52's room was observed on 12/1/15, at 7:35 a.m. The right transfer bar attached to the bed was noted to be loose and gave way two inches either way when the rail was tested.

R52's diagnoses included non-displaced bimalleolar fracture, muscle weakness, Parkinson's, difficulty walking and osteoarthritis obtained from Admission Record dated 12/3/15.

R52's fall CAA dated 9/18/15, indicated "resident is a potential risk for falls while in this facility related to having a history of falls in the past 0-30 days and 2-6 months. Resident is requiring transfer and ambulation assist and is currently

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wearing a cam boot on his right foot due to a Bimalleolar fracture." "Fall risk assessment places him at high risk for falls related to medication and history of falls and a diagnosis of Parkinson's disease."

R52's Positioning Device Evaluation dated 10/11/15, indicated resident had transfer bars in bed to aid with repositioning and mobility. The assessment did not indicate the device had been checked to make sure it was properly affixed to the bed frame.

R52's 14 day scheduled MDS dated 10/21/15, indicated R52 required extensive physical assist of one to two staff with bed mobility and transfers respectively. Care plan dated 11/14/15, indicated R52 needed help to move in bed due to limited mobility, degenerative joint disease (DJD) and had functional strength impairment. The care plan indicated R52 used transfer bars to assist with bed mobility.

R52's Fall Risk Assessment dated 12/1/15, indicated resident had a high fall risk, had a fall history, had decreased muscle coordination and required hands on assistance to move from place to place.

R71's room was observed on 12/01/15, at 8:45 a.m. and the left rail was noted to be loose on the bed with approximately 15 degrees of flexibility.

R71's annual MDS dated 8/28/15, indicated R71's diagnoses included COPD, Heart failure, diabetes, anxiety and dementia.

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R71's care plan dated 6/17/15, indicated R71 needed assistance to move in bed due to chronic back pain and decreased mobility, "I am able to reposition myself side to side in bed with transfer bars." The care plan indicated R71 used transfers bars to aide with bed mobility.

R71's Fall CAA dated 8/28/15, indicated resident had the potential risk for falls, was at a high risk for falls, required extensive assist of two for transfers, was non-ambulatory at that time and had a diagnosis of dementia.

R71's Visual Bedside Kardex Report dated 10/5/15, indicated resident used transfer to aide with bed mobility.

R71's Positioning Device Evaluation dated 11/20/15, indicated resident had transfer bars however did not indicated the reason for them and did not indicated device had been checked to make sure it was properly affixed to the bed frame.

On 12/1/15, at 3:10 p.m. the plant operations supervisor (POS) and surveyor went to R52's and R71's rooms, POS stated "it ' s a clip that snaps into the grove to prevent it from snapping out " when asked how the transfer bars were mounted to the bed frame. POS indicated he would check with the manufacturer how the bedrails would be tightened. When asked how often and who checked the transfer bars for proper fit POS stated, "They have not been checked by maintenance except nursing would as they use them. I have never gotten any reports about this and now will have to look at them. Without taking them apart I would not know until I take one or two apart and look at the wear and tear on the

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beds as they have been used for the last four years." POS verified the transfer bars were loose in R52's and R71's beds after going into another room on the same floor with the transfer bars which were observed to be firm and affixed to the bed frame.

On 12/1/15, at 3:32 p.m. CLS-B indicated R52 and R71 used the transfer bars when being assisted with cares which included turning around from side to side. When asked who maintenance concerns were reported to regarding transfer bars being loose, CLS-B stated maintenance would be updated and would then come and fix the loose transfer bars.

On 12/2/15, at 1:37 p.m. RN-A nurse manager acknowledged the transfer bars were loose after touching them indicated the MD had indicated there was a pin that maintenance director (MD) thought was supposed to be replaced as the parts would not be tightened.

On 12/2/15, at 2:02 p.m. the DNS stated when asked what her expectations was for staff to report loose transfer bars, DNS stated "staff should report loose transfer bars to supervisor and nurse should put a maintenance slip in, and would call. It's a safety concern, it would be higher up on the list for maintenance to do. We would not let it sit. This would include a call to maintenance, along with the process of putting a maintenance slip in." When asked if nursing had a system of checking to make sure transfer bars were in proper function, DNS stated that would be preventative maintenance for maintenance to do. DNS also stated the CLS's would let nurses know if resident could not use rails, then they would be re-assessed. DNS acknowledged maintenance

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should have an on-going equipment check for transfer bars.

Positioning Device: Positioning Rails/Bed Transfer Bars/Sheppard Hooks policy dated March 2013, indicated bed/wheelchair positioning device may be used to aid in mobility and promote resident independence. The policy however did not indicate if device was checked each time to make sure it was properly fitting and who was responsible for doing it.

Service Manual Hill-Rom® 100 Low Bed Service Manual Product No.P3930 147731 Rev 1 directed "Inspection: Do a periodic inspection to make sure all bed functions operate correctly, especially the safety features. Safety features include, but not limited to these:
· Connectors where the bed sections bolt together; tightened as necessary
· Siderail latching mechanism
· Caster braking systems
Even though the manual outline the above features to be checked periodically the beds had not been checked for four years within which they had been purchased and used.

On 12/2/15, at 7:21 a.m. R48 was sleeping in bed. At 8:52 a.m. R48 was seated at the breakfast table waiting for her meal.
On 12/2/15, at 1:25 p.m. R48 stated she used her transfer bars for bed mobility.
On 12/3/15, at 7:49 a.m. observed CLS-D providing cares for R48. During cares, when R48 rolled over to her right side she held the transfer bars.

Face sheet diagnoses included anxiety disorder, fracture of coccyx and history of falling.

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The MDS dated 11/5/15, indicated resident was cognitively intact, required transfers with bed mobility, was extensive two person assist with toileting, and required extensive one person assist with dressing and personal hygiene.

The CAA dated 8/14/15, indicated R48 had impaired balance during transitions.

Undated, print date 12/3/15, visual/bedside kardex report indicated R48 used transfer bars to assist with bed mobility and needed assist of two with toileting.

Care Plan dated 9/17/15, indicated R48 was at risk for falls due to history of falls with fracture and diagnosis of lumbago. It indicated R48 needed help to move in bed due to limited mobility, fracture, pain, and functional strength impairment. R48 was able to assist with use of grab bar and assist of one. It further indicated R48 used transfer bars to assist with bed mobility.

On 12/2/15, at 9:52 a.m. CLS-D stated R48's left side transfer bar was loose, the other transfer bar was just as loose, and R48 could transfer herself.
On 12/2/15, at 10:00 a.m. LPN-B observed transfer bars and stated both transfer bars were loose. She further stated it did not matter if R48 used them, they should be fixed and she would call maintenance for repair.
On 12/2/15, at 10:13 a.m. RN-A stated transfer bars were a little loose, they had a pin in them, could not be tightened and would probably have to be replaced. She further indicated R48 had a spatial mattress to prevent arms from getting caught, did not use bars for transfers, and felt more secure with them.

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| F 323 | Continued From page 18<br><br>On 12/2/15, at 1:18 p.m. LPN-B stated loose transfer bars were a safety concern.<br><br>On 12/2/15, at 2:02 p.m. DCS stated CLS's should report loose transfer bars to their supervisor, the nurse enters a maintenance slip and calls. She further stated it was a safety concern and would be higher up on the list for maintenance work. They would not let it sit. That included a call to maintenance, along with the process of entering a maintenance slip. DCS stated the system for checking transfer bars would be preventative maintenance. CLS's would inform nurses if a resident could not use transfer bars and they would be re-assessed. She indicated maintenance should have an on-going transfer bar equipment check.<br><br>Fall protocol assessment policy dated 8/11/15, indicated "II. Planning/Interventions A. resident will be reviewed and individualized interventions established to prevent or reduce falls upon admission, after each fall, and with monthly care plan review."<br><br>Positioning Device: Positioning rails/bed transfer bars/shepherd hooks policy dated 2/11, indicated "residents and family will be involved in the decision to utilize siderail/transfer bars to assist the resident to maintain their highest level of function. I. residents that would benefit from a bed positioning device will be assessed and verbal education provided as needed. B. positioning device evaluation may include education of residents on the risk/benefits of device use." | F 323 | | |
| F 329 | 483.25(l) DRUG REGIMEN IS FREE FROM | F 329 | | 1/13/16 |

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| F 329 SS=D | Continued From page 19 UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 1 of 5 residents (R25) had indications for the use of Seroquel (an antipsychotic drug used to treat various mental illness), including resident specific target behaviors related to psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), duloxetine delayed release (an antidepressant) | F 329 | Behavior and Psychological Symptoms of Dementia and Psychotropic Medications and Monitoring Policy was reviewed and revised.<br><br>All nursing staff were re-educated on the policy by 1/13/16.<br><br>R25 chart was reviewed, resident passed | |

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| F 329 | Continued From page 20<br>and for Trazodone (an antidepressant medication) used for sleep.<br><br>Findings include:<br><br>R25's Social Service Review Forms dated 6/10/15, 6/16/15, 6/30/15, indicated no behaviors. Social Service Review Form dated 9/25/15, indicated R25 was noted to be very restless and attempted to get out of wheelchair on multiple occasions. R25 was also noted to be aggressive toward staff while attempting to provide cares on two separate occasions.<br><br>Psychotropic Drug use Care Area Assessment dated 7/2/15, indicated adverse side effect of antidepressants exhibited by R25 were anxiety and delirium. The adverse side effect of antipsychotics exhibited by R25 were lethargy, depression and delirium. The adverse side effect of anxiolytics (antianxiety) exhibited by R25 included sedation, disturbances of gait, delirium and depression.<br><br>The progress notes were reviewed from August 2015 going forward and the following was noted: R25 started on Seroquel on 8/17/15. A review of R25's progress notes indicated R25 fell on 8/23/15, at 6:55 p.m. and had no injury, 8/28/15, at 7:20 a.m. with skin tears to left elbow, 9/7/15, at 5:45 p.m. with a skin tear to right forearm, 9/18/15, at 9:30 a.m. with no injury, and on 10/3/15, at 1:15 p.m. with no injury.<br><br>R25 quarterly MDS dated 9/25/15, indicated R25 was severely cognitively impaired and required assistance with activities of daily living (ADLs). The Quarterly MDS indicated R25's diagnoses included heart failure, chronic obstructive | F 329 | away 12/18/15 on hospice care.<br><br>An audit was completed on all residents whom have psychotropic meds ordered and comprehensively assessed to ensure compliance.<br><br>Ongoing audits will be completed by the Clinical Director/designee to ensure compliance for 10% of the facility and ongoing per RAI schedule. Findings will be reported quarterly at the QAA. | |

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pulmonary disease, depression and dementia. In addition, the quarterly MDS indicated R25 was not experiencing hallucinations, delusions or any behaviors.

R25's care plan printed 10/7/15, instructed staff: BEHAVIOR: "I have a history of making suicidal statements and attempting to harm myself. I also have a history of being verbally aggressive with staff and strike out at them physically. I have a history of expressions of sadness, isolation, and refusing meals. I have been evaluated by psychology and my behaviors are managed currently. I take trazodone to manage my depression and help increase my hours of restful sleep and appetite. I have become more restless/agitated/combative with cares and now take Seroquel to manage my symptoms. Interventions included administer psychotropic medication per MD/NP [medical doctor/nurse practitioner] order, monitor for adverse effects from Trazodone, Seroquel and Cymbalta. Monitor hours of sleep every shift. Provide dark, quiet environment at night and close door."

MOOD: "My diagnosis of depression and insomnia places me at risk for symptoms of depression and anxiety. At risk for confusion and altered mood. At risk for having a negative outlook and experiencing mood swings. I have episodes of delusions/hallucinations due to altered mental status. Interventions included all staff will offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a light box in my room that turns on in the morning and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark,

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quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety."

The Physician Order Summary signed 11/17/15, indicated R25 was to receive Seroquel 25 milligrams (mg) one time a day and Seroquel 50 mg two times a day for anxiety, agitation and delusions. R25 could also receive Seroquel 25 mg every six hours as needed (PRN) for agitation. The Physician Order Summary also indicated R25 was to receive duloxetine delayed release capsule 60 mg every day for depression and Trazodone 25 mg for insomnia.

Behavior symptoms:
A review of Medication Administration Record (MAR) Sheets and Target Behavior Form (TBF) Sheets from September through November 2015 noted the following:

September 2015
MAR-Seroquel 25 mg every (q) 6 hours as needed (prn) for agitation was given 17 times in September 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only twice and nonpharmacological interventions attempted prior to medication administration were charted only once in the Progress Notes which were reviewed from August 2015 going forward or the MAR.

TBF dated Sep-15 for Seroquel: Frequent movements: indicated R25 had 17 attempts to get up/down (the TBF lacked information as to where the resident would get/down from) and six delusions of the past. R25 experienced

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| **SAINT THERESE AT OXBOW LAKE** | **5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443** |

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undocumented side effects on five of 30 days. There was a check mark in the box which indicated a side effect, but it was unknown what the side effect was, and if medical intervention would be necessary. The check marks and plus signs were not explained in the progress notes, and did not match the administration times. The TBF lacked specific target for the antipsychotic medication.

October 2015
MAR-Seroquel 25 mg q 6 hours prn for agitation was given 13 times in October 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only once and nonpharmacological interventions attempted prior to medication administration were charted only once in the progress notes or medication record.

TBF-dated Sep-15 for October: Agitation (getting up/down) indicated R25 had nine attempts and delusions of the past indicated R25 had nine delusions and did not experience side effects.

November 2015
MAR-Seroquel 25 mg q 6 hours as needed (prn) for agitation was given three times in November 2015. Prior to PRN Seroquel administration, behaviors warranting medication were not charted. Nonpharmacological interventions attempted prior to medication administration were not charted in the Progress Notes or MAR.

TBF-dated November 2015 for Seroquel: Frequent movements, attempting to get up/down indicated R25 had nine attempts and delusions/hallucinations indicated R25 had one delusions/hallucinations and did not experience any side effects.

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The Cardinal Health package insert and label information dated May 2, 2013, for Seroquel lists Schizophrenia and Bipolar Disorder as indication for use. It also indicates "Seroquel is not approved for the treatment of patients with dementia related psychosis." Package insert also indicated, "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose."

Non pharmacological interventions identified on care plan printed 10/7/15, indicated all staff will offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a light box in my room that turns on in the morning and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark, quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety." All interventions except light box were in place prior to starting on Seroquel.

Mood symptoms:
TBF- dated Sep-15 for duloxetine delayed release: angry outbursts indicated R25 had four outbursts and experienced an undocumented side effect once.
TBF-dated October-15 for duloxetine delayed release: angry outbursts indicated R25 had one outburst and experienced an undocumented side effect once.

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TBF-dated November 2015, for duloxetine delayed release: angry outbursts indicated R25 did not have any outbursts and had restlessness four times. R25 did not experience any side effects.

Eli Lilly and Company prescribing information dated June 2015, for duloxetine delayed release lists major depression, generalized anxiety disorder, Diabetic peripheral neuropathic pain, Fibromyalgia, Chronic musculoskeletal pain as the indication for usage. Angry outbursts was not listed as an indication for use of Cymbalta.

Sleep:
TBF- dated Sep-15 for Remeron (an antidepressant): inability to sleep indicated R25 had trouble four evenings and did not experience side effects.
TBF-dated October-2015, for Trazodone: inability to sleep indicated R25 had trouble one day shift. Refusals of cares two times. R25 experienced side effects once.
TBF-dated November 2015, for Trazodone: inability to sleep indicated R25 did not have any trouble sleeping. R25 did not experience any restlessness and did not experience side effects.

Organon Pharmaceuticals USA Remeron package insert and label information dated October 30 2012, lists major depression as the indication for usage.

PD-RX Pharmaceuticals Inc. Trazodone package insert and label information dated March 21 3008, lists depression as the indication for usage. R25's significant MDS dated 6/30/15, and quarterly MDS dated 9/25/15, did not indicate R25 was having any trouble sleeping. Refusal of care was

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not listed as an indication of use for Remeron or Trazodone.

Even though the facility had identified target behaviors for the psychotropic medications, the target behaviors lacked appropriate specific behaviors for each of the psychotropic categories. In addition, the medications that were administration lacked non-pharmacological interventions and monitoring of adverse effects for the use of the psychotropic medication.

During interview on 12/0/15, at 2:23 p.m. clinical life specialist (CLS)-D stated, "We do not write down the behaviors, the nurses do. R25 could be physical, might try to hit staff or scream get out of my room. When doing that, we will call nurse to try to explain what we were doing. If it does not work, we would follow what nurse says, most likely leave him and reapproach later."

On 12/0/15 at 2:45 p.m. registered nurse (RN)-D stated, "We monitor residents on antipsychotics, watch how they react with cares or with other residents and daily activities. We watch for side effects, physical changes and update nurse practitioner as necessary. We monitor for side effects every day. I am not sure about orthostatic blood pressures or labs. Only the nurse's chart in the behavior book, the nursing assistants tell the nurses."

On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when

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you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same."

On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 "had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo."

On 12/4/15, at 8:32 a.m. RN-E stated for antipsychotics "We use the Psychotropic Medication Quarterly Review. I don't see any analysis that shows if this medication is working. I don't see anything in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual sig [significant] change and quarterly."

On 12/4/15, at 8:46 a.m. the director of clinical services (DCS) stated, "I would expect them to chart the reason for administering a PRN in the electronic medication record. I would expect them to complete the assessments and I would expect the assessments to contain analysis of the effectiveness of the medication side effects and need for continued use."

Psychotropic Medications and Monitoring dated January 2013 instructed staff all residents receiving a medication to alter a behavior are to have an approved diagnosis, reason for use, informed consent prior to initiation of medication, a therapeutic goal and symptoms monitored. The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have

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| F 329 | Continued From page 28<br>been attempted.<br><br>"IV. Target Behavior monitoring will be initiated for residents that have orders for any medication with the primary purpose to change or alter a behavior, and/or sleep pattern."<br>B. "Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive etc. need further explicit behaviors identified."<br>V. Side effect monitoring will be completed for all residents with psychotropic medication orders. Orthostatic hypotension will be assessed monthly and document on TAR (Treatment administration record). | F 329 | | |
| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors. | F 356 | | 1/13/16 |

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| F 356 | Continued From page 29<br>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure daily nursing hours were posted as required. This had the potential to affect all 62 residents and the public.<br><br>Findings include:<br><br>On 11/30/15, at 11:38 a.m. on entrance to the facility, at the receptionist desk was a sign that indicated the survey results and the staff posting were located inside the red three ring binder on the counter. Upon opening the observed binder the daily staff posting for 11/29/15, was posted on a clear plastic protector sheet in front of the binder instead.<br>-At 11:49 a.m. staffing coordinator (SC) stated she was supposed to change the staff posting when she got in the morning Monday through Friday and on the weekend, the receptionist or the charge person was supposed to switch it and put the previous day under her office door. SC further stated, "That was my bad I did not double check it this morning."<br><br>On 12/3/15, at 11:10 a.m. the executive director stated the staffing coordinator and the assistant administrator were supposed to switch the daily | F 356 | Posting of Nursing Hours Policy has been reviewed and updated.<br><br>Staffing coordinator and Licensed Staff will be educated on the policy by 1/13/16.<br><br>Random audits will be completed weekly for 90 days to ensure compliance. Results will be shared at the QA Committee meeting, action plans developed as needed, and determine the need for ongoing monitoring.<br><br>Administrator or designee is responsible for ongoing compliance. | |

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| F 356 | Continued From page 30<br>staff posting for the current date/day. Administrator acknowledged even though the daily staff posting for the current date was behind the previous days the public and residents would not know it behind.<br><br>Nursing hours posting policy dated April dated November 2014, directed staff to "3. Remove previous day sheet for that shift and file in staffing office." The policy did not however indicate who was responsible for removing and making sure the posting was accurate and reflected the current day." | F 356 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the pharmacist failed to ensure 1 of 5 residents (R25) had indications for the use of Seroquel (an antipsychotic drug used to treat various mental illness), including resident specific target behaviors related to psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), | F 428 | Clinical Director reviewed facility process with Pharmacy Consultant to ensure all residents have individualized consults completed per guidelines.<br><br>Behavior and Psychological Symptoms of Dementia and Psychotropic Medications and Monitoring Policy was reviewed and | 1/13/16 |

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| F 428 | Continued From page 31<br>duloxetine delayed release (an antidepressant) and for Trazodone (an antidepressant medication) used for sleep. In addition, the facility failed to respond to ensure consultant pharmacist recommendations were acted upon for R25.<br><br>Findings include:<br><br>R25's Social Service Review Forms dated 6/10/15, 6/16/15, 6/30/15, indicated no behaviors. Social Service Review Form dated 9/25/15, indicated R25 was noted to be very restless and attempted to get out of wheelchair on multiple occasions. R25 was also noted to be aggressive toward staff while attempting to provide cares on two separate occasions.<br><br>Psychotropic Drug use Care Area Assessment dated 7/2/15, indicated adverse side effect of antidepressants exhibited by R25 were anxiety and delirium. The adverse side effect of antipsychotics exhibited by R25 were lethargy, depression and delirium. The adverse side effect of anxiolytics (antianxiety) exhibited by R25 included sedation, disturbances of gait, delirium and depression.<br><br>The progress notes were reviewed from August 2015 going forward and the following was noted: R25 started on Seroquel on 8/17/15. A review of R25's progress notes indicated R25 fell on 8/23/15, at 6:55 p.m. and had no injury, 8/28/15, at 7:20 a.m. with skin tears to left elbow, 9/7/15, at 5:45 p.m. with a skin tear to right forearm, 9/18/15, at 9:30 a.m. with no injury, and on 10/3/15, at 1:15 p.m. with no injury.<br><br>R25 quarterly MDS dated 9/25/15, indicated R25 was severely cognitively impaired and required | F 428 | revised.<br><br>R25 chart reviewed and resident passed away on 12/18/15.<br><br>A facility audit was completed on Pharmacy consult reviews to ensure compliance with responses.<br><br>An audit was completed on all residents whom have psychotropic meds ordered and comprehensively assessed to ensure compliance.<br><br>Clinical Coordinators re-educated on ensuring that consults get completed timely by 1/13/16.<br><br>Ongoing audits and tracking of monthly pharmacy consults will be completed monthly by Clinical Director to ensure compliance. Findings will be reported quarterly at the QAA. | |

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assistance with activities of daily living (ADLs). The Quarterly MDS indicated R25's diagnoses included heart failure, chronic obstructive pulmonary disease, depression and dementia. In addition, the quarterly MDS indicated R25 was not experiencing hallucinations, delusions or any behaviors.

R25's care plan printed 10/7/15, instructed staff: BEHAVIOR: "I have a history of making suicidal statements and attempting to harm myself. I also have a history of being verbally aggressive with staff and strike out at them physically. I have a history of expressions of sadness, isolation, and refusing meals. I have been evaluated by psychology and my behaviors are managed currently. I take trazodone to manage my depression and help increase my hours of restful sleep and appetite. I have become more restless/agitated/combative with cares and now take Seroquel to manage my symptoms. Interventions included administer psychotropic medication per MD/NP [medical doctor/nurse practitioner] order, monitor for adverse effects from trazodone, Seroquel and Cymbalta. Monitor hours of sleep every shift. Provide dark, quiet environment at night and close door."

MOOD: "My diagnosis of depression and insomnia places me at risk for symptoms of depression and anxiety. At risk for confusion and altered mood. At risk for having a negative outlook and experiencing mood swings. I have episodes of delusions/hallucinations due to altered mental status. Interventions included all staff will offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a light box in my room that turns on in the morning

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and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark, quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety."

The Physician Order Summary signed 11/17/15, indicated R25 was to receive Seroquel 25 milligrams (mg) one time a day and Seroquel 50 mg two times a day for anxiety, agitation and delusions. R25 could also receive Seroquel 25 mg every six hours as needed (PRN) for agitation. The Physician Order Summary also indicated R25 was to receive duloxetine delayed release capsule 60 mg every day for depression and Trazodone 25 mg for insomnia.

Behavior symptoms:
A review of Medication Administration Record (MAR) Sheets and Target Behavior Form (TBF) Sheets from September through November 2015 noted the following:

September 2015
MAR-Seroquel 25 mg every (q) 6 hours as needed (prn) for agitation was given 17 times in September 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only twice and nonpharmacological interventions attempted prior to medication administration were charted only once in the Progress Notes which were reviewed from August 2015 going forward or the MAR.

TBF dated Sep-15 for Seroquel: Frequent movements: indicated R25 had 17 attempts to

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| F 428 | Continued From page 34<br>get up/down (the TBF lacked information as to where the resident would get/down from) and six delusions of the past. R25 experienced undocumented side effects on five of 30 days. There was a check mark in the box which indicated a side effect, but it was unknown what the side effect was, and if medical intervention would be necessary. The check marks and plus signs were not explained in the progress notes, and did not match the administration times. The TBF lacked specific target for the antipsychotic medication.<br><br>October 2015<br>MAR-Seroquel 25 mg q 6 hours prn for agitation was given 13 times in October 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only once and nonpharmacological interventions attempted prior to medication administration were charted only once in the progress notes or medication record.<br><br>TBF-dated Sep-15 for October: Agitation (getting up/down) indicated R25 had nine attempts and delusions of the past indicated R25 had nine delusions and did not experience side effects.<br><br>November 2015<br>MAR-Seroquel 25 mg q 6 hours as needed (prn) for agitation was given three times in November 2015. Prior to PRN Seroquel administration, behaviors warranting medication were not charted. Nonpharmacological interventions attempted prior to medication administration were not charted in the Progress Notes or MAR.<br><br>TBF-dated November 2015 for Seroquel: Frequent movements, attempting to get up/down indicated R25 had nine attempts and | F 428 | | |

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delusions/hallucinations indicated R25 had one delusions/hallucinations and did not experience any side effects.

The Cardinal Health package insert and label information dated May 2, 2013, for Seroquel lists Schizophrenia and Bipolar Disorder as indication for use. It also indicates "Seroquel is not approved for the treatment of patients with dementia related psychosis." Package insert also indicated, "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose."

Non pharmacological interventions identified on care plan printed 10/7/15, indicated all staff will offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a light box in my room that turns on in the morning and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark, quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety." All interventions except light box were in place prior to starting on Seroquel.

Mood symptoms:
TBF- dated Sep-15 for duloxetine delayed release: angry outbursts indicated R25 had four outbursts and experienced an undocumented side effect once.
TBF-dated October-15 for duloxetine delayed

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release: angry outbursts indicated R25 had one outburst and experienced an undocumented side effect once.
TBF-dated November 2015, for duloxetine delayed release: angry outbursts indicated R25 did not have any outbursts and had restlessness four times. R25 did not experience any side effects.

Eli Lilly and Company prescribing information dated June 2015, for duloxetine delayed release lists major depression, generalized anxiety disorder, Diabetic peripheral neuropathic pain, Fibromyalgia, Chronic musculoskeletal pain as the indication for usage. Angry outbursts was not listed as an indication for use of Cymbalta.

Sleep:
TBF- dated Sep-15 for Remeron (an antidepressant): inability to sleep indicated R25 had trouble four evenings and did not experience side effects.
TBF-dated October-2015, for Trazodone: inability to sleep indicated R25 had trouble one day shift. Refusals of cares two times. R25 experienced side effects once.
TBF-dated November 2015, for Trazodone: inability to sleep indicated R25 did not have any trouble sleeping. R25 did not experience any restlessness and did not experience side effects.

Organon Pharmaceuticals USA Remeron package insert and label information dated October 30 2012, lists major depression as the indication for usage.

PD-RX Pharmaceuticals Inc. Trazodone package insert and label information dated March 21 3008, lists depression as the indication for usage. R25's

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significant MDS dated 6/30/15, and quarterly MDS dated 9/25/15, did not indicate R25 was having any trouble sleeping. Refusal of care was not listed as an indication of use for Remeron or Trazodone.

Even though the facility had identified target behaviors for the psychotropic medications, the target behaviors lacked appropriate specific behaviors for each of the psychotropic categories. In addition, the medications that were administration lacked non-pharmacological interventions and monitoring of adverse effects for the use of the psychotropic medication.

The Undated Pharmacy Visit Log indicated the consultant pharmacist reviewed R25's chart and made recommendations as indicated:
-7/23/15, "labs in chart, hitting x1, agitation x1, AIMS [Abnormal Involuntary Movement Scale] done non-significant irregularity"
-8/28/15, "res [resident] stable, morphine increased, non-significant irregularity"
-9/30/15, "1 hour of agitation, seroquel increased, non significant irregularity"
-10/23/15, "Dx [diagnosis] for delusional disorder, non significant irregularity"
-11/16/15, "? ortho [orthostatic] bp [blood pressure]-unable res stable non significant irreg [irregularity]"
Copy of Pharmacy Visit Log was requested and was not provided. The pharmacist did not address the use of non-pharmacological interventions prior to the use of the medications and the lack of the appropriate target behavior/symptoms for use of the psychotropic medications.

During interview on 12/0/15, at 2:23 p.m. clinical

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life specialist (CLS)-D stated, "We do not write down the behaviors, the nurses do. R25 could be physical, might try to hit staff or scream get out of my room. When doing that, we will call nurse to try to explain what we were doing. If it does not work, we would follow what nurse says, most likely leave him and reapproach later."

On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same."

On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 "had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo."

On 12/4/15, at 8:32 a.m. RN-E stated for antipsychotics "We use the Psychotropic Medication Quarterly Review. I don't see any analysis that shows if this medication is working. I don't see anything in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual sig [significant] change and quarterly."

On 12/4/15, at 8:46 a.m. the director of clinical services (DCS) stated, "I would expect them to chart the reason for administering a PRN in the

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electronic medication record. I would expect them to complete the assessments and I would expect the assessments to contain analysis of the effectiveness of the medication side effects and need for continued use."

During interview on 12/4/15, at 9:32 a.m. pharmacist stated, "We started coming to the facility in July. I will make a note on the pharmacy log every time I check the chart. If I write non significant irregularity on the log I will write a pharmacy recommendation and expect a response by next visit. A request will be re-written if no response. For residents on an antipsychotic I expect an AIMs when the medication is started, and every six months. I would expect orthostatic blood pressures at minimum quarterly although I believe the facility is doing them monthly. I would expect to see documentation in the chart of usage of non pharmacological interventions. I would expect to see them document the behaviors that triggers use of a prn and it's effectiveness The diagnosis for R25 is not what I would choose but it is appropriate."

Psychotropic Medications and Monitoring dated January 2013 instructed staff all residents receiving a medication to alter a behavior are to have an approved diagnosis, reason for use, informed consent prior to initiation of medication, a therapeutic goal and symptoms monitored. The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have been attempted.

"IV. Target Behavior monitoring will be initiated for residents that have orders for any medication with the primary purpose to change or alter a

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| F 428 | Continued From page 40<br>behavior, and/or sleep pattern."<br>B. "Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive etc. need further explicit behaviors identified."<br>V. "Side effect monitoring will be completed for all residents with psychotropic medication orders. Orthostatic hypotension will be assessed monthly and document on TAR [Treatment Administration Record]." | F 428 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>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.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and | F 431 | | 1/13/16 |

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| F 431 | Continued From page 41<br>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 2 of 5 narcotic boxes were double locked to prevent diversion. This had the potential to affect the 10 residents who had narcotic medications stored in cabinet located in the nursing station.<br><br>Findings include:<br><br>Rhode House<br>On 11/30/15, at 12:11 p.m. during a medication observation for R25, registered nurse (RN)-B was observed open a cabinet above the sink located in the back of the nursing station. Upon opening the cabinet using a small key, two red boxes were observed stored on each of the shelves. The two boxes labelled ProBox were observed to have pad locks that were not locked even though RN- indicated the facility used those to store narcotics.<br><br>On 11/30/15, at 6:07 p.m. during a random observation on the Rhode House neighborhood, two red boxes were observed when a staff member unlocked a cabinet at the nurse ' s station. The boxes were observed with padlocks on both but the padlocks were not locked.<br><br>On 12/1/15, at 8:39 a.m. registered nurse (RN)-C stated residents who received Tramadol and | F 431 | Controlled Substance policy was reviewed, all Licensed staff were re-educated on current policy by 1/13/16.<br><br>Audits will be completed to ensure that the narcotic medications are double locked per policy weekly x 90 days by the Clinical Director/designee and findings will be reported quarterly at the QAA. | |

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narcotic had those stored at the nursing station in the cabinet and were supposed to be double locked.

On 12/3/15, at 6:22 a.m. licensed practical nurse (LPN)-B was observed open the cabinet above the sink where the narcotic boxes were stored. LPN- reached out grabbed both red narcotic boxes off the shelves and set them on top of the counter and both had the padlock but was not locked, opened one after the other and counted the narcotics with the night LPN-A. At 6:25 a.m. LPN-B put the boxes back into the cabinet and locked it. At 6:26 a.m. surveyor requested LPN-B to open the cabinet and RN verified both red narcotic boxes padlocks were left unlocked. When asked if the padlocks were supposed to be locked LPN-B acknowledged the padlocks were supposed to be double locked even though the cabinet was locked as narcotic were stored in the boxes.

On 12/3/15, at 2:30 p.m. the director of clinical services stated "I would expect them to follow the double locked narcotic policy" when asked her expectation of staff nurses.

On 12/4/15, at 7:48 a.m. LPN-C stated the cabinets are supposed to be kept locked because the red boxes are narcotic boxes. LPN-C the narcotic boxes are supposed to be locked with the padlocks. LPN-C indicated one of the box had Morphine, Dilaudid, Norco, Clonopin and Methadone.

Medications: Controlled Substance policy dated January 2015, directed staff "F. All Controlled Drugs will be stored in a locked box in a locked cabinet or medication room."

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| F 465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure environment was maintained in a sanitary manner and was in good repair for 13 of 35 residents.<br><br>Findings include:<br><br>On 12/3/15, at 9:02 a.m. an environmental tour was completed with executive director, assistant administrator, administrative intern, housekeeping supervisor, and plant operations director.<br><br>R25's bathroom toilet front had been observed stained yellow.<br><br>During tour, housekeeping supervisor (HS) stated bathroom toilets and entire rooms get cleaned once a week and indicated the room may be cleaned either today or tomorrow. He further stated staff calls if they had an immediate concern. In addition, they have access to the housekeeping closet supplies after hours.<br><br>R25's Quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R25 had severe cognitive impairment and required extensive one to two person assistance with most activities of daily living (ADL's). | F 465 | R25, R60, R40, R52, R44, and R71 bathrooms were cleaned and sanitized.<br><br>R25, R60, R44, R9, R24, R19, and R45 walls in resident room were repaired.<br><br>R52 scooter was cleaned.<br><br>All resident rooms were reviewed for necessary repairs. Repairs were completed.<br><br>All cleaning schedules for resident rooms were reviewed and updated to include increased cleanings of resident bathrooms.<br><br>The Department Housekeeping policy was reviewed and a Cleaning of Residents Bathrooms policy was created. Micromain scheduling policy and preventative maintenance inspections policy were reviewed.<br><br>Staff education on policies and environment cleaning/maintenance will be completed by 1/13/16.<br><br>Environmental audits will be completed on | 1/13/16 |

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| F 465 | Continued From page 44<br><br>R60's toilet riser observed with multiple large bowel movement smears.<br><br>During tour, HS confirmed smears on toilet riser and stated it had not been cleaned and would find out when it would be cleaned. Plant operations director (POD) stated he would repair wall entryway scratches and wall scratches near the bed.<br><br>R60's annual MDS assessment dated 9/25/15, indicated R60 had moderate cognitive impairment and required extensive one to two person assistance with most ADL's.<br><br>R40's bathroom toilet riser was observed with bowel movement smears on the seat.<br><br>On 12/3/15, at 9:42 a.m. HS stated he would find out when the room was scheduled for cleaning and indicated toilet risers, surfaces, all around toilets were cleaned. In addition, executive director (ED) stated it would be cleaned.<br><br>R40's quarterly MDS assessment dated 10/8/15, indicated R40 did not have a cognitive assessment and required extensive one person assistance with most ADL's.<br><br>R52's scooter's foot area was observed to be stained yellow.<br><br>On 12/3/15, at 9:52 a.m. HS stated scooters were privately owned and indicated R44 recently moved to facility. ED stated it would be cleaned.<br><br>R52's 14 day MDS assessment dated 10/21/15, indicated R52 was cognitively intact and required | F 465 | 15% of resident rooms weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring.<br><br>Plant Operations Director and/or designee is responsible for ongoing compliance. | |

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extensive one to two person assistance with most ADL's.

R44's room near bed was observed to have urine odor, there were several four to six inch light colored stains were dripping down room wall near entryway, a short gray line on the wall near head of bed, and bathroom floor had red/brown colored stains on it.

On 12/3/15, at 9:32 a.m. POD stated gray wall line was from wheelchair and would be repaired. ED stated stains would be cleaned and HS stated wall would be spot painted.

R44's quarterly MDS assessment dated 11/15/15, indicated R44 was cognitively intact and required one to two person assistance with most ADL's.

R25's oxygen tubing had been observed on the floor and several vertical lines on wall across from sink in entryway. ED stated these would be repaired.

R25's Quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R25 had severe cognitive impairment and required extensive one to two person assistance with most activities of daily living (ADL's).

R9's room observed with long scratch marks on walls near entryway. POD stated they would be repaired.

R9's annual MDS assessment dated 9/4/15, indicated R9 had moderate cognitive impairment and required extensive one to two person assistance with most ADL's.

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| F 465 | Continued From page 46<br>R24's room observed with long wall scratches near entryway.<br><br>On 12/3/15, at 9:41 a.m. POD stated they would be repaired.<br><br>R24's annual MDS assessment dated 8/25/15, indicated R24 was cognitively intact and required extensive one person assistance with most ADL's.<br><br>R19's admission MDS dated 9/9/15, indicated R19 was cognitively intact and required extensive one to two person assistance with most ADL's.<br><br>On 11/30/15, at 6:27 p.m. R19's bedroom wall was observed with long scratch mark in entryway. On 12/3/15, at 9:45 a.m. POD stated it would be repaired.<br><br>R19's admission MDS dated 9/9/15, indicated R19 was cognitively intact and required extensive one to two person assistance with most ADL's.<br><br>R71's annual MDS assessment dated 8/28/15, indicated R71 had severe cognitive impairment and required extensive one to two person assistance with most ADL's.<br><br>On 12/1/15, at 8:40 a.m. R71's bathroom wall observed with black line across from sink and several gouges on wall.<br><br>On 12/3/15, POD stated repairs would be made.<br><br>R45's bathroom wall observed with gouges in it.<br><br>POD stated it would be repaired. | F 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245619 | A. BUILDING ______<br>B. WING ______ | 12/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT THERESE AT OXBOW LAKE | 5200 OAK GROVE PARKWAY<br>BROOKLYN PARK, MN 55443 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 465 | Continued From page 47<br>R45's annual MDS assessment dated 8/25/15, indicated R45 was cognitively intact and required extensive one person assistance with most ADL's.<br><br>On 12/3/15, at 9:21 a.m. ED stated before Thanksgiving they were going to begin weekly building walk-through environmental tours. Previously it was done on an as needed basis. HS stated he routinely did daily building walk-through's with staff. He also did weekly and monthly building walk-through's with his supervisors.<br><br>On 12/3/15, at 9:26 a.m. POD stated he did periodic painting maintenance, including any reported nursing and housekeeping staff concerns. He stated the facility used Micromain system for maintenance. Staff entered a work order and maintenance picked up and resolved issues.<br><br>On 12/3/15, at 10:40 a.m. ED stated she did not think it acceptable that room toilets were cleaned only once a week. She further stated that was the reason for housekeeping closets on each unit, to enable staff to clean a toilet when it was dirty.<br><br>On 12/3/15, at 11:52 a.m. HS stated community life specialists (CLS) should be spot cleaning in between weekly room cleanings.<br>On 12/3/15, at 12:25 p.m. POD stated he did daily walk-through's to observe for any issues.<br>On 12/4/15, at 8:50 a.m. registered nurse (RN)-C, stated if he had a housekeeping concern he would call the HS and report it. If call lights were not working or he had another maintenance concern, he would update the clinical coordinator and maintenance. | F 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245619 | A. BUILDING ______ B. WING ______ | 12/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT THERESE AT OXBOW LAKE | 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 |

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|---|---|---|---|---|
| F 465 | Continued From page 48<br>12/4/15 at 8:55 a.m. CLS-(C), stated if she had a housekeeping or maintenance concern, she would call housekeeping or maintenance.<br><br>Micromain scheduling policy dated 1/16/15, indicated "policy: to ensure that all work orders are attended to in a timely manner. Purpose: Micromain work orders need to be timely and all maintenance staff need to have clear communication regarding the status of work orders and who is working on the work order so none are missed for periods of time."<br>Work order request - building maintenance and repairs policy dated 8/7/07, indicated "policy: requests for repair work orders will be routed through Micromain software system."<br>Preventative maintenance inspections policy dated 9/10, indicated "plant operations staff will conduct regular inspections of the facility to identify maintenance issues and provide repair services to remedy all issues. Purpose: to maintain a sanitary, orderly and comfortable interior. Procedure: D) all areas for inspections will be scheduled on a quarterly basis. E) follow-up random audits will be conducted by the plant operations director on a quarterly basis to ensure proper completion and quality."<br>Department Housekeeping policy dated 10/15/11, policy indicated "resident rooms will be cleaned on a regular basis." | F 465 | | |

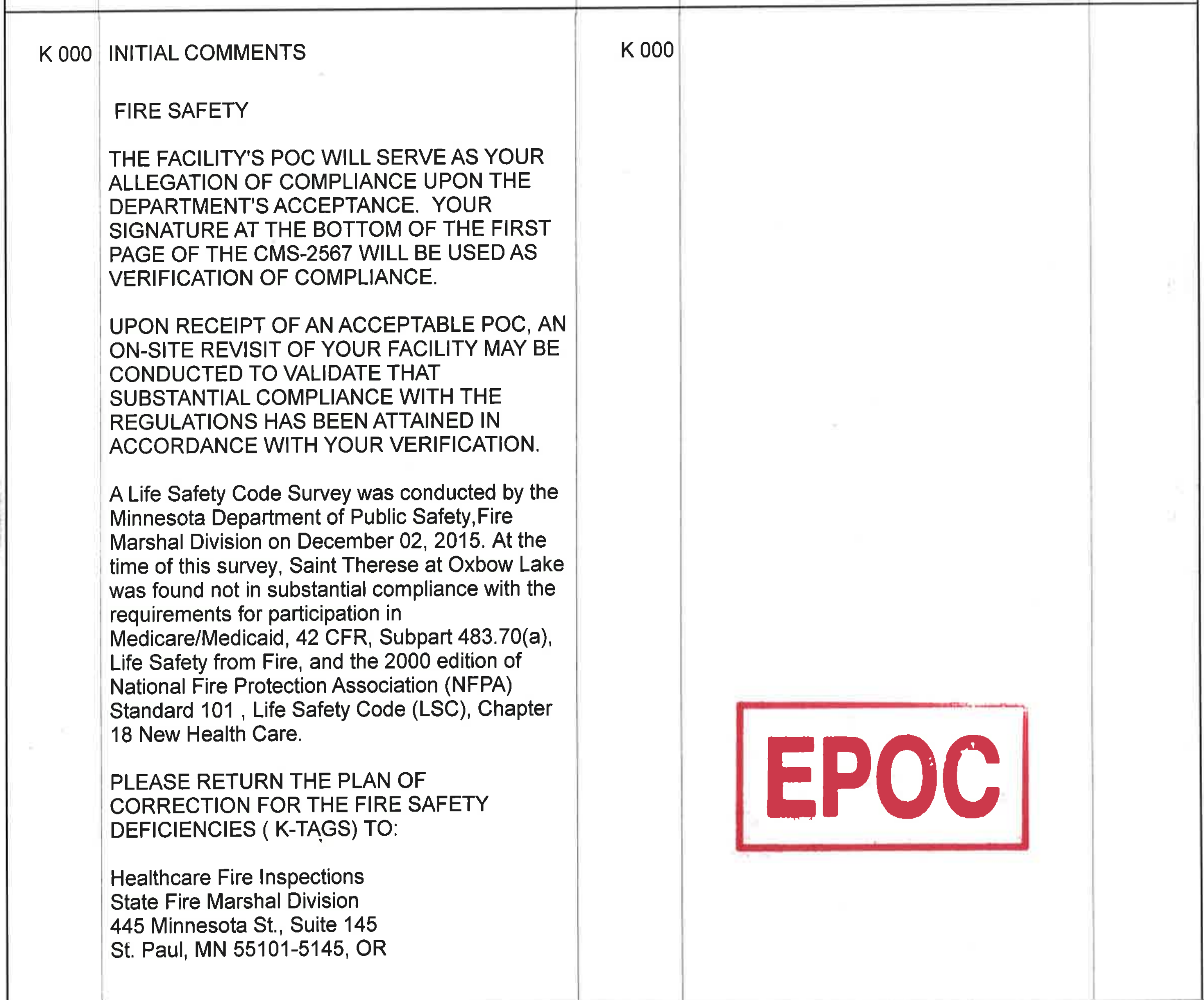
PRINTED: 01/04/2016
FORM APPROVED
OMB NO. 0938-0391

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

F5619003

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245619 | A. BUILDING **01 - MAIN BLDG**<br>B. WING ____ | **12/02/2015** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT THERESE AT OXBOW LAKE** | **5200 OAK GROVE PARKWAY**<br>**BROOKLYN PARK, MN 55443** |



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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety,Fire Marshal Division on December 02, 2015. At the time of this survey, Saint Therese at Oxbow Lake was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 , Life Safety Code (LSC), Chapter 18 New Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/30/2015 |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245619 | A. BUILDING **01 - MAIN BLDG**<br>B. WING ______ | **12/02/2015** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT THERESE AT OXBOW LAKE** | **5200 OAK GROVE PARKWAY**<br>**BROOKLYN PARK, MN 55443** |

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| K 000 | Continued From page 1<br>By email to:<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Oxbow Lake Care Center is a 2-story building with a basement. The building was constructed in 2012 and was determined to be of Type II (111) construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. The facility has a capacity of 64 beds with a census of 62 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 029<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 | K 029 | | 12/6/15 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 029 | Continued From page 2<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and staff interview, the facility has failed to provide proper protection from a hazardous area in the facility. This deficient practice could affect 20 residents, as smoke from a fire in this room could enter the corridor making it untenable.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12:00 PM on 12/02/2015, it was observed in the Road House Wing that the soiled utility room door had a 20-minute fire rated door and not a 45-minute fire rated door.<br><br>This deficient practice was verified by the Administrator at the time of inspection. | K 029 | On 12/6/15 doors were installed on the soiled utility room that have a one hour fire rating.<br><br>Plant Operations Director is responsible for monitoring these practices and to perform regular review of the fire rated doors. | |
| K 050<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on review of reports, records and staff | K 050 | On 12/21/15 a new schedule was created | 12/21/15 |

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

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| K 050 | Continued From page 3<br>interview, it was determined that the facility failed to vary the times fire drills in the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents.<br><br>Findings include:<br><br>On facility tour between between 9:00 AM and 12:00 PM on 12/02/2015, a record review revealed that the facility conducted the Evening-Shift fire drills in 2015 between the hours of 2:45 PM-3:30 PM and the Night-Shift fire drills between the hours of 5:40 AM-6:05 AM not varied times as required.<br><br>This deficient practice was verified by the Administrator at the time of the inspection. | K 050 | for the 2016 Fire Drill Schedule to identify the month, date, time of day, and location. All items will be staggered to meet the requirements of the fire drill portion of the Life Safety Code.<br><br>Plant Operations Director is responsible for monitoring the Fire drill information and documentation and will be reviewed with the Safety Committee and the Administrator. | |

Electronically delivered
December 21, 2015

Ms. Brandi Barthel, Administrator
Saint Therese At Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 55443

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5619003

Dear Ms. Barthel:

The above facility was surveyed on November 30, 2015 through December 4, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order.

This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Feel free to contact me if you have questions related to the eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 27752 | A. BUILDING: ______ B. WING ______ | 12/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>On November 30, December 1, 2, and 4, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. | 2 000 | | |

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| 2 000 | Continued From page 2<br>THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure necessary supervision for meals was provided for 4 of 5 residents (R71, R52, R25, R60) who were assessed to need supervision for meals. In addition, the facility failed to ensure bedside rails were safely secured to the bed frame to minimize the risk of injury for 3 of 3 residents (R71, R44, R52) reviewed for accidents.<br><br>Findings include:<br><br>R71, R44, R52, and R60 were left unsupervised | 2 830 | Orders received on R71, R60 for re-evaluation of swallowing and need for supervision. Care plan will be reviewed and will be updated with final recommendations per SLP.<br><br>Hospice referral made for R52 to review swallowing and meal supervisory needs. Care plan will be reviewed and updated with final recommendations.<br><br>R25 chart review completed, resident passed away 12/18/15 on hospice care. | 1/13/16 |

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| 2 830 | Continued From page 3<br>in the dining room during continuous observation of the Rhode house dining room on 12/3/15, from 7:17 a.m. to 8:37 a.m. No nursing staff was observed in the dining room during that time frame.<br><br>R71:<br>On 12/3/15, R71 was observed and the following was noted:<br>- At 7:17 a.m. one resident in dining room was eating peaches, coffee and orange juice on table.<br>- At 7:27 a.m. R71 and three other residents were in the dining room eating breakfast.<br>- At 7:28 a.m. R71 drank thickened coffee and then coughed twice. The thickened water and juice were placed in front of R71.<br>- At 7:31 a.m. R71 coughed twice.<br>- At 7:32 a.m. household coordinator (HC)-E stopped by and spoke to R71 then left.<br>- At 7:43 a.m. a staff member brought a resident to the dining room and gave the resident juice and coffee and then left immediately. Five residents remained in the dining room eating breakfast.<br>- At 7:57 a.m. staff brought three residents to the dining room and left immediately. Eight residents were in the dining room with beverages and or food in front of them.<br>- At 7:59 a.m. R71 was eating oatmeal and started coughing hard. R71 had two coughing bouts at that time.<br>- At 8:05 a.m. licensed practical nurse (LPN)-B moved the medication cart outside the dining room,<br>- At 8:14 a.m. LPN-B left the dining area HC-E entered the dining room. No nursing staff remained in dining room. Eight residents were in the dining room eating breakfast or drinking. HC-A sat down next to a resident.<br>- At 8:28 a.m. director of clinical services (DCS) | 2 830 | Residents with altered diets/consistencies will be reviewed for the need of supervision with meals. Care plan will be updated as needed.<br><br>Dining times were adjusted to ensure proper supervision of the dining room during meals by nurse/designee.<br><br>Resident Dining Policy has been reviewed and updated to ensure supervision for resident safety that require an altered diet and feeding assistance.<br><br>Education will be completed by 1/13/16.<br><br>Random audits will be completed weekly on varying meals for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring. Clinical Director and/or designee will be responsible for ongoing compliance.<br><br>R52, R71, and R44(R48 is not in the resident sample) side rails were inspected by the bed manufacturing company s technician on 12/8/15. Repairs that were needed were completed. New side rails were ordered for R52, R71, and R44 and will be replaced upon arrival.<br><br>A preventative maintenance procedure/checklist for the electric beds including side rails has been added and will be completed on all beds. | |

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| SAINT THERESE AT OXBOW LAKE | 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 2 830 | Continued From page 4<br>was overheard speaking to HC-E. DCS asked about the reason there were no nursing assistants, HC-E stated "[LPN-B] asked me to watch the dining room."<br>- At 8:30 a.m. HC-E had left the dining room and then no nursing staff was present in the dining room.<br>- At 8:37 a.m. R71 coughed after drinking thickened juice.<br><br>R71's annual Minimum Data Set (MDS) dated 8/28/15, indicated R71 was severely cognitively impaired, requiring assistance with all activities of daily living (ADLs) including supervision with eating. R71's diagnoses included chronic obstructive pulmonary disease (COPD) Heart failure, diabetes, anxiety, dementia and dysphagia (difficulty swallowing).<br><br>Nutrition Care Area Assessment (CAA) dated 8/28/15, indicated R71 was receiving a No Concentrated Sweet diet NDD2 diet (a mechanically altered dysphagia diet) with nectar thickened liquids because of dysphagia.<br><br>The Speech Therapy Evaluation and Plan of Treatment dated 1/13/15, indicated R71 was at high risk of choking and aspiration pneumonia.<br><br>During interview on 12/3/15, at 1:26 p.m. nurse practitioner (NP) stated R71 would be at risk for choking because of dementia. The NP confirmed it was expected R71 would be supervised when eating in the dining room.<br><br>During interview on 12/3/15, at 2:00 p.m. family member (F)-A stated R71 was in the hospital in January 2015 with influenza, urinary tract infection (UTI) and pneumonia (viral). "I would expect him to be supervised in the dining room. | 2 830 | The Positioning Device: Positioning Rails/Bed Transfer Bars/Sheppard Hooks policy was reviewed.<br><br>Staff will be educated on functionality of the side rails and when to report safety concerns by 1/13/16. Maintenance staff will be educated on preventative maintenance procedure and functionality of the side rails by 1/13/16.<br><br>Audits will be completed on 10% of beds weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring. Plant Operations Director and/or designee will be responsible for ongoing compliance. | |

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They should encourage him to slow down [to eat]."

R52:
On 12/3/15, from 7:17 a.m. to 8:37 a.m. R52 was observed and the following was noted:
- At 7:17 a.m. one resident in dining room eating peaches, coffee and orange juice on table.
- At 7:27 a.m. four residents eating breakfast.
- At 7:36 a.m. HC-E walked through the dining room.
- At 7:43 a.m. R52 was brought to dining room and given juice and coffee. Five residents were eating breakfast and no nursing staff were in the dining room.
- At 8:00 a.m. dietary staff brought R52 breakfast including scrambled eggs and toast.
- At 8:14 a.m. HC-E entered the dining room. Eight residents were eating breakfast.
- At 8:28 a.m. the director of clinical services (DCS) was overheard speaking to HC-E DCS asked about the reason there were no nursing assistants, HC-E stated "[LPN-B] asked me to watch the dining room."
- At 8:30 a.m. HC-E left the dining room and R52 coughed four times after drinking coffee. There were no nursing staff in the dining room.
- At 8:31 a.m. R52 coughed three more times after drinking coffee. No nursing staff in dining room.

R52's admission MDS dated 9/12/15, indicated R52 was cognitively intact and required assistance with ADLs. R52's diagnoses on admission MDS include Parkinson's and arthritis.

R52's Nutritional CAA dated 9/16/15, noted R52 needed assist with eating at times related to Parkinson's.

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R52's care card dated 11/7/15, indicated R52 required assistance with eating.

R25:
On 11/30/15, at 5:52 p.m. HC-E was observed feeding R25 three bites of turkey. No coughing observed.

On 12/2/15, continuous observation from 8:12 a.m. to 8:23 a.m. noted the following:
- At 8:12 a.m. registered nurse (RN)-A encouraged R25 to use a spoon, not a fork for oatmeal.
- At 8:15 a.m. RN-A sat down and fed R25.
- At 8:16 a.m. R25 coughed after eating oatmeal. RN-A asked "are you having trouble swallowing today?
- At 8:17 a.m. R25 ate a spoonful of oatmeal and then coughed.
- At 8:19 a.m. R25 coughed twice after drinking thin water.
- At 8:19 a.m. RN-A went out to kitchen
- At 8:20 a.m. RN-A offered sip of nectar thickened apple juice, no coughing heard.
At 8:23 a.m. R25 ate a bite of oatmeal and then coughed. RN-A heard to say to LPN-B "I want a temp taken and listen to lungs, update hospice."

On 12/3/15, R25 was in the Rhode House dining room and was continuously observed from 7:17 a.m. to 8:37 a.m.
- At 7:17 a.m. one resident in dining room eating peaches, coffee and orange juice on table.
- At 8:33 a.m. the clinical life specialist (CLS)-E brought R25 to the dining room brought R25 thickened water and juice, then left.

R25 quarterly MDS dated 9/25/15, indicated R25

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was severely cognitively impaired and required assistance with ADLs including eating. The quarterly MDS indicated R25 experienced coughing or choking during meals or medications.

During an interview on 12/3/15, at 8:52 a.m. RN-A stated we are fully staffed. When asked if residents normally ate in the dining room without nursing staff being present, RN-A replied, "No." If the staff are unavailable the nurse was supposed to monitor the dining room. There may be a short time that the might be unattended, five minutes. RN-A said that there was no risk if the residents are on a regular diet and able to feed themselves. Someone should have been in the dining room with R71 and R25 should be supervised. RN-A said, "My expectation is that there should be someone in there if there is a feeder in the dining room. There should be staff in there."

During interview on 12/3/15, at 11:59 a.m. dietary aide-A said, "If I hear someone coughing I ask if they are ok. I will give them some water to try to rinse it down. I will go get the nurse if it is bad or if it sounds like choking. I heard [R71] coughing today. I did not check on him, I was pretty busy trying to get everyone food."

During interview on 12/3/15, at 12:50 p.m. when asked how do you know a resident's choking risk, HC-A replied, "I think you should be able to make that decision based on their diets; NDD2 and NDD3 is at risk. I read the cards, no one needs to tell me no one has told me." When asked what he would to do if heard a resident coughing, HC-A replied, "Make sure they are ok, get the nurse as soon as possible or get [RN-A]. While I was in there I did not hear any one coughing. I cannot remember hearing [R52] coughing. I do remember [R71] coughing this morning I turned

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around and did an assessment. I supervise the dining room for breakfast most days, I pass through the dining room at lunch 80 % of time and supper sometime. I have not had any training on dining rooms or feeding since starting here."

During interview on 12/3/15, at 10:09 a.m. DCS said all of the dietary staff are trained to do the Heimlich maneuver. Dietary staff do monitor only, if anyone required eating assistance nursing staff would help them. "I would expect a CLS or other nursing staff member to be in the dining room." Dietary staff are not trained to observe for other risks involved with eating.

During interview on 12/3/15, at 10:45 a.m. the administrator said we should have a minimum of one staff in dining room during meals.

On 12/3/15, at 1:16 p.m. CLS-E said, "When we bring residents to the dining room we give them liquids and tell kitchen they are here. We do not stay in the dining room until all the residents are up. I brought (R25) to the dining room this morning I gave thickened liquids and let the kitchen know."

R60 was observed on 12/2/15, at 7:40 a.m. to 7:59 a.m. during breakfast, several residents were observed in the dining room. The dietary aide was observed serve out beverages, bananas and breakfast plate. During that time noted staff come in and out of the dining room and residents were alone in the dining room except when dietary aide brought the food from the kitchenette and would retrieve back briefly leaving the residents who were eating unsupervised.
-At 7:59 a.m. R60 was observed resident coughing after taking the last bite of eggs, then

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| 2 830 | Continued From page 9<br>sneezed three times, then was able to cough some more and spit the eggs out of mouth into a napkin and some fell on the clothing protector. Resident then continued to take a bite of the toast. No facility staff were in the dining room at the time of the observation.<br>-At 8:02 a.m. dietary aide came out of the kitchenette and stood at the far table.<br><br>R60's care plan for nutrition dated 7/3/15, indicated resident history of dysphagia, but tolerate a regular texture diet currently. The care plan directed staff "Assist me with eating." R60's annual MDS dated 9/25/15, indicated resident required supervision with eating after set up.<br><br>R60's Nutritional Assessment dated 9/26/15, indicated resident was on a regular diet, had no chewing/swallowing concerns, had history of dysphagia, but tolerated a regular textured diet. The assessment also indicated factors that affected nutrition/hydration status included history of dysphagia and indicated "Needs assist with eating."<br><br>On 12/3/15, at 12:28 p.m. RN-A stated "The care plan should read she is variable from day to day and if she was tired staff will provide assistance." When asked if a staff person was supposed to be in the dining room when residents were being served breakfast and were eating RN-A stated "There should be someone around the dining room when residents are eating." When asked if R60 was safe to eat by herself in the dining room RN-A stated "I say if she is awake and fine she is able to do it fine. There has not been any issues."<br>-At 12:37 p.m. RN-A reviewed R60's chart indicated R60 did not have dysphagia as one of the listed active diagnoses in the physician most recent progress note dated 11/1/15. RN-A verified | 2 830 | | |

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the speech therapy evaluation and treatment plan dated 12/2/14, had indicated R60 was at high risk for aspiration pneumonia and/or chocking and required close supervision with oral intakes. When asked what her expectation was of her staff during meals RN-A stated resident was supposed to be supervised during meals if R60 had dysphagia. RN-A did not agree however that R60 had a diagnoses of dysphagia in spite it being listed even on the current physician orders.

On 12/3/15, at 1:27 p.m. via telephone the NP stated staff was supposed to be in the dining room during meal time to supervise residents and all other residents she thought. NP indicated she would have deferred to the recommendations speech therapy had indicated to provide supervision with meals as resident was at risk for aspiration pneumonia and choking Even though the family had declined to follow with diet consistency recommendation. NP further verified R60 had a diagnosis of dysphagia however had not been notified of any concerns with coughing.

Resident Dining policy dated November 2012, directed staff:
"I. The nurse is responsible to designate at least 1 nursing staff member to be physically present in the dining room until the meal had been completed.
A. Nurse monitors for adequate assistance, safety issues, and infection control practices, dignity of residents, proper positioning, adequate food intake, and resident behaviors needing attention. The nurse assists with feeding residents as needed..."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could train all staff and perform audits to ensure each resident

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| 2 830 | Continued From page 11<br>is receiving appropriate care during the meal service.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 850 | MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving<br><br>Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:<br>D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interview and document review, the facility failed to provide grooming for 1 of 3 residents (R4) who was dependent for activities of daily living (ADL) reviewed for ADL.<br><br>Findings include:<br><br>On 11/30/15, at 4:43 p.m. R4 was observed seated on the wheelchair in her room eyes closed. When approached R4 was observed to have multiple white facial hairs approximately quarter inch long (1/4) on her lower chin and on her cheeks.<br><br>On 12/1/15, at 8:17 a.m. when asked if the facial hairs bothered her R4 stated "Yes. I would like them removed the barber used to take them off for me" as she felt the hairs on her left cheek. When asked if the staff help me to remove them | 2 850 | R4 was given grooming assistance for facial hair on 12/3/15.<br><br>Facility wide audit on grooming was completed. Care plans were updated per individualized preferences.<br><br>The policy and procedure on Resident Care Grooming was reviewed.<br><br>Staff will be re-educated on the policy by 1/13/16.<br><br>Audits will be completed on 10% of residents weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring. | 1/13/16 |

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| 2 850 | Continued From page 12<br>on her bath day R4 stated, "They have not told me they would."<br><br>On 12/2/15, at 7:13 a.m. R4 was observed to be up and dressed. When approached and asked how she had slept R4 indicated "good." R4 stated the community life specialist (CLS)-A was really good to her. R4 was still observed still with multiple facial hairs around her mouth and cheeks. CLS-A cued R4 to brush her teeth after CLS-A wheeled R4 close to the sink R4 was observed brush the teeth and applied her dentures as CLS-A was straightening the bed. At 7:17 a.m. CLS-A was observed wet a wash towel then handed it to R4 to wash the face. At 7:18 a.m. CLS-A was observed comb R4's hair as she turned around and looked at R4's face never offered to remove the facial hair. At 7:19 a.m. CLS-A wheeled R4 out of the bathroom into the room by the bed, got R4 eye glasses from the dresser handed them to R4 to put them on and a Kleenex. At 7:21 a.m. CLS-A wheeled R4 out of the room to the dining room (DR) table. At 7:23 a.m. CLS-A brought R4 into the dining room and offered coffee still never offered to remove the facial hair. At 7:25 a.m. the household coordinator approached R4 said "good morning" looked at R4's face never offered to remove the visible facial hairs. At 7:47 a.m. another staff approach R4 provided condiments and spoke briefly to R4 never offered to remove the facial hairs which were visible. At 8:31 a.m. R4 wheeled out of the DR into the hallway. At 8:33 a.m. the household coordinator and another staff both approached R4 and offered to ride back to room. Both staff went into R4's room were observed and heard converse with R4 about her life/family door wide open at this time never offered to remove the facial hairs. At 9:20 a.m. to 9:25 a.m. registered nurse (RN)-C was observed completed wound | 2 850 | Clinical Director and/or designee will be responsible for ongoing compliance. | |

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care for R4 never offered to remove the facial hairs.

On 12/2/15, at 1:57 p.m. RN-C stated he would at least expect the CLS's who worked with him to provide residents with assistance for all cares required which included grooming, personal hygiene, dressing and eating as some residents need extensive assist with cares.

On 12/3/15, at 7:57 a.m. when approached R4 was still observed with multiple facial hairs on her lips and cheeks.

On 12/3/15, at 8:29 a.m. RN-A verified R4 had facial hairs. RN-A was overheard asked R4 if the hairs bothered here and R4 stated "Yes they do because I touch them." R4 asked RN-A to remove them for her and RN-A indicated she was going to get a razor to remove them. At 8:32 a.m. when asked what the expectation was to remove the chin hair, RN-A stated on bath days. RN-A provided the bath schedule which indicated R4's bath day was Thursday evening and when asked if the staff documented if facial hair had been removed RN-A stated "no they don't" as she indicated she was going to take care of it.

R4's diagnoses included glaucoma and abnormal posture obtained from Admission Record dated 12/3/15.

R4's ADL Care Area Assessment (CAA) dated 2/10/15, indicated resident required extensive assist with most ADL functions at this time.

R4's quarterly Minimum Data Set (MDS) 10/8/15, indicated R4 had intact cognition and required extensive assist with personal hygiene including shaving. Grooming care plan dated 10/9/15,

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| **SAINT THERESE AT OXBOW LAKE** | **5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443** |

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| 2 850 | Continued From page 14<br>indicated resident required extensive assist with grooming/hygiene related to debility and glaucoma. Goal "I want to participate as I am able in personal hygiene and remain neatly groomed." The care plan directed staff to provide extensive assist of one staff member for grooming tasks, hygiene and oral care.<br><br>On 12/3/15, at 9:44 a.m. the director of clinical services (DNS) stated she expected staff to provide grooming as directed by the care plan and the care guide sheets.<br><br>The Resident Care Grooming policy dated July 2014, indicated nursing staff was to provide assistance with grooming AM and PM according to resident needs.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff on performing activities of daily living (such as shaving) for residents. Also the director of nursing or designee could monitor for compliance.<br><br>TIME PERIOD FOR CORRECTIONL: Twenty-one (21) days. | 2 850 | | |
| 21535 | MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General<br><br>Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:<br>A. in excessive dose, including duplicate drug therapy;<br>B. for excessive duration;<br>C. without adequate indications for its use; or<br>D. in the presence of adverse consequences | 21535 | | 1/13/16 |

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| 21535 | Continued From page 15<br>which indicate the dose should be reduced or discontinued.<br>In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 1 of 5 residents (R25) had indications for the use of Seroquel (an antipsychotic drug used to treat various mental illness), including resident specific target behaviors related to psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), duloxetine delayed release (an antidepressant) and for Trazodone (an antidepressant medication) used for sleep.<br><br>Findings include:<br><br>R25's Social Service Review Forms dated 6/10/15, 6/16/15, 6/30/15, indicated no behaviors. Social Service Review Form dated 9/25/15, indicated R25 was noted to be very restless and attempted to get out of wheelchair on multiple occasions. R25 was also noted to be aggressive toward staff while attempting to provide cares on | 21535 | Behavior and Psychological Symptoms of Dementia and Psychotropic Medications and Monitoring Policy was reviewed and revised.<br><br>All nursing staff were re-educated on the policy by 1/13/16.<br><br>R25 chart was reviewed, resident passed away 12/18/15 on hospice care.<br><br>An audit was completed on all residents whom have psychotropic meds ordered and comprehensively assessed to ensure compliance.<br><br>Ongoing audits will be completed by the Clinical Director/designee to ensure compliance for 10% of the facility and ongoing per RAI schedule. Findings will be reported quarterly at the QAA. | |

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two separate occasions.

Psychotropic Drug use Care Area Assessment dated 7/2/15, indicated adverse side effect of antidepressants exhibited by R25 were anxiety and delirium. The adverse side effect of antipsychotics exhibited by R25 were lethargy, depression and delirium. The adverse side effect of anxiolytics (antianxiety) exhibited by R25 included sedation, disturbances of gait, delirium and depression.

The progress notes were reviewed from August 2015 going forward and the following was noted: R25 started on Seroquel on 8/17/15. A review of R25's progress notes indicated R25 fell on 8/23/15, at 6:55 p.m. and had no injury, 8/28/15, at 7:20 a.m. with skin tears to left elbow, 9/7/15, at 5:45 p.m. with a skin tear to right forearm, 9/18/15, at 9:30 a.m. with no injury, and on 10/3/15, at 1:15 p.m. with no injury.

R25 quarterly MDS dated 9/25/15, indicated R25 was severely cognitively impaired and required assistance with activities of daily living (ADLs). The Quarterly MDS indicated R25's diagnoses included heart failure, chronic obstructive pulmonary disease, depression and dementia. In addition, the quarterly MDS indicated R25 was not experiencing hallucinations, delusions or any behaviors.

R25's care plan printed 10/7/15, instructed staff: BEHAVIOR: "I have a history of making suicidal statements and attempting to harm myself. I also have a history of being verbally aggressive with staff and strike out at them physically. I have a history of expressions of sadness, isolation, and refusing meals. I have been evaluated by psychology and my behaviors are managed

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currently. I take trazodone to manage my depression and help increase my hours of restful sleep and appetite. I have become more restless/agitated/combative with cares and now take Seroquel to manage my symptoms. Interventions included administer psychotropic medication per MD/NP [medical doctor/nurse practitioner] order, monitor for adverse effects from trazodone, Seroquel and Cymbalta. Monitor hours of sleep every shift. Provide dark, quiet environment at night and close door."

MOOD: "My diagnosis of depression and insomnia places me at risk for symptoms of depression and anxiety. At risk for confusion and altered mood. At risk for having a negative outlook and experiencing mood swings. I have episodes of delusions/hallucinations due to altered mental status. Interventions included all staff will offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a light box in my room that turns on in the morning and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark, quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety."

The Physician Order Summary signed 11/17/15, indicated R25 was to receive Seroquel 25 milligrams (mg) one time a day and Seroquel 50 mg two times a day for anxiety, agitation and delusions. R25 could also receive Seroquel 25 mg every six hours as needed (PRN) for agitation. The Physician Order Summary also indicated R25 was to receive duloxetine delayed

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release capsule 60 mg every day for depression and Trazodone 25 mg for insomnia.

Behavior symptoms:
A review of Medication Administration Record (MAR) Sheets and Target Behavior Form (TBF) Sheets from September through November 2015 noted the following:

September 2015
MAR-Seroquel 25 mg every (q) 6 hours as needed (prn) for agitation was given 17 times in September 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only twice and nonpharmacological interventions attempted prior to medication administration were charted only once in the Progress Notes which were reviewed from August 2015 going forward or the MAR.

TBF dated Sep-15 for Seroquel: Frequent movements: indicated R25 had 17 attempts to get up/down (the TBF lacked information as to where the resident would get/down from) and six delusions of the past. R25 experienced undocumented side effects on five of 30 days. There was a check mark in the box which indicated a side effect, but it was unknown what the side effect was, and if medical intervention would be necessary. The check marks and plus signs were not explained in the progress notes, and did not match the administration times. The TBF lacked specific target for the antipsychotic medication.

October 2015
MAR-Seroquel 25 mg q 6 hours prn for agitation was given 13 times in October 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only once and

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nonpharmacological interventions attempted prior to medication administration were charted only once in the progress notes or medication record.

TBF-dated Sep-15 for October: Agitation (getting up/down) indicated R25 had nine attempts and delusions of the past indicated R25 had nine delusions and did not experience side effects.

November 2015
MAR-Seroquel 25 mg q 6 hours as needed (prn) for agitation was given three times in November 2015. Prior to PRN Seroquel administration, behaviors warranting medication were not charted. Nonpharmacological interventions attempted prior to medication administration were not charted in the Progress Notes or MAR.

TBF-dated November 2015 for Seroquel: Frequent movements, attempting to get up/down indicated R25 had nine attempts and delusions/hallucinations indicated R25 had one delusions/hallucinations and did not experience any side effects.

The Cardinal Health package insert and label information dated May 2, 2013, for Seroquel lists Schizophrenia and Bipolar Disorder as indication for use. It also indicates "Seroquel is not approved for the treatment of patients with dementia related psychosis." Package insert also indicated, "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose."

Non pharmacological interventions identified on care plan printed 10/7/15, indicated all staff will

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offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a light box in my room that turns on in the morning and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark, quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety." All interventions except light box were in place prior to starting on Seroquel.

Mood symptoms:
TBF- dated Sep-15 for duloxetine delayed release: angry outbursts indicated R25 had four outbursts and experienced an undocumented side effect once.
TBF-dated October-15 for duloxetine delayed release: angry outbursts indicated R25 had one outburst and experienced an undocumented side effect once.
TBF-dated November 2015, for duloxetine delayed release: angry outbursts indicated R25 did not have any outbursts and had restlessness four times. R25 did not experience any side effects.

Eli Lilly and Company prescribing information dated June 2015, for duloxetine delayed release lists major depression, generalized anxiety disorder, Diabetic peripheral neuropathic pain, Fibromyalgia, Chronic musculoskeletal pain as the indication for usage. Angry outbursts was not listed as an indication for use of Cymbalta.

Sleep:
TBF- dated Sep-15 for Remeron (an antidepressant): inability to sleep indicated R25

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had trouble four evenings and did not experience side effects.
TBF-dated October-2015, for Trazodone: inability to sleep indicated R25 had trouble one day shift. Refusals of cares two times. R25 experienced side effects once.
TBF-dated November 2015, for Trazodone: inability to sleep indicated R25 did not have any trouble sleeping. R25 did not experience any restlessness and did not experience side effects.

Organon Pharmaceuticals USA Remeron package insert and label information dated October 30 2012, lists major depression as the indication for usage.

PD-RX Pharmaceuticals Inc. Trazodone package insert and label information dated March 21 3008, lists depression as the indication for usage. R25's significant MDS dated 6/30/15, and quarterly MDS dated 9/25/15, did not indicate R25 was having any trouble sleeping. Refusal of care was not listed as an indication of use for Remeron or Trazodone.

Even though the facility had identified target behaviors for the psychotropic medications, the target behaviors lacked appropriate specific behaviors for each of the psychotropic categories. In addition, the medications that were administration lacked non-pharmacological interventions and monitoring of adverse effects for the use of the psychotropic medication.

During interview on 12/0/15, at 2:23 p.m. clinical life specialist (CLS)-D stated, "We do not write down the behaviors, the nurses do. R25 could be physical, might try to hit staff or scream get out of my room. When doing that, we will call nurse to try to explain what we were doing. If it does not

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work, we would follow what nurse says, most likely leave him and reapproach later."

On 12/0/15 at 2:45 p.m. registered nurse (RN)-D stated, "We monitor residents on antipsychotics, watch how they react with cares or with other residents and daily activities. We watch for side effects, physical changes and update nurse practitioner as necessary. We monitor for side effects every day. I am not sure about orthostatic blood pressures or labs. Only the nurse's chart in the behavior book, the nursing assistants tell the nurses."

On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same."

On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 "had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo."

On 12/4/15, at 8:32 a.m. RN-E stated for antipsychotics "We use the Psychotropic Medication Quarterly Review. I don't see any analysis that shows if this medication is working. I don't see anything in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual

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sig [significant] change and quarterly."

On 12/4/15, at 8:46 a.m. the director of clinical services (DCS) stated, "I would expect them to chart the reason for administering a PRN in the electronic medication record. I would expect them to complete the assessments and I would expect the assessments to contain analysis of the effectiveness of the medication side effects and need for continued use."

Psychotropic Medications and Monitoring dated January 2013 instructed staff all residents receiving a medication to alter a behavior are to have an approved diagnosis, reason for use, informed consent prior to initiation of medication, a therapeutic goal and symptoms monitored. The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have been attempted.

"IV. Target Behavior monitoring will be initiated for residents that have orders for any medication with the primary purpose to change or alter a behavior, and/or sleep pattern."
B. "Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive etc. need further explicit behaviors identified."
V. Side effect monitoring will be completed for all residents with psychotropic medication orders. Orthostatic hypotension will be assessed monthly and document on TAR (Treatment administration record).

SUGGESTED METHOD OF CORRECTION:
The director of nursing could in-service staff responsible for pain medication administration regarding rating pain, trying non-pharmacological interventions and assessing if pain medication

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| 21535 | Continued From page 24<br>was affective for pain relief.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21535 | | |
| 21540 | MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring<br><br>Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the pharmacist failed to ensure 1 of 5 residents (R25) had indications for the use of Seroquel (an antipsychotic drug used to treat various mental illness), including resident specific target | 21540 | Clinical Director reviewed facility process with Pharmacy Consultant to ensure all residents have individualized consults completed per guidelines. | 1/13/16 |

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| 21540 | Continued From page 25<br>behaviors related to psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality), duloxetine delayed release (an antidepressant) and for Trazodone (an antidepressant medication) used for sleep. In addition, the facility failed to respond to ensure consultant pharmacist recommendations were acted upon for R25.<br><br>Findings include:<br><br>R25's Social Service Review Forms dated 6/10/15, 6/16/15, 6/30/15, indicated no behaviors. Social Service Review Form dated 9/25/15, indicated R25 was noted to be very restless and attempted to get out of wheelchair on multiple occasions. R25 was also noted to be aggressive toward staff while attempting to provide cares on two separate occasions.<br><br>Psychotropic Drug use Care Area Assessment dated 7/2/15, indicated adverse side effect of antidepressants exhibited by R25 were anxiety and delirium. The adverse side effect of antipsychotics exhibited by R25 were lethargy, depression and delirium. The adverse side effect of anxiolytics (antianxiety) exhibited by R25 included sedation, disturbances of gait, delirium and depression.<br><br>The progress notes were reviewed from August 2015 going forward and the following was noted: R25 started on Seroquel on 8/17/15. A review of R25's progress notes indicated R25 fell on 8/23/15, at 6:55 p.m. and had no injury, 8/28/15, at 7:20 a.m. with skin tears to left elbow, 9/7/15, at 5:45 p.m. with a skin tear to right forearm, 9/18/15, at 9:30 a.m. with no injury, and on 10/3/15, at 1:15 p.m. with no injury. | 21540 | Behavior and Psychological Symptoms of Dementia and Psychotropic Medications and Monitoring Policy was reviewed and revised.<br><br>R25 chart reviewed and resident passed away on 12/18/15.<br><br>A facility audit was completed on Pharmacy consult reviews to ensure compliance with responses.<br><br>An audit was completed on all residents whom have psychotropic meds ordered and comprehensively assessed to ensure compliance.<br><br>Clinical Coordinators re-educated on ensuring that consults get completed timely by 1/13/16. | |

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R25 quarterly MDS dated 9/25/15, indicated R25 was severely cognitively impaired and required assistance with activities of daily living (ADLs). The Quarterly MDS indicated R25's diagnoses included heart failure, chronic obstructive pulmonary disease, depression and dementia. In addition, the quarterly MDS indicated R25 was not experiencing hallucinations, delusions or any behaviors.

R25's care plan printed 10/7/15, instructed staff: BEHAVIOR: "I have a history of making suicidal statements and attempting to harm myself. I also have a history of being verbally aggressive with staff and strike out at them physically. I have a history of expressions of sadness, isolation, and refusing meals. I have been evaluated by psychology and my behaviors are managed currently. I take trazodone to manage my depression and help increase my hours of restful sleep and appetite. I have become more restless/agitated/combative with cares and now take Seroquel to manage my symptoms. Interventions included administer psychotropic medication per MD/NP [medical doctor/nurse practitioner] order, monitor for adverse effects from trazodone, Seroquel and Cymbalta. Monitor hours of sleep every shift. Provide dark, quiet environment at night and close door."

MOOD: "My diagnosis of depression and insomnia places me at risk for symptoms of depression and anxiety. At risk for confusion and altered mood. At risk for having a negative outlook and experiencing mood swings. I have episodes of delusions/hallucinations due to altered mental status. Interventions included all staff will offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a

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light box in my room that turns on in the morning and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark, quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety."

The Physician Order Summary signed 11/17/15, indicated R25 was to receive Seroquel 25 milligrams (mg) one time a day and Seroquel 50 mg two times a day for anxiety, agitation and delusions. R25 could also receive Seroquel 25 mg every six hours as needed (PRN) for agitation. The Physician Order Summary also indicated R25 was to receive duloxetine delayed release capsule 60 mg every day for depression and Trazodone 25 mg for insomnia.

Behavior symptoms:
A review of Medication Administration Record (MAR) Sheets and Target Behavior Form (TBF) Sheets from September through November 2015 noted the following:

September 2015
MAR-Seroquel 25 mg every (q) 6 hours as needed (prn) for agitation was given 17 times in September 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only twice and nonpharmacological interventions attempted prior to medication administration were charted only once in the Progress Notes which were reviewed from August 2015 going forward or the MAR.

TBF dated Sep-15 for Seroquel: Frequent movements: indicated R25 had 17 attempts to

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get up/down (the TBF lacked information as to where the resident would get/down from) and six delusions of the past. R25 experienced undocumented side effects on five of 30 days. There was a check mark in the box which indicated a side effect, but it was unknown what the side effect was, and if medical intervention would be necessary. The check marks and plus signs were not explained in the progress notes, and did not match the administration times. The TBF lacked specific target for the antipsychotic medication.

October 2015
MAR-Seroquel 25 mg q 6 hours prn for agitation was given 13 times in October 2015. Prior to PRN Seroquel administration, behaviors warranting medication were charted only once and nonpharmacological interventions attempted prior to medication administration were charted only once in the progress notes or medication record.

TBF-dated Sep-15 for October: Agitation (getting up/down) indicated R25 had nine attempts and delusions of the past indicated R25 had nine delusions and did not experience side effects.

November 2015
MAR-Seroquel 25 mg q 6 hours as needed (prn) for agitation was given three times in November 2015. Prior to PRN Seroquel administration, behaviors warranting medication were not charted. Nonpharmacological interventions attempted prior to medication administration were not charted in the Progress Notes or MAR.

TBF-dated November 2015 for Seroquel: Frequent movements, attempting to get up/down indicated R25 had nine attempts and delusions/hallucinations indicated R25 had one

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delusions/hallucinations and did not experience any side effects.

The Cardinal Health package insert and label information dated May 2, 2013, for Seroquel lists Schizophrenia and Bipolar Disorder as indication for use. It also indicates "Seroquel is not approved for the treatment of patients with dementia related psychosis." Package insert also indicated, "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose."

Non pharmacological interventions identified on care plan printed 10/7/15, indicated all staff will offer TLC [tender loving care], reassurance, and 1:1 prn. Assess for reasons behind my symptoms and notify MD/NP. I have a light box in my room that turns on in the morning and shuts off at night. Involve spiritual care. Look to family for reassurance prn, Open shades and turn light on during the day prn. Provide a dark, quiet environment at night and close his door. Social service to visit 1:1 prn to assist with questions/concerns, encourage activity, offer socialization and observe for symptoms of depression/anxiety." All interventions except light box were in place prior to starting on Seroquel.

Mood symptoms:
TBF- dated Sep-15 for duloxetine delayed release: angry outbursts indicated R25 had four outbursts and experienced an undocumented side effect once.
TBF-dated October-15 for duloxetine delayed release: angry outbursts indicated R25 had one outburst and experienced an undocumented side

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effect once.
TBF-dated November 2015, for duloxetine delayed release: angry outbursts indicated R25 did not have any outbursts and had restlessness four times. R25 did not experience any side effects.

Eli Lilly and Company prescribing information dated June 2015, for duloxetine delayed release lists major depression, generalized anxiety disorder, Diabetic peripheral neuropathic pain, Fibromyalgia, Chronic musculoskeletal pain as the indication for usage. Angry outbursts was not listed as an indication for use of Cymbalta.

Sleep:
TBF- dated Sep-15 for Remeron (an antidepressant): inability to sleep indicated R25 had trouble four evenings and did not experience side effects.
TBF-dated October-2015, for Trazodone: inability to sleep indicated R25 had trouble one day shift. Refusals of cares two times. R25 experienced side effects once.
TBF-dated November 2015, for Trazodone: inability to sleep indicated R25 did not have any trouble sleeping. R25 did not experience any restlessness and did not experience side effects.

Organon Pharmaceuticals USA Remeron package insert and label information dated October 30 2012, lists major depression as the indication for usage.

PD-RX Pharmaceuticals Inc. Trazodone package insert and label information dated March 21 3008, lists depression as the indication for usage. R25's significant MDS dated 6/30/15, and quarterly MDS dated 9/25/15, did not indicate R25 was having any trouble sleeping. Refusal of care was

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not listed as an indication of use for Remeron or Trazodone.

Even though the facility had identified target behaviors for the psychotropic medications, the target behaviors lacked appropriate specific behaviors for each of the psychotropic categories. In addition, the medications that were administration lacked non-pharmacological interventions and monitoring of adverse effects for the use of the psychotropic medication.

The Undated Pharmacy Visit Log indicated the consultant pharmacist reviewed R25's chart and made recommendations as indicated:
-7/23/15, "labs in chart, hitting x1, agitation x1, AIMS [Abnormal Involuntary Movement Scale] done non-significant irregularity"
-8/28/15, "res [resident] stable, morphine increased, non-significant irregularity"
-9/30/15, "1 hour of agitation, seroquel increased, non significant irregularity"
-10/23/15, "Dx [diagnosis] for delusional disorder, non significant irregularity"
-11/16/15, "? ortho bp [blood pressure]-unable res stable non significant irreg [irregularity]"
Copy of Pharmacy Visit Log was requested and was not provided. The pharmacist did not address the use of non-pharmacological interventions prior to the use of the medications and the lack of the appropriate target behavior/symptoms for use of the psychotropic medications.

During interview on 12/0/15, at 2:23 p.m. clinical life specialist (CLS)-D stated, "We do not write down the behaviors, the nurses do. R25 could be physical, might try to hit staff or scream get out of my room. When doing that, we will call nurse to try to explain what we were doing. If it does not

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work, we would follow what nurse says, most likely leave him and reapproach later."

On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same."

On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 "had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo."

On 12/4/15, at 8:32 a.m. RN-E stated for antipsychotics "We use the Psychotropic Medication Quarterly Review. I don't see any analysis that shows if this medication is working. I don't see anything in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual sig [significant] change and quarterly."

On 12/4/15, at 8:46 a.m. the director of clinical services (DCS) stated, "I would expect them to chart the reason for administering a PRN in the electronic medication record. I would expect them to complete the assessments and I would expect the assessments to contain analysis of the effectiveness of the medication side effects and need for continued use."

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During interview on 12/4/15, at 9:32 a.m. pharmacist stated, "We started coming to the facility in July. I will make a note on the pharmacy log every time I check the chart. If I write non significant irregularity on the log I will write a pharmacy recommendation and expect a response by next visit. A request will be rewritten if no response. For residents on an antipsychotic I expect an AIMs when the medication is started, and every six months. I would expect orthostatic blood pressures at minimum quarterly although I believe the facility is doing them monthly. I would expect to see documentation in the chart of usage of non pharmacological interventions. I would expect to see them document the behaviors that triggers use of a prn and it's effectiveness The diagnosis for R25 is not what I would choose but it is appropriate.

Psychotropic Medications and Monitoring dated January 2013 instructed staff all residents receiving a medication to alter a behavior are to have an approved diagnosis, reason for use, informed consent prior to initiation of medication, a therapeutic goal and symptoms monitored. The drug chosen should be administered in the lowest dose possible only after non pharmaceutical interventions to control/alter the behavior have been attempted.

"IV. Target Behavior monitoring will be initiated for residents that have orders for any medication with the primary purpose to change or alter a behavior, and/or sleep pattern."
B. "Behaviors must be specific and appropriate to the drug ordered. Agitation, anxiety, abusive etc. need further explicit behaviors identified."
V. "Side effect monitoring will be completed for all residents with psychotropic medication orders. Orthostatic hypotension will be assessed monthly

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| 21540 | Continued From page 34<br>and document on TAR [Treatment Administration Record]."<br><br>A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise the policies and procedures related medication monitoring. DON or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21540 | | |
| 21615 | MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII<br><br>Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 2 of 5 narcotic boxes were double locked to prevent diversion. This had the potential to affect the 10 residents who had narcotic medications stored in cabinet located in the nursing station.<br><br>Findings include:<br><br>Rhode House | 21615 | Controlled Substance policy was reviewed, all Licensed staff were re-educated on current policy by 1/13/16.<br><br>Audits will be completed to ensure that the narcotic medications are double locked per policy weekly x 90 days by the Clinical Director/designee and findings will be reported quarterly at the QAA. | 1/13/16 |

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On 11/30/15, at 12:11 p.m. during a medication observation for R25, registered nurse (RN)-B was observed open a cabinet above the sink located in the back of the nursing station. Upon opening the cabinet using a small key, two red boxes were observed stored on each of the shelves. The two boxes labelled ProBox were observed to have pad locks that were not locked even though RN- indicated the facility used those to store narcotics.

On 11/30/15, at 6:07 p.m. during a random observation on the Rhode House neighborhood, two red boxes were observed when a staff member unlocked a cabinet at the nurse ' s station. The boxes were observed with padlocks on both but the padlocks were not locked.

On 12/1/15, at 8:39 a.m. registered nurse (RN)-C stated residents who received Tramadol and narcotic had those stored at the nursing station in the cabinet and were supposed to be double locked.

On 12/3/15, at 6:22 a.m. licensed practical nurse (LPN)-B was observed open the cabinet above the sink where the narcotic boxes were stored. LPN- reached out grabbed both red narcotic boxes off the shelves and set them on top of the counter and both had the padlock but was not locked, opened one after the other and counted the narcotics with the night LPN-A. At 6:25 a.m. LPN-B put the boxes back into the cabinet and locked it. At 6:26 a.m. surveyor requested LPN-B to open the cabinet and RN verified both red narcotic boxes padlocks were left unlocked. When asked if the padlocks were supposed to be locked LPN-B acknowledged the padlocks were supposed to be double locked even though the cabinet was locked as narcotic were stored in the boxes.

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| 21615 | Continued From page 36<br><br>On 12/3/15, at 2:30 p.m. the director of clinical services stated "I would expect them to follow the double locked narcotic policy" when asked her expectation of staff nurses.<br><br>On 12/4/15, at 7:48 a.m. LPN-C stated the cabinets are supposed to be kept locked because the red boxes are narcotic boxes. LPN-C the narcotic boxes are supposed to be locked with the padlocks. LPN-C indicated one of the box had Morphine, Dilaudid, Norco, Clonopin and Methadone.<br><br>Medications: Controlled Substance policy dated January 2015, directed staff "F. All Controlled Drugs will be stored in a locked box in a locked cabinet or medication room."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and or designees could assure the narcotic box is double locked, that staff are trained regarding the proper procedure and that the system is monitored, assessed and evaluated to assure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21615 | | |
| 21665 | MN Rule 4658.1400 Physical Environment<br><br>A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.<br><br>This MN Requirement is not met as evidenced by: | 21665 | | 1/13/16 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 21665 | Continued From page 37<br><br>Based on observation, interview and document review, the facility failed to ensure environment was maintained in a sanitary manner and was in good repair for 13 of 35 residents.<br><br>Findings include:<br><br>On 12/3/15, at 9:02 a.m. an environmental tour was completed with executive director, assistant administrator, administrative intern, housekeeping supervisor, and plant operations director.<br><br>R25's bathroom toilet front had been observed stained yellow.<br><br>During tour, housekeeping supervisor (HS) stated bathroom toilets and entire rooms get cleaned once a week and indicated the room may be cleaned either today or tomorrow. He further stated staff calls if they had an immediate concern. In addition, they have access to the housekeeping closet supplies after hours.<br><br>R25's Quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R25 had severe cognitive impairment and required extensive one to two person assistance with most activities of daily living (ADL's).<br><br>R60's toilet riser observed with multiple large bowel movement smears.<br><br>During tour, HS confirmed smears on toilet riser and stated it had not been cleaned and would find out when it would be cleaned. Plant operations director (POD) stated he would repair wall entryway scratches and wall scratches near the bed. | 21665 | R25, R60, R40, R52, R44, and R71 bathrooms were cleaned and sanitized.<br><br>R25, R60, R44, R9, R24, R19, and R45 walls in resident room were repaired.<br><br>R52 scooter was cleaned.<br><br>All resident rooms were reviewed for necessary repairs. Repairs were completed.<br><br>All resident rooms cleaning schedules were reviewed and updated to include increased cleanings of resident bathrooms.<br><br>The Department Housekeeping policy, Micromain scheduling policy and preventative maintenance inspections policy were reviewed.<br><br>Staff education on environment cleaning and maintenance will be completed on 1/13/16.<br><br>Environmental audits will be completed on 15% of resident rooms weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring.<br><br>Plant Operations Director and/or designee is responsible for ongoing compliance. | |

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| | 27752 | A. BUILDING: ______ B. WING ______ | 12/04/2015 |

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| 21665 | Continued From page 38<br>R60's annual MDS assessment dated 9/25/15, indicated R60 had moderate cognitive impairment and required extensive one to two person assistance with most ADL's.<br><br>R40's bathroom toilet riser was observed with bowel movement smears on the seat.<br><br>On 12/3/15, at 9:42 a.m. HS stated he would find out when the room was scheduled for cleaning and indicated toilet risers, surfaces, all around toilets were cleaned. In addition, executive director (ED) stated it would be cleaned.<br><br>R40's quarterly MDS assessment dated 10/8/15, indicated R40 did not have a cognitive assessment and required extensive one person assistance with most ADL's.<br><br>R52's scooter's foot area was observed to be stained yellow.<br><br>On 12/3/15, at 9:52 a.m. HS stated scooters were privately owned and indicated R44 recently moved to facility. ED stated it would be cleaned.<br><br>R52's 14 day MDS assessment dated 10/21/15, indicated R52 was cognitively intact and required extensive one to two person assistance with most ADL's.<br><br>R44's room near bed was observed to have urine odor, there were several four to six inch light colored stains were dripping down room wall near entryway, a short gray line on the wall near head of bed, and bathroom floor had red/brown colored stains on it.<br><br>On 12/3/15, at 9:32 a.m. POD stated gray wall line was from wheelchair and would be repaired. | 21665 | | |

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| 21665 | Continued From page 39<br>ED stated stains would be cleaned and HS stated wall would be spot painted.<br><br>R44's quarterly MDS assessment dated 11/15/15, indicated R44 was cognitively intact and required one to two person assistance with most ADL's.<br><br>R25's oxygen tubing had been observed on the floor and several vertical lines on wall across from sink in entryway. ED stated these would be repaired.<br><br>R25's Quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R25 had severe cognitive impairment and required extensive one to two person assistance with most activities of daily living (ADL's).<br><br>R9's room observed with long scratch marks on walls near entryway. POD stated they would be repaired.<br><br>R9's annual MDS assessment dated 9/4/15, indicated R9 had moderate cognitive impairment and required extensive one to two person assistance with most ADL's.<br><br>R24's room observed with long wall scratches near entryway.<br><br>On 12/3/15, at 9:41 a.m. POD stated they would be repaired.<br><br>R24's annual MDS assessment dated 8/25/15, indicated R24 was cognitively intact and required extensive one person assistance with most ADL's.<br><br>R19's admission MDS dated 9/9/15, indicated R19 was cognitively intact and required extensive | 21665 | | |

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| 21665 | Continued From page 40 | 21665 | | |

one to two person assistance with most ADL's.

On 11/30/15, at 6:27 p.m. R19's bedroom wall was observed with long scratch mark in entryway. On 12/3/15, at 9:45 a.m. POD stated it would be repaired.

R19's admission MDS dated 9/9/15, indicated R19 was cognitively intact and required extensive one to two person assistance with most ADL's.

R71's annual MDS assessment dated 8/28/15, indicated R71 had severe cognitive impairment and required extensive one to two person assistance with most ADL's.

On 12/1/15, at 8:40 a.m. R71's bathroom wall observed with black line across from sink and several gouges on wall.

On 12/3/15, POD stated repairs would be made.

R45's bathroom wall observed with gouges in it.

POD stated it would be repaired.

R45's annual MDS assessment dated 8/25/15, indicated R45 was cognitively intact and required extensive one person assistance with most ADL's.

On 12/3/15, at 9:21 a.m. ED stated before Thanksgiving they were going to begin weekly building walk-through environmental tours. Previously it was done on an as needed basis. HS stated he routinely did daily building walk-through's with staff. He also did weekly and monthly building walk-through's with his supervisors.

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| 21665 | Continued From page 41<br><br>On 12/3/15, at 9:26 a.m. POD stated he did periodic painting maintenance, including any reported nursing and housekeeping staff concerns. He stated the facility used Micromain system for maintenance. Staff entered a work order and maintenance picked up and resolved issues.<br><br>On 12/3/15, at 10:40 a.m. ED stated she did not think it acceptable that room toilets were cleaned only once a week. She further stated that was the reason for housekeeping closets on each unit, to enable staff to clean a toilet when it was dirty.<br><br>On 12/3/15, at 11:52 a.m. HS stated community life specialists (CLS) should be spot cleaning in between weekly room cleanings.<br>On 12/3/15, at 12:25 p.m. POD stated he did daily walk-through's to observe for any issues.<br>On 12/4/15, at 8:50 a.m. registered nurse (RN)-C, stated if he had a housekeeping concern he would call the HS and report it. If call lights were not working or he had another maintenance concern, he would update the clinical coordinator and maintenance.<br>12/4/15 at 8:55 a.m. CLS-(C), stated if she had a housekeeping or maintenance concern, she would call housekeeping or maintenance.<br><br>Micromain scheduling policy dated 1/16/15, indicated "policy: to ensure that all work orders are attended to in a timely manner. Purpose: Micromain work orders need to be timely and all maintenance staff need to have clear communication regarding the status of work orders and who is working on the work order so none are missed for periods of time."<br>Work order request - building maintenance and repairs policy dated 8/7/07, indicated "policy: requests for repair work orders will be routed | 21665 | | |

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| 21665 | Continued From page 42<br>through Micromain software system." Preventative maintenance inspections policy dated 9/10, indicated "plant operations staff will conduct regular inspections of the facility to identify maintenance issues and provide repair services to remedy all issues. Purpose: to maintain a sanitary, orderly and comfortable interior. Procedure: D) all areas for inspections will be scheduled on a quarterly basis. E) follow-up random audits will be conducted by the plant operations director on a quarterly basis to ensure proper completion and quality." Department Housekeeping policy dated 10/15/11, policy indicated "resident rooms will be cleaned on a regular basis."<br><br>SUGGESTED METHOD OF CORRECTION: The director of facility operations could review and revise the policies, educate maintenance staff and identify trends of repeated building disrepair. The director of facility operations could work with the director of nursing (DON) to ensure staff are reporting environmental issues appropriately.<br><br>Time Period for Correction: Twenty-one (21) days. | 21665 | | |